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**PARTNERSHIP, POWER AND POLITICS:
FEMINIST PERCEPTIONS OF MIDWIFERY PRACTICE**

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ABSTRACT

This thesis provides an interpretative critique of the partnership of a group of independent midwives and their clients in urban New Zealand. A theoretical basis grounded in the principles of feminism but incorporating aspects of critical social science and postmodernism underpins both the methodological approach and analysis of data. The major concepts of subjectivity, power/knowledge and praxis have been utilised as tools for analysis of data, primarily collected through semi-structured interviews.

Results of this study showed that while the partnership of midwife and client became increasingly intense as each pregnancy progressed, and participants reported that it was important that clients knew their midwives prior to labour, feelings of intimacy and trust only emerged during and after labour. Midwives in this study were aware of the power they had and the potential for abuse of this power despite the notion of partnership.

It is argued that the reflexive processes involved with this research have motivated the participants to become aware that their knowledge and actions are shaped by aspects of the dominant social order. While collective political action by midwives and clients with a view to overcoming this was not fully demonstrated in this study, it is suggested that by engaging in this research there may be ongoing emancipatory effects for the participants and other midwives.

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PREFACE

This thesis is written entirely in the first person. Initially this felt somewhat uncomfortable, as academic writers rarely use the personal pronoun "I" for reasons of maintaining objectivity. However, as noted by Reason (1981) the concept of objectivity becomes redundant as researchers move from a controlling position to that of a facilitator. Sandelowski (1993) also points out that the loss of objectivity need not mean the loss of rigour.

Feminist researchers such as Duffy (1985) and Webb (1992) have further developed the ideas proposed by Reason and have suggested that the use of the third person is inappropriate in feminist research in which reflexivity between the researcher and participants is a key concept. Such reflexivity is particularly appropriate in this study which focuses on subjectivities and relationships.

It is also equally appropriate that the participants are acknowledged and although for reasons of confidentiality it is not possible to name these participants, pseudonyms approved by each, rather than initials or codes have been used. This helps to maintain the personhood of each participant and is in keeping with feminist thought.

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CHAPTER ONE

Introduction and Overview

This study was initially conceived shortly after August 1990 when section 54 of the 1977 Nurses Act was amended by Government, to allow midwives in New Zealand to take responsibility for the care of a woman throughout pregnancy, labour and post-natal period. This was an area which, since 1971, had been legally restricted to medical practitioners¹ although for many years prior to this the practice setting of midwives in New Zealand had mainly been within hospitals. Here they worked alongside nurses, with whom there was little differentiation in terms of their expected duties. Midwives, therefore, like nurses had become entrenched in rigidly defined structures which were controlled by the medical profession and bureaucratic regimes.

The enactment of the 1990 legislation was hailed by the then Minister of Health, Helen Clark, as offering, "greater choice in childbirth services to pregnant women and their families" (Department of Health, 1990, p. 3). However, the legislation was simply the vehicle in which change could occur; it was the challenge for midwives to foster creative ways of practising.

Outlining the problem

Since the 1990 Amendment to the Nurses Act was enacted, midwives throughout New Zealand have taken advantage of the changes to work independently of, or to renegotiate their relationship with the medical

¹ In this thesis, medical practitioner refers to all physicians providing maternity services while general practitioner refers to family physicians.

profession. There are several group midwifery practices in the larger towns and cities of New Zealand which provide continuity of care for women based upon the "Know your midwife" scheme outlined by Flint and Poulengris (1987). Other midwives continue to work alone, providing domiciliary care, with or without a general practitioner (GP), while others still have negotiated contracts with Crown Health Enterprises to provide DOMINO² type care.

As one of the first midwives to engage in independent practice following the law change, I enjoyed the opportunity to undertake both home and DOMINO births. The area in which I practised was fairly isolated and the clients generally Maori women and their *whanau*³. For most of the clients with whom I worked I was the sole health care provider but occasionally I shared the pre-natal care with one of the town's general medical practitioners. The births were not attended by medical practitioners. Women who experienced complications in the pre-natal period were referred to the nearest obstetrician and on the very rare occasions when complications occurred in labour were transferred to one of two base hospitals, by ambulance or helicopter.

The arrangements in this town appeared satisfactory to most clients, myself and the general practitioners. I enjoyed a collegial relationship with the latter and we often shared informal discussions on topics relevant to clients in my care, and if a second opinion was needed this was generally willingly given.

Working in isolation, however, increased the necessity for midwifery contact from outside the area and at first I shared with interest the development of many midwifery initiatives (refer Chapter Two pp. 17-

2 A commonly used acronym for Domiciliary Midwife In and Out of hospital.

3 The Maori conceptualisation of the extended family.

27 for more details). While these initiatives are continuing throughout the country, in some cases the excitement was replaced by a gradual feeling of disquiet as I began to see some of the unintended consequences of the law change which were later documented by Lovell and Virtue (1991).

Midwives who were leaving the hospital service, initially in the more populated areas were often working solely in shared care arrangements with doctors. Not only did this permit medical domination over childbearing women and midwives to continue but also it led to accusations of midwives "blowing the budget" as both parties could claim the costs of all care (within the Department of Health schedule) that they had carried out.

However, and more worrying, in terms of client care, was that such relationships between midwives and doctors often led to the acceptance of a higher client workload than midwives could comfortably manage according to the New Zealand College of Midwives' guidelines of 50 to 60 births per year. In turn, this necessitated an adherence by those midwives concerned to the medical model of childbirth, whereby it is the professional who is the power-holder and the client not encouraged to participate as a partner in her care (Fisher, 1986). This has led to critics of the law change suggesting that midwives are just like doctors while midwives who are practising within a midwifery framework according to Rothman (1982) argue that this is most certainly not the case; that the chief distinction is that women who choose midwifery care are an integral part of the decision making.

So while the law change ensured that there were more choices available for midwifery practice, the benefits to childbearing women are less obvious. In the period since the change in legislation the midwifery,

nursing and medical literature has contained little or no documentation on the effects of the change for the clients of the service.

Any debate, however, remains at a superficial level and uninformed by theory, due to the paucity of research on midwifery practice. The meaning of the concept of partnership, for example, which is integral to the New Zealand College of Midwives' philosophy of midwifery practice, has been little debated amongst midwives. In addition, how do midwives in independent practice use the concept of power which has been bestowed upon them with the enactment of the 1990 Nurses Amendment Act? Are power and partnership related? If so, what is their relationship?

Aims of the study

The above questions, all of which are problematic for a profession reclaiming its identity, have formed the basis of this research. This study has engaged a group of midwives and their clients in a process of self-reflective inquiry in order to examine how together they co-created and shaped their mutual experience of pregnancy and childbirth.

This research, which has been informed by feminist theory, has focused on the conceptualisation of partnership within the midwife/client relationship. Further, as abuse of power by obstetricians has been widely publicised in New Zealand (Coney & Bunkle, 1987; Cartwright, 1988), it has examined how midwives perceive and utilise power in their relationships with clients.

Overview of the study

The account of this study's background, process and outcomes are presented in subsequent chapters. Chapter One has introduced the study and Chapter Two continues by outlining the historical and socio-political context in which midwifery is practised in New Zealand and in which the study took place. This background information enables interpretation of the study findings within the broader context of a rapidly changing environment in which midwifery is practised.

Chapters Three, Four and Five provide further background in the form of an exploration of literature relevant to this study, the theoretical stance taken in this study and the data collection and analysis methods used. By the presentation of this material the reader will be assisted to follow the decision trail used in this study.

In Chapter Three, literature on midwifery is examined in relation to other texts on childbirth. This chapter shows how, while there is a large body of literature taking cognisance of the socio-political context in which childbirth occurs, this has tended to be obscured in the midwifery research literature. Reliance on quantitative methods such as surveys has tended to reify the day to day actions of midwives within pre-defined social structures.

Chapter Four shows how this study, which is emancipatory in its intent draws on concepts from feminist theory, critical social science and to a limited extent postmodernism both to shape the data collection and its analysis. Thus this study moves beyond descriptive and explanatory analyses to provide a critically reflexive analysis of key concepts which influence the actions of midwives and their clients.

Methods and data collection techniques utilised in this study are outlined in Chapter Five. The complexities of engaging in research with an emancipatory intent are discussed in relation to the practicalities of carrying out the research.

Chapters Six to Ten contain a theoretically-informed critical-feminist analysis of the midwife/client relationship throughout the period of pregnancy, birth and the post-natal period. Each of Chapters Six to Nine represents a phase of the developing midwife/client partnership which does not necessarily correspond to the gestational period⁴ of the clients.

Chapter Ten presents the implications and limitations of the findings for midwifery practice and areas for further research are identified. A concluding statement summarises the research.

This study presents the first research-based exploration of independent midwifery practice in New Zealand. The findings of this study may assist midwives to recognise and reconceptualise their own practices. Such reflections and actions would be of value to midwives and clients alike.

In addition, this research may also be of value to other health professionals with whom midwives are affiliated such as doctors, nurses and social workers as it documents the essence of midwifery practice in New Zealand.

⁴ stage of pregnancy

CHAPTER TWO

Midwifery in New Zealand

The context of the 1990 amendment to the Nurses Act (1977)

The 1990 Amendment to the Nurses Act which was discussed in Chapter One did not occur in isolation from other events happening both in New Zealand and internationally. To understand the rationale behind the legislative change and the subsequent reason for undertaking this research, an overview of midwifery in New Zealand over the last 20 to 25 years is presented. The first part of this chapter discusses several major themes each of which had some bearing on the 1990 Amendment. These are legislation, special reports, the consumer movement, midwifery initiatives and development of a partnership between midwives and consumers through the formation of the New Zealand College of Midwives. The second part of the chapter considers changes in New Zealand midwifery from the 1990 Amendment to the present.

Although I shall refer to various milestones in history it is not my intention to provide a detailed history of midwifery in New Zealand as such publications are already available (Hill, 1981; Donley, 1986; Mein-Smith, 1986). The starting point for this overview is therefore the early 1970's.

Legislation

Throughout the twentieth century, midwives in New Zealand, like those in most other countries, saw the gradual erosion of their practice as the science of obstetrics became increasingly fashionable. It was to be the 1971 Amendment to the Nurses Act, however, which effectively

ended autonomous midwifery practice in New Zealand, as this required all births to be supervised by a doctor. The enactment of this legislation meant that midwives' status became indistinguishable from that of obstetric nurses and their practice operated along similar lines.

Although meetings for midwives were held in a number of parts of the country, there appears to have been little organised resistance by midwives to this restriction on their practice. No doubt this is because at that time, due to successful campaigning by the obstetric profession, almost all births were taking place in hospitals. Consequently, this was the normal area of practice for the majority of the country's midwives. However, the effects of the 1971 Amendment, in essentially failing to provide any differential between midwives and nurses, were to be far reaching for midwives and childbearing women.

The 1971 Amendment to the Nurses Act was reinforced when the Act was rewritten in 1977. In the interim period, however, midwives were to come further under the control of the obstetric profession with the implementation of the 1975 Obstetric Regulations.

These regulations, which had been prepared by a committee whose dominant membership was obstetricians, stipulated very precisely the documentation which was required for all births. Every midwife and institution was expected to comply with these regulations which specifically focused on certain routine procedures which should be undertaken during the post partum period. Accompanying the regulations was a large blue folder giving further detailed instructions for midwives and doctors.

The next revision of the Obstetric Regulations (1986), however, saw a considerably shorter document in which an explanatory note said:

The regulations revoke and replace the Obstetric Regulation 1975, and their amendments. Many of the matters covered by those regulations are now dealt with in legislation, or are now considered best left to good professional practice or administrative instructions (p. 6).

It is interesting to note that the new Regulations were aimed almost exclusively at the practice of domiciliary midwives. It was only domiciliary midwives who were now **required** to maintain registers of their clients, for example, although hospitals have continued this practice.

The committee charged with drafting the revised Obstetric Regulations was, once again, comprised mainly of obstetricians. Several of these obstetricians had been attempting to discredit domiciliary midwives whose visibility had been increased through the formation of the Homebirth Association (refer pp. 13-16). The emphasis on domiciliary midwives in the 1986 Obstetric Regulations reflected an attitude of medical control which had been becoming increasingly overt throughout the 1970s and early 1980s.

Medical and nursing control over midwifery was also manifest in a further Amendment to the Nurses Act in 1983. Section 54 of the 1977 Nurses Act was amended to prohibit midwives, who were not also registered nurses, from attending birth in "any place other than an institution under the control of an Area Health Board or Hospital Board" (Nurses Amendment Act, 1983, p. 10). So, with the exception of direct entry midwives **already** in domiciliary midwifery practice, midwives who were not also registered nurses could now only practise in hospitals where supervision was deemed to be adequate.

The Act also affected midwives who practised in hospitals in that there was no differentiation between nurses and midwives. Midwives had therefore become all but invisible, being incorporated under the broader

category of nurses. The first draft of the Act had also proposed that only Registered Comprehensive Nurses be admitted to education programmes leading to registration as a midwife, thereby excluding the majority of New Zealand nurses, who held General and Obstetric Registration, from becoming midwives in New Zealand. Although this clause was to be deleted before the legislation was enacted, it was through the 1983 Act that control by obstetricians and nurses over midwifery was seen to be at its peak. However, this was to be the final piece of legislation which restricted, rather than facilitated midwifery practice.

Special reports

Several Board of Health reports are integral to dictating the parameters of midwifery practice in the 1980's. Again the members of all of these committees were predominantly obstetricians, with token representation of general practitioners and midwives and no consumer representation.

The first report (Board of Health, 1976) considered the very broad concept of "Maternity Services" and devoted most of its recommendations to the centralisation and further specialisation of the country's obstetric services. This notion was further developed by Bonham (1982) in a paper which became compulsory reading for all those undertaking the Diploma of Obstetrics at New Zealand's only Post Graduate School of Obstetrics and Gynaecology, located in National Women's Hospital, Auckland.

Recommendations 23.14.1 and 23.14.2 were specifically aimed at the need to improve midwifery training and incorporating the provision of a special course "on monitoring the high risk patient in labour" (Board of Health, 1976, p. 89). The main thrust of these recommendations

served to further increase the control of the obstetric profession over midwifery.

The Board of Health report (1982) entitled "**The mother and baby at home: the early days**" stated that it could not recommend birthing at home but acknowledged that some women might choose to ignore the risk factor involved with such practices. The recommendations again narrowed down the potential scope of practice of the domiciliary midwife, specifically pointing out where her post-registration experience should take place and that her competence needs to be certified by "a senior midwife and the senior obstetrician of the hospital" (Board of Health, 1982, p. 7). Fifty-five risk factors are listed as necessitating referral to an obstetrician. Once referred, the women were not usually returned to the care of a domiciliary midwife (Donley, 1986).

These reports, together with the legislation and the relocation of midwifery education into Advanced Diploma of Nursing courses at four polytechnics put midwives in a very vulnerable position in the early 1980's. Midwifery was on the verge of extinction, just as it had been in the United States 70 years previously (Arney, 1982) while obstetricians held the control of all births taking place throughout New Zealand.

However, the domination of the obstetric profession was not to go unchallenged and in 1985 an article was published which suggested that obstetrics was safer in small hospitals staffed by midwives, than in larger teaching hospitals (Rosenblatt, Reinken & Shoemak, 1985). This research-based article was totally contrary to the activities of the Post Graduate School of Obstetrics and Gynaecology which were aimed at centralising maternity services. The larger, more detailed report, was never put into general circulation.

The findings of the "Rosenblatt Report" as it came to be known were not dissimilar to those reported by Tew (1990) in England. As in New Zealand, Tew identified obstetricians in Britain as having used only statistics which favoured their cause and ignoring those which ran counter to it. It was to be such reports, however, that the consumer movement, which was on the increase, was to use as weapons to promote their cause, and ultimately to benefit midwifery.

The consumer movement

New Zealand in the 1960s, as elsewhere in the world, experienced a surge of "alternative lifestylers" seeking to remove themselves from the increasing technological developments of the western world. These groups sought to distance themselves from such developments rather than directly challenge them but they laid the foundation for the wave of feminism which developed the following decade and which did challenge the status quo. The feminist movement in New Zealand encouraged women from varied backgrounds to join together and seek alternatives to the patriarchal social structures which had dominated New Zealand throughout the twentieth century.

Nowhere was this challenge more visible than in the area of childbirth, which feminists recognised as rightfully belonging to women, a right which has been eroded with the rise to power of the profession of obstetrics. As Mein-Smith (1986) notes, the power of the obstetric profession was visible in New Zealand very early this century, earlier than was apparent in many other western countries.

However, Dye (1986) points out that in the United States of America there was a united effort from the medical profession to have total control over childbirth from the late 1800s. That they were not entirely successful until the 1930s was mainly due to the large numbers of

European immigrants in the early 1900s who were used to midwives' attendance at childbirth and saw no reason to discontinue this practice until future generations became more integrated into American society (Litoff, 1986).

In Europe the medicalisation of childbirth has been less evident in the twentieth century, though in the fourteenth and fifteenth centuries, medicine and the church had formed a powerful alliance, which successfully condemned several midwives as witches (Donnison, 1988). Over the succeeding centuries medicine, and later the specialist branch of obstetrics, continued to erode midwives' rights and responsibilities. Most European countries afforded some protection to midwives and less directly to their clients, by Registration Acts. England, in 1902, was the last European country to legislate for Registration of midwives.

Registration of midwives, however, did not prevent medicalisation of childbirth. In some countries it afforded women ongoing choice by virtue of alternative practitioners, while in others, such as New Zealand, it was the beginning of the medical control of both midwives and clients.

Homebirth Association

One of the first tasks of feminist activists in New Zealand, therefore, was to challenge the medicalisation of childbirth. The group that is mainly credited for doing this was the Homebirth Association which was founded in Auckland in 1978. While birth at home had always been legal in New Zealand, it was not a common option. This was mainly due to successful campaigns by medical practitioners in the 1920s and 1930s who publicised the perils of homebirth (Gordon, 1957; Mein-Smith, 1986).

The 1937 Social Security Act which was passed only after much negotiation with the medical profession, provided 14 days free hospital care for all women following childbirth. This must have seemed an attractive option for many New Zealand women, particularly those in rural areas. Small cottage hospitals sprang up throughout the country, providing relatively homelike environments for birthing women, thereby reducing the perceived need for homebirths.

However, with the growth of the Post Graduate School of Obstetrics and Gynaecology in the 1950s and 1960s, Donley believed that there was a need by the obstetricians for more "clinical material" (Donley, 1992, p. 9). So began centralisation of obstetric services throughout New Zealand. However, in response there arose a growing interest in homebirth as an alternative to the impersonal and increasingly technological hospital experience.

Donley (1992) provides a detailed history of the homebirth movement, which fought to preserve women's rights to choose their place of birth. The early group consisted mostly of feminist women who were consumers of maternity services but also of one or two midwives who supported their goals, and were willing to provide a homebirth service. The aim of the movement was to raise awareness of the option of birthing at home to both potential consumers and their attendants.

The movement and the resistance to it by obstetricians was generally reflective of international trends. In the United States, for example, a resurgence of interest in natural childbirth had occurred in the years following the second world war (Edwards & Waldorf, 1984). Out of this interest grew numerous consumer organisations, one of the most notable being the Association for Childbirth at Home. Despite numerous attempts to prosecute this group in various states, this group

lobbied successfully throughout the country for homebirth and the recognition of lay midwives.

A major success of the Homebirth Association in New Zealand was, unlike its counterpart in Australia, its bringing together of midwives and consumers to work together for a common goal. While the impetus had come from the consumer, there was the realisation that "women need midwives need women," a slogan which was to become popularised later in the 1980s. Together, consumers and midwives publicised the positive aspects of homebirth, and lobbied for medical practitioners to supervise the midwives' practice, as was required by law.

Obtaining such medical support was one of the hardest tasks of the movement. Even in Auckland, where there were around 300 GPs, as well as specialist obstetricians in practice in 1980, only a few were willing to be affiliated to what was seen as such a radical fringe. All medical practitioners who attended maternity cases were required to hold contracts with the various institutions (later the Area Health Board) in which they practised. Such contracts were controlled by local obstetricians and were easily revokable. To come to the notice of the powerful obstetricians by taking responsibility for a few homebirths was a risk which, in the minds of most GPs, was not worth taking as to lose their contracts meant also losing a lucrative source of income. Therefore, most were not willing to offer active support to the Homebirth Association.

Despite the lack of medical support, however, the Homebirth Association flourished, and although the numbers of women birthing at home did not increase dramatically in relation to the total number of births in New Zealand, the demand for homebirths in the larger towns and cities far outstripped the availability of midwives. Many midwives

were sympathetic to women desirous of birthing at home, but were unable to take on the work of domiciliary midwives due to the lack of financial reward for the long hours of work.

Such radical movements as the Homebirth Association naturally did not go unchallenged by obstetricians from the Post Graduate School of Obstetrics and Gynaecology. The Maternity Services Committee (1979) published a document condemning homebirth as endangering the safety of the baby. This was widely circulated and gained general acceptance amongst midwives and medical practitioners who practised in hospitals.

However, this publication only served to fuel the debate and in 1980 the Homebirth Association became an incorporated society with branches nationwide, which continued to lobby for homebirth and condemn the over-use and abuse of technology in hospital births. In the years since then the Association has continued its struggle to establish homebirth as mainstream, rather than a radical alternative. The Association has been extremely successful and plans in the future, to continue its campaign.

Save the Midwives Association

Just as the Homebirth Association had its beginnings in Auckland, so too did the Save the Midwives Association, founded in 1983 to challenge the Nurses Amendment Act which was then in draft form. This Association consisted mainly of consumers but also some midwives. From its beginnings, the aim of this group was to emancipate midwifery from domination by the medical and nursing professions through the development of direct entry midwifery education programmes.

Save the Midwives Association rapidly gained national support and served to unite hospital and domiciliary midwives, both of whom were

threatened by the proposed legislative changes (refer pp. 7-12). The Homebirth and Save the Midwives Associations worked together and raised awareness amongst the general public of the abilities of midwives to practise according to the World Health Organisation's (1966) definition of a midwife (refer Appendix One) which had been adopted by the International Council of Midwives in 1972.

Save the Midwives Association communicated with its growing number of members through regular newsletters which exhorted its members to lobby women's groups in particular, as it was these which the Association's executive believed would have the most influence on women in childbirth. The tactics of this group were also successful, as women's groups took up the cause of midwifery and, in turn, lobbied Members of Parliament to recognise the potential contribution that midwives could offer women.

The Homebirth and Save the Midwives Associations were two of the most politically active groups in raising the profile of midwives but other groups such as Parent Centre and the Domiciliary Midwives' Society, too, assisted in helping midwives achieve their independence. Midwives themselves were also active and through their own structures were trying to overcome the obstacles which had previously prevented independent practice.

Midwifery initiatives

While it appeared that consumers were most active in the attempts to re-establish midwifery, some midwives were also protesting against the medicalisation of childbirth and the resulting restrictions on midwifery practice. In order to become registered with the International Council of Midwives, it was necessary to form a special organisation of

midwives. So began the Midwives' Special Interest Section of the New Zealand Nurses' Association in 1972.

The Midwives' Section initially operated on a regional basis and later one region took responsibility for the national coordination. Regular meetings of the regional chairpersons were also held, assisting midwives to form networks throughout the country. The relationship between the Section and its parent body, the New Zealand Nurses' Association (NZNA), was often one of antagonism as the fundamental philosophies of nursing and midwifery differed.

In 1981, for example, the NZNA Policy statement on Maternal and Infant Nursing proclaimed that a midwife was a, "Nurse who is qualified to care for women during pregnancy" (NZNA, 1981, p. 19, emphasis added). This was despite the World Health Organisation's definition of a midwife as a **person** qualified to provide this care; a definition which was supported by the International Council of Midwives.

The Section's policy of the 1980s, however, was to ensure that relevant remits were passed through the NZNA national conferences. One of the most controversial of these was the passing at the 1982 conference of the remit advocating the move of midwifery education programmes from under the auspices of the Advanced Diploma of Nursing. Despite this, in 1984 the NZNA's Policy Statement on Nursing Education outlined the Association's difficulties concerning such a course of action. In 1985 a further remit was passed stating that the NZNA should reaffirm its policy regarding midwifery education.

While such debates continued, a national midwives' workshop was held in 1986 at Massey University where, "midwives were really looking at their resources and ability to represent themselves" (Donley, 1987, p. 7).

This was closely followed by the first National Midwives' Conference which continued in the same political vein.

Over the next two years, midwives were to gain further impetus in the political field. A midwifery philosophy was developed as were standards of education and practice which were oriented to a future of independent practice. Together with the consumer-initiated action groups discussed above, the scene was set for the development of a new body, the New Zealand College of Midwives.

The New Zealand College of Midwives

The New Zealand College of Midwives had its beginnings at the second National Midwives' Conference in 1988 following the presentation of a stirring paper by Joan Donley entitled "Midwives or Moas⁵?" Participants were urged to form an organisation of midwives for midwifery. Enthusiasm was high and several of the participants gave \$50.00 each as seeding funding for the new organisation.

Following this conference, a working party was established to develop a constitution for the new organisation and by early 1989 the New Zealand College of Midwives was officially launched. It offered a unique opportunity for a partnership between midwives and consumers, as membership was open to both groups.

The formation of the College removed the perceived bondage of midwives to nursing which had underpinned the structures of the New Zealand Nurses' Association. The Midwives' Special Interest Section of the NZNA was disbanded and, after negotiation, funding transferred to the new organisation whose major task was to continue the drive

5 An extinct bird known for its ability to hide from danger.

towards the independence of midwifery practice through amendments to legislation.

The College members, many of them having not been previously politically active, achieved this in a remarkably short period of time. Each region worked hard to promote midwifery as a viable alternative for childbearing women, and the only birth option which was women-centred. Members used every opportunity to meet with women's organisations and Members of Parliament to educate them as to the potential of midwifery.

Finally the Nurses Amendment Bill was introduced to Parliament in 1989. Following its first reading it was referred to a Select Committee which advertised for submissions, setting a closing date of 9 February, 1990. Ninety-nine submissions were received, twelve of which requested a personal appearance before the Committee. Submissions to the Select Committee (1990) generally fell into two categories:

those supporting the Bill and indicating brief reasons for that support, and those supporting the principle of autonomy for midwives but raising specific concerns (p. 6).

Support for the Bill came mainly from consumer groups and the College of Midwives, though some Area Health Boards also offered unconditional support. "Specific concerns" were raised by the medical profession (New Zealand Medical Association and the Royal New Zealand College of Obstetricians and Gynaecologists) and also the National Council of Women and several Area Health Boards. Yet again, the medical profession, rather than voicing their outright objection, couched this in terms of concern for the women and their babies.

However, the concerns of the medical profession were to no avail, and following review of the submissions, the Committee recommended that the Bill be returned to Parliament without amendment. Eventually the amendments to the 1977 Nurses Act were passed in August 1990 and midwives were once more permitted to practise independently of doctors.

The first National College of Midwives' Conference was held three weeks prior to the passing of the Act. The keynote speaker, Helen Clark, the then Minister of Health, who was an acknowledged supporter of midwives suggested that the next challenge for the College was "to make autonomy work" (Clark,1990, p. 10). The mood was celebratory.

The next section considers how midwives have responded to Clark's challenge by providing an overview of midwifery practice since 1990.

Changes in midwifery practice since 1990

When the 1990 Amendment to the Nurses Act was passed on August 15, there were a few practitioners throughout the country who were immediately ready to take up the challenge of independent practice. However, the reality of the 1990 Amendment was that it was a beginning rather than an end and the majority of midwives had to become confident with new and innovative ways of practice. In addition, since its enactment the government-funded health services have faced several major structural changes presenting other challenges for midwives.

The concept of partnership between midwives and clients, which was stated by the New Zealand College of Midwives (1990) as pivotal for midwifery practice, had to contend with stiff resistance from the

International Council of Midwives at its triennial meeting in 1990. Member organisations felt that midwifery was a profession and it was therefore inappropriate to include consumer representation on its Board of Management. New Zealand College of Midwives was nearly expelled from the International body and its representatives had to lobby members from other countries to ensure continued membership. However, since then the notion of partnership, although not clearly defined, has continued to gain in strength and added to impetus for change both in New Zealand and overseas. In 1993 the International Council of Midwives unanimously accepted New Zealand's constitution.

Changes in New Zealand have affected both midwifery education and practice. In the education sector two three year direct entry pilot programmes are currently under way while four midwifery programmes for registered nurses have developed new curricula so that their graduates may be equipped for practice in the new era. This thesis, however, is concerned with midwifery practice and the next section outlines and critiques this new era of midwifery practice.

Independent midwifery practice

Prior to 1990 the majority of practising midwives were employed in hospitals. Of the few who were community based, most carried out post-natal care for women who had opted for early discharge from hospital, while only a few practised as domiciliary midwives providing a full range of services for their clients.

With the amended legislation however, the requirement for a doctor to supervise the pregnancy and birth was removed. The financial incentives to midwives were also much greater, as midwives were now able to claim the standard fee of \$285 for attendance at labour and births up to three hours duration and \$70 per half hour thereafter.

For either or both of these reasons a number of midwives, therefore, have moved from being employees in hospitals to being self-employed, community-based and practising continuity of care. As a result of the variety of services offered, there are now many different classifications of midwives, for example "independent midwife," "domiciliary midwife," "homebirth midwife" and "domino midwife" as well as "hospital midwife". These definitions are not mutually exclusive, and often the title is dependent upon the person who is using it. Only the title "Independent Midwife" will be used in this thesis when describing present day midwifery practice by midwives who are non-hospital employees.

Approximately 300 midwives are presently recorded by the New Zealand College of Midwives as independent practitioners. This implies that many more women are opting for maternity care which provides for continuity of midwifery care throughout pregnancy, labour and birth and the post-natal period up to six weeks post-partum. By accessing midwives early in the pregnancy, women and their chosen midwives are able to form a relationship and establish a trust in each other, before labour. In this way the woman would know and have confidence in her birth attendant (Flint, 1986).

General practitioners and private obstetricians would argue that they, too, provide a continuity of care for pregnant women. This is not disputed by midwives, but despite this continuity of medical care, women still enter a hospital for the birth not knowing the midwife who will be her primary caregiver throughout labour. In instances, especially when labour lasts longer than one eight hour shift, more than one midwife may be in attendance.

Independent midwives, therefore, frequently provide a service which complements that of the general practitioner or obstetrician, with the

woman having her pre-natal care shared between midwives and doctors. Many women are opting for shared care and with the present system of the maternity benefit paid to each practitioner, the arrangement is financially satisfactory for practitioners although costly for the country. Currently a number of alternative fee structures are being considered by the four Regional Health Authorities who administer the funds (Coopers and Lybrand, 1993).

While, since 1990, the number of homebirths nationally has increased slightly from one to two percent, the most popular option for women seeking continuity of midwifery care is a **DOMINO** birth. Here, with her chosen midwife, the woman enters hospital when in labour. The midwife, in conjunction with the doctor if shared care has been selected, provides the necessary care during labour, the birth and the immediate post-natal period. The woman generally returns home shortly after the birth.

This option became popular in England in the late 1960s as the obstetricians sought to control women and midwives by removing the option of homebirth (Savage, 1986). In New Zealand, however, it is serving as the transition for reversal of that trend. However, as Donley (1993) points out, midwives who favour the **DOMINO** option are in danger of continuing to have their practice controlled by medicine as it is extremely difficult to practise using a midwifery model, which is client-centred, within institutions.

The **DOMINO** arrangement has also meant that, like medical practitioners, midwives are required to apply for access agreements with the institutions in which they wish to practise. In some areas, notably Waikato, these were available within a very short period after the change in the law, but in others such as Auckland, which were

dominated by the obstetricians, contracts for midwives were delayed for as long as 18 months.

Both the homebirth and **DOMINO** options focus on the continuity of care which can be offered by one midwife, an option which is extremely attractive to many women, particularly those who have had negative experiences with hospitals and the fragmented care therein. The success of such arrangements led to the application by some midwives to participate in block funding schemes for Primary Health Care providers, which are being piloted by the Department of Health. One Wellington midwifery practice is currently involved with this programme and another midwife in Auckland is providing *marae*⁶-based care under the same scheme.

However, it is not just independent midwifery practice where innovations are taking place. In an effort to be competitive, some midwives in hospitals are also finding innovative ways to practise and so to improve the quality of care to their clients.

Hospital midwifery

Despite the immediate readiness of some midwives to enter independent practice, and the subsequent gradual increase of midwives practising independently since the 1990 Nurses Amendment Act, the majority of midwives in New Zealand still practise in hospitals. Most midwives in larger hospitals practise within a medical model of childbirth, as the institutions are fragmented into pre- and post-natal wards and labour and delivery suites. Opportunities for continuity of care in such organisations have either not been proposed by midwives or have been rejected by managers (Moloney, 1992).

⁶ the traditional meeting places for families of a Maori tribe.

However, in 1991 in one large organisation a "Know your midwife" scheme as outlined by Flint and Poulengris (1987) was introduced. All women who use the hospital's facilities, unless under the care of an independent midwife, have the opportunity for continuity of care from a team of hospital midwives. Such a change has involved the use of innovative rosters and the willingness of midwives to move away from the concept of eight hour shifts.

While successful from the point of view of clients involved, for some midwives, practising in this way has been undesirable as it is too disruptive to their off-duty life. However, other midwives have responded positively to the challenge and now several other obstetric hospitals are developing similar schemes.

It is in small hospitals and birthing units, however, that midwives are best able to offer continuity of care. Prior to the 1990 Amendment, continuity was able to be offered through labour, the birth and the post-natal hospital stay, if the same midwife was on duty. Other than a booking-in visit, virtually no pre-natal care was offered by the small hospitals. This has now changed and the adoption of creative rostering patterns has facilitated continuity of care for women giving birth.

As hospital stays became shorter, under an experimental scheme, one Area Health Board began to offer continuity of care with hospital midwives following their clients into the community for as long as required (Fleming, 1988). This has now been extended with midwives in small hospitals frequently assuming primary responsibility for a group of clients throughout their pregnancy, labour and post-natal period, generally in cooperation with local general practitioners.

Midwives in all spheres of practice have thus taken the opportunity, both prior and subsequent to the 1990 Amendment, to find innovative

ways of practising which will be of mutual benefit to women in their care and to themselves. It is not to say that all midwives are interested in change; some are happy to retain the status quo which existed prior to the legislative changes. In addition there remains, amongst midwives, dispute as to the best ways to practise. However, the changes which have occurred are far-reaching and have affected the medical profession, especially general practitioners who have lost both clients and income to midwives. This has resulted in a backlash against independent midwives which is now beginning to be felt.

The backlash against independent midwifery

Prior to the 1990 Nurses Amendment Act, there was vigorous campaigning against the concept of independent midwifery by some medical practitioners. Written submissions to the Select Committee were couched in the form of qualified support for the changes but oral submissions were more overtly seen to be opposing midwives and predicting disastrous consequences for women if midwives were to be granted autonomy (Select Committee, 1990).

Two years later the repercussions began in earnest. Early in 1992 newspaper articles claiming that independent midwives were "blowing the budget" were being written. None of these articles, which quoted the New Zealand Medical Association's perspective, discussed the true costs of medical practitioners' claims; for example the salaries of hospital midwives and other personnel involved, and the equipment which is provided either by the midwife (in the case of homebirths) or the hospital.

However, the publicity succeeded in forcing the Minister of Health to convene a Tribunal to consider the whole issue of maternity benefits. This Tribunal sat in November, 1992 and considered evidence from the

New Zealand Medical Association, the New Zealand College of Midwives and the Department of Health.

In presenting their evidence to the Tribunal, the New Zealand Medical Association argued for separate schedules of payment to doctors and midwives claiming that doctors had superior knowledge which must be recognised. In addition, the suggestion was made that all pregnant women should be assessed by a doctor at least once in the course of their pregnancy. The doctor would then assess that woman's fitness for midwifery care.

The New Zealand College of Midwives, conversely, argued for one schedule of payments, maintaining that midwives were the experts in normal childbirth. New Zealand College of Midwives also successfully argued that the issue of assessment of women by medical practitioners was beyond the scope of the Tribunal's terms of reference.

By May 1993, the Minister of Health's decision was made public, and the New Zealand College of Midwives claimed victory. A single schedule of payments was to be retained and a reasonable increase in attendance fees awarded. Most midwives were pleased with the results though the decrease in mileage allowance has affected rural midwives negatively.

Shortly before the Tribunal was due to sit, however, a leading newspaper article (Sunday Times, 1992) outlined the case against an Auckland midwife who, claimed the New Zealand Medical Association, had been negligent in her management of a home birth. This was followed up some three weeks later by a television documentary discussing the same incident (Television New Zealand, 1992a).

The outcome of this programme was to discredit midwives, because even though the incident highlighted was **prior** to the 1990 Nurses Amendment Act, the date was not revealed. Three weeks later a follow up programme was televised, this time focusing on births which went wrong in hospitals. Yet again, however, in the four incidents highlighted, independent midwives were singled out for blame. Midwives were the only people to be specifically named in a case which involved shared care.

These programmes served to bring to the attention of the public the so-called "unsafe practices" of midwives. It also prompted the suggestion from the Royal New Zealand College of Obstetricians and Gynaecologists that once again a medical practitioner should be in charge of all births (Television New Zealand, 1992b). Such actions may be seen to be a modern day equivalent of the witch-hunts of Europe in the fourteenth to sixteenth centuries and the routing of midwives in the United States of America in the early twentieth century (Edwards and Waldorf, 1984).

According to Ehrenreich and English (1979) the success of the witch-hunts in Europe was mainly due to the scientific knowledge of the medical profession which was used to discredit midwives and their supposedly inferior knowledge. However, to counter the more recent backlash, midwives have been building their own body of knowledge with which to argue their case. Just as midwifery practice is developing in innovative ways, so too is midwifery education. As more midwives graduate from direct entry and the revised post-nursing midwifery programmes, the resultant body of midwifery knowledge will grow and add to the voice of midwifery. Further, as the midwifery movement grows in strength internationally, new dimensions may be added.

Midwifery practice internationally

Although New Zealand has been a world leader in the midwifery practice arena, innovative midwifery practice is also happening in other countries. This is most notable in Britain which has enjoyed a resurgence of autonomous midwifery practice in recent years. Unlike, New Zealand, midwives in Britain were never required to be supervised by medical practitioners, but the increasing medicalisation of childbirth meant that midwives had very rigid boundaries placed around their practice by the medical profession (Savage, 1986; Benoit, 1991).

Midwives now have begun to shake off some of these restrictions. Some have started to leave the National Health Service and operate as independent practitioners. Other British midwives are working within the parameters of the National Health Service to provide continuity of care programmes for their clients.

British midwives have been given much encouragement by the recent publication of a House of Commons Health Committee (1992) review of maternity services. The report suggests that midwives were the group best placed and equipped to provide continuity of care through pregnancy and childbirth and that midwives' status as independent professionals must be acknowledged. This was closely followed by a further report of an expert committee of professionals and consumers which made recommendations for provision of childbirth services in the future (Department of Health, 1993).

However, many of the innovative methods of practice which have been developed in New Zealand and Britain have not occurred in other countries. In the Netherlands, for example, which during New Zealand's campaign for independent midwifery, was cited as an

example of how midwifery practice could work, homebirth with midwives in attendance, has always been the norm. However, despite the National Health Insurance system only recompensing clients' hospital costs if there is no midwife in the locality or if there are serious complications (Oakley & Houd, 1990) now more than 50% of all births take place in hospitals (Phaff, 1986).

Phaff suggests that this is due to better knowledge of potential complications but does not acknowledge it as part of the increasing worldwide trend towards medicalisation of childbirth. However, Dutch midwives are now beginning to acknowledge their anxieties about the increasing numbers of women being referred to obstetricians and giving birth in hospitals (Wiegers & Berghs, 1993).

The midwifery debate continues in Canada. Although midwifery has now been legalised in some provinces, as in New Zealand the press continues to support the medical model of childbirth. The editorial of a leading British Columbian newspaper suggested that while the province was ready for midwives, homebirth would be a "disastrous retrograde step" (Vancouver Sun, 1993, p. 3). Midwives, therefore, according to this journalist, should work in hospitals, under supervision of the medical profession.

In eastern Canada, the registration of midwives with the Ontario Midwives' Association is now taking place. Two groups of midwives are seeking registration, those who have practised as lay midwives and those who have registered as midwives outside of Canada. There is some animosity between the two groups as the registration board is attempting to reach an equitable position. Midwives continue to practise mainly in women's homes, though some are seeking access agreements with hospitals.

Midwives in Australia are now also beginning to practise outside of the medical model of childbirth. In Newcastle, for example, a group practice of midwives is offering women the opportunity to meet pre-natally with midwives in the practice. These midwives, in cooperation with the woman's general practitioner or obstetrician, will provide some of the pre-natal care as well as support throughout labour, the birth and post-natally.

Most Australian midwives, however, are continuing to practise in hospitals where they are classified as nurses and are subject to the same supervision as nurses (McDonell, 1991). This was recently reinforced in Victoria with the revision of the Nurses Act permitting free interchange in the practice setting between general nurses and midwives. The Australian College of Midwives continues to recommend midwifery independence as this is what its executive believes will facilitate changes to practice.

Conclusion

The above discussion shows that midwifery in New Zealand has been a highly political issue for many years. While ten years ago it appeared that midwifery was on the verge of disappearing altogether, except as a short post-basic nursing certificate, midwifery is now a profession independent from both medicine and nursing. Midwifery in New Zealand has led the way internationally in making these changes and now midwives in other countries are looking towards New Zealand for guidance (Guilliland, 1993). Midwifery research in New Zealand, however, is not yet well established and work must be done in that area to provide a knowledge base for both midwifery education and practice in the future.

CHAPTER THREE

Literature Review

The previous two chapters have outlined the main issues affecting midwifery practice in New Zealand, so providing the background for this research. In addition, these developments were placed in the context of a more global perspective, by the provision of an overview of midwifery practice in several countries. This chapter will provide further background to the study, by identifying and discussing some of the relevant literature.

While the focus of this thesis is the partnership of the midwife and client inherent in independent midwifery practice, to restrict the literature review to texts which are solely focused on midwifery would ignore the huge body of feminist literature on childbirth. In particular, that which has been written in the last decade has greatly encouraged New Zealand midwives to extend the parameters of their practice. Conversely, it is beyond the scope of this thesis to do more than simply acknowledge many of these works as they alone could form the basis of an entire chapter.

This chapter, therefore, will consider firstly the historical literature from New Zealand and elsewhere. This shows how the increasing medicalisation of birth succeeded in placing midwifery in such a vulnerable position that the 1971 Nurses Amendment Act ending autonomous midwifery practice was possible. Critiques of the medical model of birth are then introduced as they form the grounds for change of the 1970s and 1980s. Finally the beginning of a research culture in midwifery which is becoming evident from recently published articles is discussed.

Early history of midwifery

In ancient societies the practice of midwifery has traditionally been associated with the mystique of the female body. In most societies it was considered that only women had the special knowledge and understanding to deal with matters concerning childbirth and so act as midwives. Most of these societies have no written record of their beliefs and practices and so it has become a task of modern anthropologists to observe such customs, many of which are still practised today.

Goldsmith (1990), for example, using carefully constructed vignettes of tribal births, describes women's involvement with birth in societies which still adhere to ancient traditions. In her introduction she comments that the concept of "midwife" is problematic, as it was freely interchangeable with that of "birth assistants" in many of the societies whose birthing practices she observed. However, Goldsmith does not offer her own definition of midwife and from her writing it must be assumed that she adheres to a narrow view of midwife as a doctor's assistant rather than the literal interpretation of midwife as "with woman."

However, Goldsmith's book does show clearly the affinity of the birthing woman and her attendants with nature, in particular the deity known as the "great earth mother." This relationship was also very strong in traditional Maori childbirth beliefs and practices (Hooker, 1869). In modern day New Zealand, the practice is less common but in some rural Maori societies a woman elder is present at births to pray to "*Papatuanuku*" (the earth goddess) for a healthy outcome.

The idea of women being closer to the earth than men persisted, even in European societies when the female deities had largely been

superseded by christianity. Donnison (1988) notes that such an idea was enshrined in Aristotelian scientific thought, so having the potential to lay down the foundations for modern midwifery practice. The idea of midwifery as a science was also discussed by Towler and Bramall (1986), who noted that it received little support in the context of seventeenth century puritanism.

The historical interpretation of the rise and fall of midwifery by Towler and Bramall appears to imply that there is a certain inevitability about the relationship of the ascendancy of science to the decline of midwifery. When childbirth became associated with science, then to these authors it appears natural that it became associated with men. Neither they nor Donnison, whose (1988) text details the decline of the midwife throughout Europe as science became more established and credible, question **why** this should occur. Both note, however, that such a decline was hastened as medicine and the christian church formed an uneasy alliance in order to eliminate all midwives.

So great was the desire to eliminate midwives that, from the late middle ages to the mid-seventeenth century, many midwives and other female healers were burnt at the stake as witches. While Donnison briefly alludes to this routing of midwives, Ehrenreich and English (1979) detail several examples of midwives in Europe and America who were executed as witches. Oakley & Houd (1990) also briefly discuss the phenomenon of witchcraft in relation to midwives suggesting that:

... female midwives were thus part of a female controlled reproductive care system. It was precisely this that posed so much of a threat to the church, the state and the emerging medical profession (p. 26).

Midwifery in Europe and America did not really recover from such a rout and little is written about its practice in the eighteenth and nineteenth centuries, except within the contexts of medical developments and the need to maintain a service for women who were

too poor to pay for the services of a doctor (Litoff, 1986; Donnison, 1988). These texts also outline the attempts in various countries to standardise and upgrade midwifery education programmes.

However it was not until after the witch hunts, in the nineteenth century that emigration to New Zealand began in earnest. The relative isolation of the early settlements meant that, like the Maori women, European women attended each other in childbirth. Although midwifery registration became mandatory in New Zealand in 1904, lay midwives continued to practise until the 1930s.

The ascendancy of obstetricians

Oakley and Houd (1990) describe the rise of the speciality of obstetrics as causing a crisis in midwifery which was second only to that of the witch hunts. The development of the speciality was part of the huge scientific advance of medicine which was taking place in the latter part of the nineteenth century. It was this development which was to be the greatest strategic success of medicine (Arney, 1982).

Once the speciality of obstetrics had been developed it made itself felt by subtly pervading attitudes to childbirth amongst women, midwives and society generally. Midwives, who were traditionally women of the village, became displaced by the technologies offered by the new science. Stockham's (1895) classic text "**Tokology**" for example describes the necessity of enemas for women in labour and the desirability of stirrups for the birth as "with this simple contrivance, a physician requires less assistance" (Stockham, 1895, p. 176).

However, Stockham, a medical practitioner, also retained several traditions and warned birth attendants not to engage in meddlesome midwifery such as supporting the perineum or cutting the cord before

pulsation has ceased. However, later texts became progressively more interventionist culminating in the work by Koster and Perrotta (1943). This described the total control obstetricians had over childbirth when, by the administration of spinal analgesia, they were able to manually dilate the woman's cervix and extract the baby with forceps.

Such manipulation of the natural childbirth processes by obstetricians resulted in a decline in the ability of midwives to practise from outside the medical framework. Arney (1982) specifically addresses this issue as he attempts to look at the reasons for the rise to power of obstetricians in the United States. He considers the history from the perspective of both midwives and obstetricians and concludes that the success of obstetricians is due to extremely good strategic planning and political manipulation of services affecting pregnant and birthing women.

One of the major themes adopted by obstetricians is that of safety. Oakley (1984) described how obstetricians were able to instill fear into women by changing the focus of health from an environmental philosophy to a more personal approach. The link between the health of the baby and the health of the mother was emphasised as a basis for the beginnings of pre-natal care. Oakley points out that the ritual of ante-natal care which was instituted in 1914 has continued until present times although circumstances are now very different.

The theme of safety for both mother and baby has also been emphasised in American texts. Meigs (1986) like Oakley, discusses how maternal mortality statistics were used by obstetricians from early in the twentieth century as a means of ensuring their own power over women and midwives. Arney (1982) talks less directly of safety but rather of the power and control which obstetricians have been able to assume as they develop more and more devices aimed at ensuring fetal wellbeing.

The emphasis on safety by obstetricians has ensured that it is also an issue which is of considerable concern to women. Patterson, Freese and Goldenberg (1990), using grounded theory, describe how women identified safety for their babies as the most important focus when seeking care during their pregnancies. The technocratic focus of the American health care system, which shapes the perceptions of women towards accepting intervention, is emphasised throughout this article.

New Zealand literature, too, describes the ascendancy of obstetricians and the desire to outlaw midwives. Mein-Smith (1986) outlines the initial development of the St. Helen's hospitals in the first decade of the twentieth century. While the function of these hospitals was ostensibly to train midwives and provide a safe place for the wives of working class men, they also served to keep the midwives and clients under the control of the medical superintendent, thereby ensuring the domination of the medical profession.

Later in New Zealand's history Doris Gordon, an obstetrician, tells of her personal campaign to establish a Post Graduate School of Obstetrics and Gynaecology with its own Chair in New Zealand (Gordon, 1958). She speaks of the unsafe practices of midwives, and how what she so earnestly desires is in the interests of the safety of all women and babies. Gordon, a highly successful woman, took her message all round the country and used the feminist movement of the 1920s to support her aims by asserting that it was every woman's right to give birth in a hospital with the latest technology.

Both Donley (1986) and Mein-Smith (1986) discuss and critique the motives of Gordon and her colleagues, which can now be seen as part of the rise in power of obstetricians and the corresponding demise of midwives. However in the 1920s Doris Gordon was extremely successful and was credited for the founding of the New Zealand

Obstetric and Gynaecological Society in 1927. Her aim of a Post Graduate School of Obstetrics and Gynaecology was not achieved until after her death.

With the establishment of the Post Graduate School in 1963 came the further medicalisation of birth in New Zealand. The Board of Health Committees, some of whose publications were referred to in Chapter Two (refer pp. 10-12), were each chaired by a member of the Post Graduate School and it was while these committees were at their most productive that obstetricians achieved their aim; the 1971 Amendment to the Nurses Act prohibiting midwives to practise independently of medical practitioners.

Critiques of the medical model of birth

Feminist critique of the medical model of childbirth

The ramifications of the 1971 Amendment and the eventual drawing into politics of midwives have been discussed in Chapter Two (refer pp. 17-21). However, what occurred in New Zealand since 1971 was part of a worldwide trend led mainly by the feminist movement. Feminists have critiqued not only the medicalisation of birth but the very nature of motherhood. Some of these publications are now discussed.

Feminist theory was not initially concerned with issues such as childbirth. With the development of the radical feminist movement in the early 1960s, however, this was to change. Radical feminism, in showing how divisions of gender structured all of life, opened the way for critique of childbirth and motherhood. Firestone's (1970) work claimed that these divisions went so deep that they were generally unrecognised. The only way, she claims, to overturn those which affected women's reproductive capacity was to ensure that in the future

reproduction should only take place by means of artificial technology such as *in vitro fertilisation*. Firestone's ideas, however, were not generally supported even from within the feminist movement but they did open the way for further critique of the medical model of childbirth.

O'Brien (1981), a midwife, critiques the medical model as lacking in discussion on "questions of reproductive consciousness" (p. 45). She considers the politics of reproduction from a Marxist feminist perspective and develops a theoretical position through analysis of the dialectics of reproduction. She proposes the hypothesis that "women by virtue of their reproductive function are 'closer' to nature" (p. 64). Her challenge to masculinist thought is profound and provides a conceptual framework for further feminist analysis of reproduction.

Rich (1976) offers an alternative history of both birth and motherhood. She returns to the theme of mother earth and the great goddesses and shows how the spirituality of birth and motherhood were lost as christianity was forced upon women. She sees christianity as the beginnings of the domination of women by the patriarchy which now dominates western societies, as in christianity, god who made disease decreed that women were inferior and unclean. In such societies, Rich argues, it is easy to see how midwives became downgraded and associated with ignorance and dirt.

Although one chapter of Rich's book focuses on the birthing woman, throughout the text her major argument aims at destroying the power of patriarchy, and even patriarchy itself. She cautions that:

to destroy the institution is not to abolish motherhood. It is to release the creation and sustenance of life into the same realm of decision, struggle, surprise, imagination, and conscious intelligence, as any other difficult, but freely chosen work (p. 280).

Ruddick (1980) also considers the issue of motherhood and engages in a philosophical discussion as to the meaning of this concept. She asks if motherhood is something which can only be practised by women or, conversely, if giving birth naturally equips women for motherhood. Some of Ruddick's questions have been further explored in a later publication (Ruddick, 1989) when the issues are more fully debated. Ruddick offers no answers to her questions but leaves it to readers to decide their own views.

Oakley (1980, 1984) does not challenge the concept of motherhood but critiques the processes to which women are subjected in becoming mothers. The titles themselves of Oakley's two publications: "**Women confined**" and "**The captured womb**" imply a challenge to the medical domination of childbirth. She firstly sets out to challenge the power of patriarchy which has dictated the parameters in which women must behave, and continues this challenge in her detailed look at the history of ante-natal care. Both texts offer some very powerful arguments and provide credible critiques of the twentieth century way of birth.

Rakusen and Davidson (1982), like Oakley, critically reflect on pre-natal care in the United Kingdom. They raise many issues which are important to women in the pre-natal area but which are seldom discussed by medical practitioners. In particular, the authors focus on environmental issues such as lead fumes and toxic wastes which they felt had not been well addressed by the medical profession, but which were important to pregnant women.

Roberts (1981) however, writes from the broader perspective of the lack of power women have over their fertility and argues that women must attack the solid base of male power which has amassed over the twentieth century. Ryan (1986) offers similar arguments, from within New Zealand. Ryan looks at the power inherent in the 1977

Contraception, Sterilisation and Abortion Act and is critical of women's lack of input into this Act. This came about, she notes, as a result of those charged with drafting the Act being concerned with the preservation of the nuclear family and control of women's fertility, rather than the needs of women.

The concept of birth has also been challenged by feminist scholars. Rothman's (1982) text dedicates separate chapters to fertility, pre-natal, labour and post-natal issues. She offers a comprehensive critique of the standard American way of birth which is not unlike the standard New Zealand approach. Rothman raises many interesting issues, such as pre-natal blood testing and labour ward routines, which have generally been unchallenged by other writers of the time.

Edwards and Waldorf (1984, p. *vii*) "discovered common ground in lingering disappointment with ... first experiences in giving birth" and from this went on to research women who had challenged the nature of obstetric intervention. Their text focuses on women's birth stories and reveals widespread practices of nurses holding babies back until the physician arrived, and women being left alone to labour while strapped in lithotomy position. Edwards and Waldorf single out six women whom they consider have successfully confronted and changed the dominant view of birth.

One woman who has been featured by Edwards and Waldorf is Sheila Kitzinger, an English anthropologist and childbirth educator. Kitzinger, who viewed childbirth as a psycho-sexual experience, criticised childbirth educators who advocated techniques such as the Lamaze approach in an effort to distract women from the experience (Kitzinger, 1962). Kitzinger's own beliefs about the sexuality of birthing have, in turn, been criticised as sexist and heterosexist (Rich, 1976). Kitzinger, however, has continued writing throughout the 1970s to the 1990s and

in her 1979 publication "**Women as Mothers**" she includes for the first time single women and lesbian women when discussing birth.

It is interesting to note that many of the feminist critiques of childbirth have been written in the early to mid 1980s. There can be no doubt that these publications have influenced women and midwives throughout the world to take political action but there has been very little literature which links feminism with midwifery and none which specifically addresses issues of partnership within the midwife/client relationship. The small amount of relevant literature found will be discussed later in this chapter but first it is necessary to examine literature, other than feminist, which critiques the medical approach to childbirth.

Further critiques of the medical model of birth

It was not only feminists, who in the 1970s and 80s, were alarmed at the increasing medicalisation of birth. Those interested in public health and a number of consumer groups were also considering the issue. From this concern arose a number of research based publications which are relevant for this study.

Returning to the theme of "safety", Richards (1978) questioned the ability of public hospitals in England and Wales to provide the necessary safeguards for women in childbirth. Using a retrospective analysis of mortality and morbidity statistics with regard to place of birth and a number of interventions, Richards concluded that a number of women who could have had normal, uncomplicated births at home were being subjected to unnecessary risks in hospital.

Conversely Mehl (1978) examines the safety of homebirth in the United States. He assesses the effectiveness of a number of previous studies which have been carried out and appears to be particularly interested

in the control of the childbearing couple. He notes the effect of hospital birth on the self esteem of women in a number of the studies he reviews and concludes that a number of options are "safe medical alternatives" (Mehl, 1978, p. 114). However, he acknowledges that the trend towards increasing medicalisation does not have all the solutions and homebirth is a viable option for many women.

Similar findings were more recently reported in the United States by Durand (1992) who looked at variables such as planned and unplanned homebirths, the tracking of transfers to hospital and controlling for the effects of birth weight, birth attendant and demographic characteristics of the mother. Durand sampled a total of 1707 births from the Farm Midwifery Service in rural Tennessee and 14033 births from the 1980 US National Natality/National Fetal Mortality Survey. He concluded that:

for relatively low risk pregnancies, home births with attendance by lay midwives is not necessarily less safe than conventional (hospital-physician) delivery. Support by the medical and legal communities for those electing and those attending, home birth should not be withheld on the grounds that this option is inherently unsafe (p. 452).

Tew (1990) also examines statistical instruments which have been used to evaluate maternity care and create a doctor-dependent society. She concludes that, in many instances, statistics have been poorly presented so providing a false picture of mortality and morbidity in comparative studies. Tew builds up a critical history of maternity services in the United Kingdom by disputing statistics of maternal and perinatal mortality over the twentieth century. She suggests, for example, that the "miraculous decline in maternal mortality after 1935" was not through an advance in obstetric technology as had been widely believed, but through the advances in pharmacology at the time (Tew, 1990, p. 211).

A further example of the power of statistics was found in the work by Prendiville, Harding, Elbourne and Stirrat (1988). Widely known as "The Bristol Study" these researchers carried out a prospective randomised controlled trial of the third stage of labour in women over a one year period. Participating women were allocated to be actively or physiologically⁷ managed in the third stage of labour. Their study reported that the incidence of post partum haemorrhage was 5.9% in the active management group as compared to 17.9% in the physiological group. Such results caused an outcry amongst proponents of natural childbirth, and further investigation showed that 61% of the midwives involved had never previously experienced the physiological management of third stage of labour and so were intervening rather than allowing nature to expel the placentae.

In New Zealand, too, challenges have been made to some of the statistics concerning birth. The most noted of these is the study by Rosenblatt, Reinken and Shoemack (1985). This showed, through careful re-evaluation of statistics, that birth was less likely to be safe in large hospitals than in small ones staffed primarily by midwives. As discussed in Chapter Two (refer p. 11) senior staff of the Post Graduate School of Obstetrics and Gynaecology were able to prevent the larger report being released.

However, the Post Graduate School was not powerful enough to prevent an inquiry into their practices following the publication of an article entitled, "The Unfortunate Experiment" (Coney & Bunkle, 1987) in a widely read popular magazine. This article suggested that unethical research in the treatment of cervical cancer, leading to the death of some women, had been carried out for over 20 years in

⁷ active management of labour involves the administration of a drug to hasten contractions and once achieved the placenta is pulled out by the birth attendant. Physiological management involves the birth attendant waiting for nature to contract the uterus and expel the placenta.

National Women's Hospital by the members of the Post Graduate School. The publication of this article led to a ministerial inquiry which was to last for 68 sitting days and hear submissions from 74 parties. The report (Cartwright, 1988) widely condemned the practices of the Post Graduate School which was exposed to the public as having grossly misused its power.

A similar inquiry had taken place in England some two years previously, this time into the practices of Wendy Savage an obstetrician who had challenged the medical establishment on a number of occasions. Savage (1986) described her attempts to provide more choices for women and the reactions of her colleagues. Eventually she was suspended from practice and an inquiry called. Savage's actions were completely vindicated but some interesting questions were raised, namely who had the power and control over birth, and how women were able to access the type of services they wanted.

The findings of both of these Inquiries have been utilised by midwives in New Zealand in their bid for independence. However, it is a later British report (Department of Health, 1993) which critiques the medical approach to birth and offers midwives and other health professionals the opportunity to participate in a completely new approach to the provision of maternity services.

Members of the multidisciplinary "Expert Maternity Group" consulted widely and produced a blueprint for change which has already started to be implemented in the United Kingdom. Such an approach would have been invaluable in New Zealand before the law change as it may have helped prevent some of the conflict which is now occurring.

Midwifery literature

As discussed above, it is mainly literature from disciplines other than midwifery which has had a direct effect on midwifery in New Zealand. Midwifery literature, until recently, has tended to reflect the beliefs of groups dominant at the time. In many instances, too, midwifery textbooks have been written by medical practitioners. Examples of two of the texts in common use by student midwives in New Zealand in the 1970s and 1980s are now discussed.

A popular textbook was a publication by Green (1970), an obstetrician. In this text, Green, implicated in the 1988 cervical cancer inquiry discussed above, outlined some of the procedures midwives should be undertaking. The flavour of the text was highly medical, and although Green feels he cannot comment on "nursing aspects" the foreword by the Matron-in-Chief of the Auckland Hospital Board states that his text would be valuable for tutor sisters, midwives and student nurses.

Conversely, however, Myles (1975) sets out to present "the subject of obstetrics from the midwife's point of view" (Myles, 1975, p. *vii*). Myles, a British midwife, describes the midwife in her opening chapter as:

a highly competent professional woman (who) is legally licensed as a practitioner of normal obstetrics... the midwife's knowledge has been greatly extended; fresh insights having enabled her to adapt her role to keep pace with scientific advances in obstetrics and neonatology (p. *xxi*).

Myles outlines many procedures in which the midwife must become competent but nowhere does she suggest that the midwife and woman work together. Rather, she perpetuates the dominant power relations in which the midwife is subordinate to the doctor, and in turn superior

to the woman. She does, however, tend to use the word "woman" rather than "patient" which is more commonplace in Green's text.

One British article which helped midwives rethink their relationship to both the medical and nursing professions discussed the concepts of normality and continuity of care (Walker, 1976). The author concluded that if midwives were truly to be practitioners in their own right, they would have to accept the accompanying responsibilities and free themselves of nursing and medical shackles.

The challenge was not immediately taken up in Britain but the United States began to offer challenges of its own. Gaskin (1977), for example, describes the practices of lay midwives in Tennessee where standards of care are high, births generally take place without analgesia and women are encouraged to give birth with the support of friends and families in a relaxed environment. Gaskin's text has been a source of inspiration to midwives in New Zealand in their own struggle for autonomy.

Feminism and midwifery

Rothman (1982), in one of the few texts which link feminism to midwifery, proposes a midwifery model which challenges the dominant beliefs about childbirth and in which the midwife and pregnant woman each empower the other. She presents three case studies of how this model has been used, in both lay midwifery and nurse-midwifery, a distinction which is currently under discussion in the United States.

In Canada, too, a movement to resurrect midwifery has been described by Barrington (1985). This author describes the style of a midwife's practice as coming from the community which she serves. She also suggests that in midwifery philosophy, birth is an accomplishment unique to mothers. Midwives can assist this process by catching the babies. Barrington acknowledges the links between midwifery and

feminism, links which she suggests are only recent developments after years of mutual suspicion. However, she stops short of discussing the midwife/client partnership.

The links between midwifery and feminism are also acknowledged by Kirkham (1986) who does suggest that midwives need to work in partnership with individual women. Kirkham's work, unlike that of Barrington and Rothman, however, does not suggest that midwives need to become political. Rather, by working in individual client-centred frameworks, she believes feminist ways of practice will prevail.

McCool & McCool (1989) present an overview of feminism and nurse-midwifery and urge midwives to practise from a feminist philosophy. Feminist thought has been linked to midwifery and, according to the authors, has generated in nurse-midwives the need for much personal and professional self-examination. The authors suggest that feminism is fundamental to midwifery and without it midwifery will not survive.

However, generally speaking the links between feminism and midwifery remain tenuous. An Australian study (Barclay, 1986) shows midwives widely recognising the problem of their own subservience to obstetricians. Like Walker, a decade before, Barclay urges midwives to define their own status, accept the accompanying responsibilities and stop seeking prestige from the science of obstetrics. She does not suggest that feminist theory could be the basis on which to campaign.

Likewise, Garfield (1988) in summing up the international literature on midwifery uses medical language such as "patient" and "delivery." He does not consider that there is a link between midwifery and feminism although he presents an overview of literature on midwifery. He concludes that nurse-midwifery is a distinct profession which has been underutilised. He has some difficulty in suggesting nurse-midwifery's

future development and proffers the suggestion that its practitioners could be trained to assist in the AIDS epidemic.

The relationship of feminism to midwifery practice has not been overtly addressed in New Zealand literature though Tulley (1993, p. 11) comments that "feminism is just a social theory - midwifery has aspects of that theory." Tulley's comments do not do justice to either feminism or midwifery, and the relationship has yet to be made explicit in New Zealand.

Feminist theory, therefore, has been slow to be linked with midwifery practice. Rather, the ideas of continuity of care and partnership without grounding in particular theoretical frameworks have become popular amongst midwives in New Zealand. It is these interrelated concepts which are next discussed.

Continuity of care and partnership in midwifery

The perceived benefit to women of continuity of care was to be the platform on which the New Zealand College of Midwives launched its campaign for independence. As Guilliland (1990) notes:

the fragmentation of the pregnant woman into her ante-natal, labour and post-natal parts to suit medical direction and hospital management played a major role not only in breaking up the midwifery tradition but also in demoralising and undermining the woman's control over her own normal birth process (p. 2).

For midwives in New Zealand to be able to reach such a position the research by Flint and Poulengris (1987) was widely utilised. This research showed that women had better pregnancy outcomes when continuity of care was offered by a small group of midwives from early in pregnancy till after the birth. This research also brought to the attention of the scientific community the real potential of such a midwifery model.

The theme of continuity of care was further addressed by Oakley (1989) who suggests that social support, also defined as love and caring, was as important as science. She also cautions that definitions of caring by midwives and by obstetricians are different and will continue to be so. She suggests that midwives must reclaim their own concept of care both for the sake of women and babies and themselves.

While the academic community debated these arguments it was to be the practical text, "**Sensitive midwifery**" (Flint, 1986) which was to inspire many New Zealand midwives with its descriptions of alternative ways of practice. Page (1988) builds on Flint's theme of continuity of care and suggests that midwifery would not be midwifery without the basis of continuity of care. She adds a further four dimensions which she also considers should be characteristics of modern midwifery: respect for the normal, the enablement of informed choices, recognition of birth as more than a medical event and family-centred care.

In a keynote address at the International Congress of Midwives, Page (1993) further developed these themes and suggested that midwives, in looking to the future, need to draw on the best of the ancient art of midwifery combined with modern principles. As part of this she highlights the necessity for midwives and their clients to work together in partnership.

Partnership between health care providers and consumers has also been addressed in the British report "**Changing Childbirth**" (Department of Health, 1993) in which it was acknowledged that women, who were clients of maternity services, must be central to their planning and operations.

In New Zealand, although partnership of midwife and client is a central component of the New Zealand College of Midwives' philosophy, the

meaning of the concept in relation to midwifery has not been researched. However, in nursing, the concept was researched by Christensen (1990) whose grounded theory outlined the phases inherent in a nurse/client partnership in an acute surgical setting. While not relevant for midwifery because of the dependence associated with the acute care area, some of the questions posed in Christensen's study could equally be asked of the midwife/client partnership. Likewise, some of the psychiatric nursing literature on partnership such as that of Paterson and Zderad (1976) and McMahon and Pearson (1991) in which the nature of partnership in longer term relationships is addressed has relevance for midwives.

It is essential that midwives begin to address this issue and others which are relevant to their practice through research. Although Hicks (1992) has suggested that midwives are their own worst enemies when it comes to undertaking and utilising research, this chapter has demonstrated that midwives in New Zealand have utilised research findings. The final section of this chapter highlights some of the recent published research relevant to midwifery.

Midwifery research

As midwifery experienced a resurgence in the mid 1980s, the need for new forms of curricula for midwifery education became apparent. Midwife researchers both in New Zealand and overseas have made midwifery education the major focus of their research. As education provides the essential foundation for practice some of these studies are now discussed. Most studies located are in the nature of evaluation research using frameworks derived from descriptive statistics.

A study carried out by Kennedy and Taylor (1987) surveyed 574 graduates of Advanced Diploma of Nursing courses, including

midwives who had gained their midwifery registration through such programmes. While not specifically concerned with midwifery education, the results of this study were to have immediate and profound effects on midwifery education in this country. Pressure groups such as "Save the Midwife" and the Midwives' Section of the New Zealand Nurses' Association used the findings of this study to campaign for midwifery to be separated from the Advanced Diploma of Nursing. The Department of Health, however, attempted to resist such pressures claiming that the findings were inconclusive as some midwives wanted to have the dual qualification. However, the pressure groups were successful in their campaign and from 1988, in three polytechnics, midwifery became separated from the Advanced Diploma of Nursing programmes.

An unpublished descriptive study by Hedwig (1990) has also sought to evaluate pre-registration midwifery education in this country. Hedwig explored midwives' perceptions of how their education had contributed to their ability to practise midwifery. Hedwig's study was carried out immediately prior to the 1990 Amendment to the Nurses Act and her 22 participants had graduated from Advanced Diploma of Nursing programmes, throughout New Zealand between 1985 and 1988.

Half of the midwives interviewed spoke very positively about the Advanced Diploma of Nursing component of their one year course, but the remainder felt that this was time wasted which could have been better spent on midwifery issues. The findings of this study, therefore, supported those of Kennedy and Taylor (1987) and provided a more in depth analysis of some of the main issues, such as the ability to practise independently and the gap between the education and practice sectors, which was of great concern to the 22 midwives.

The findings from Hedwig's study have not been utilised. By the time they were made available, much of what she suggested had already been implemented or was in the process of being implemented through the enactment of the legislation. However, for those midwives who participated, her study forms a record of their thoughts and concerns.

A Canadian study by Benoit (1988) compared the education of midwives in three settings, an apprenticeship programme, a hospital based programme and a programme located in a tertiary education institution. Participants in her study, all of whom were midwives engaged in clinical practice, found the second of these options to be the most satisfactory educationally.

Evaluation research into pre-registration midwifery education has also been carried out in the United Kingdom. Two studies have been located which assess attitudes of clinical and tutorial staff to the concept of direct entry midwifery education (Downe, Kenner, Few and Foster, 1986; Downe, Brooks and Gillespie, 1991).

Questionnaires were administered to clinical and tutorial staff in 12 Health Authorities and to all senior midwifery tutors in England and some in Wales. Findings from each of these studies established that myths abound as to the ability of women to undertake direct entry midwifery, and that obstructions to the successful operation of such programmes were lack of tutors and finance.

Another in-depth study on direct entry midwifery has also been carried out by Radford and Thompson (1988a & b). Questionnaires which covered various aspects of direct entry were sent to all midwifery training schools, District and Regional Health Authorities. The questionnaire was supplemented by visits and interviews. The authors of this study found that inhibitors and encouragers to the provision of

direct entry midwifery programmes were pragmatic, historic and ideological.

In New Zealand as well as elsewhere there are also a few reported studies on continuing education for midwives. Allen (1991) was commissioned by the New Zealand College of Midwives to research the continuing education needs of midwives. A questionnaire was sent to both midwives and consumers seeking their opinion on various aspects of education and its applicability to practice. The author claimed that qualitative and quantitative methods were used for analysis of the questionnaire but the framework for analysis was generally unclear. The reliability and validity of the study were also questionable as results could not be linked back to the questionnaire.

In the United Kingdom, McCrea (1989) investigated the motivation for hospital-employed midwives in Northern Ireland to participate in continuing education. The analysis of questionnaires indicated that although midwives found continuing education to be of importance frequently they lacked the motivation to participate. Lack of support from managers, distance to travel and shift work were identified as the main inhibitors to their participation in such programmes.

As well as education, however, researchers have been turning their attention to researching midwifery practice. Until recently research into aspects of midwifery practice has been carried out by sociologists, psychologists, medical practitioners and economists. Reported research by midwives, however, is scarce, though in New Zealand midwives are avid consumers of research related to childbirth.

In recent years, midwives are contributing to the published research in the areas of clinical procedures and the broader aspect of ways of practising. Some of the published studies are now discussed.

Clinical procedures

Published research by midwives on clinical procedures falls mainly into three categories: care in labour, perineal care and breast feeding. The reported studies have all been carried out from an empirico-analytic research approach, generally by use of questionnaires, or in a few instances by randomised controlled trials.

One issue which has dominated the literature on labour throughout the twentieth century is that of pain relief. As outlined in Chapter Two (refer pp. 13-14) the move away from homebirth to hospitalisation was due to the offer of painless labour through the use of twilight sleep. Since then narcotics, inhalational and epidural analgesia have become commonplace in the western world.

Pain relief in labour has been researched by psychologists (Niven, 1990) and obstetricians (Chamberlain & Wraight, 1990). Midwives and nurses have also investigated pain relief in labour mostly in relation to the satisfaction of the woman with her experience. Skibsted and Lange (1992), for example, found that pain relief with pethidine was four times less common in women who gave birth in an alternative birth centre. Flint (1986) found that women who knew their midwife and felt confident with her required less pain relief.

In addition, Hillan (1985) found that maternal posture in labour reduced the need for pharmacological pain relief. This study has been supported by several others (Sakala, 1988; Stewart and Spiby, 1989) showing that ambulation not only reduced the need for pain relief but also shortened the duration of labour. The use of water and massage have also been shown to have reduced the need for pharmacological pain relief (Sakala, 1988).

Active management of labour, especially the third stage, has also been widely researched by midwives and others. Levy and Moore (1985) surveyed a small number of midwives regarding their preference for management of third stage of labour. Only two methods of applying controlled cord traction (with or without signs of placental separation) were surveyed. They found that many midwives preferred to wait until signs of placental separation were present before applying controlled cord traction.

In New Zealand a survey, to which 101 midwives responded, (Smythe, Macaulay, Keirns, Schollum and Gunn, 1991) asked midwives their preferred management of the third stage of labour. Results showed that 24% would not give any ecobolic preparation, preferring a physiological third stage. This research surveyed midwives who practised in hospitals and the community.

Perineal care is another area of concern to midwives. In labour, the question of whether or not to perform an episiotomy has been the subject of much debate. Begely (1986) found in a retrospective study of 2422 women that the episiotomy rates were 54% in primigravidae and decreased according to parity thereafter. She reported that one of the main factors which affected midwives' decisions as to whether to perform an episiotomy was whether or not a consultant obstetrician was present. However, from her retrospective chart audit it is unclear how she could reach this conclusion. Following dissemination of the research findings, Begely (1987) repeated her study and found that reduction in episiotomy rate from 54 to 34% in the primigravid group was achieved. There was no corresponding increase in the number of lacerations requiring suturing. No studies were located which looked at the effect of maternal position on perineal trauma.

Midwife researcher, Sleep has been involved in a number of published studies on clinical procedures. One of these has looked at the effects of pure salt and savlon baths for perineal pain and found no significant difference in wound healing between either of the three treatments, and each group reported some relief from pain after ten days of treatment (Sleep & Grant, 1988). Sleep has also surveyed midwifery practices such as the use of ultrasound and a comparison of different suture methods (Sleep, 1991).

The establishment of breast feeding and prevention of related problems remains an issue for midwives. Following recommendations from the World Health Organisation, health professionals actively promote breast feeding in New Zealand. Until recently timing of feeding was by the clock and duration of feeds built up gradually in an attempt to prevent cracked nipples and engorged breasts.

An evaluation of infant feeding practices by Howie, Houston, Cook, Smart, McArdle and McNeilly (1981) showed that feeding should not be routinised but rather be determined by the baby. This practice is now widely accepted in New Zealand and advocated by most midwives. Houston & Howie (1983), in a study which used both quantitative and qualitative methodologies, found that women who were breast feeding encountered many problems, mostly of a physical nature which led them to stop breast feeding.

The studies cited above consider some of the components of midwifery practice which are often discussed in the literature as well as at conferences and workshops in New Zealand. In addition, where findings have been conclusive, they have often been used to change midwifery practices. Other studies have been carried out into a variety of clinical procedures but it is beyond the scope of this work to examine them all. However, of equal importance are some of the mostly

qualitative studies which are beginning to document the **essence of midwifery practice** both in New Zealand and overseas. Some of these are now discussed.

The essence of midwifery practice

In England, concern at the lack of job satisfaction of midwives led to a longitudinal study, which was carried out over three years, by Robinson, Golden and Bradley (1983). The findings were considered to be so important to midwives that parts were documented in a number of British journals which are read by midwives. Questionnaires were analysed from over 4000 midwives as well as health visitors and medical practitioners. The findings indicated that medical practitioners dominated the childbirth arena and recommended that maternity services be organised in ways which made better use of midwives' skills.

Midwives perspectives of the midwife/client relationship was the focus of a qualitative study reported by McCrea and Crute (1991). The researchers carried out in-depth interviews with 22 midwives identifying four main issues as important in midwives' relationships with clients. These were the nature and value of the midwife's role, recognition of authority and autonomy in practising this role, emotional involvement with clients and maintenance of personal integrity. The findings of this study have limited value in relation to New Zealand as the researchers failed to take into account knowledge and skills which the client brings to the relationship.

It was to be another British study, that of Flint and Poulengris (1987), which showed the advantages of a continuity of care scheme in which one small group of midwives provided all care for clients pre-natally, during labour and the birth and post-natally, which had a great effect on New Zealand midwives. This study, coming at a time when interest

in alternative ways of practising midwifery was growing, provided a vehicle for changing the philosophy of midwifery practice. Further studies with similar results have been since been carried out elsewhere (Lester & Farrow, 1989; Currell, 1990).

In New Zealand, Bassett-Smith (1988) used a grounded theory approach to examine midwifery care in labour in a base hospital. This was prior to the 1990 Amendment but her recommendations are still relevant today. The study identified strengths and problems intrinsic to midwifery practice in a base hospital. She identified many of these as ideological and recommended independently run midwifery units which provided continuity of care as an example of change which could be considered. A strong link between the education of midwives and their subsequent practice was also noted together with a recommendation for change. Some of these recommendations have been implemented but as indicated above, many midwives, despite the opportunities afforded them, have not changed their approach to practice.

White (1991) conducted a study using both qualitative and quantitative methodologies to assess the beliefs, expectations and aspirations of student midwives. She found considerable confusion amongst student midwives as to whether midwifery should be independent of nursing. White's study appears to reflect a medicalised view of midwifery with her participants describing women as "patients" and readily assessing situations such as breech birth as "abnormal". However, such language may have come from the initial questionnaire rather than from the participants. Nevertheless, White's study provides an alternative view of midwifery from that which was dominant in New Zealand at the time it was conducted.

A short study by Jakobsen (1991) also undertaken before the law change explored the perceptions of six women having homebirths concerning the nature of their experience. While not specifically about midwifery practice Jakobsen's study indicated a strong degree of support and reciprocity between these women and their midwives:

the women clearly emphasised what a positive role their midwife played during their labour and birth as well as in visits etc, before and after the birth. There were, in fact, very few things that the women wished their midwife had done differently and in most cases these were not major kinds of things that made a good deal of difference to them (p. 63).

Since the 1990 Amendment, two studies of midwifery practice in two different settings have been undertaken in New Zealand. Scotney (1992) used evaluation research to identify the extent to which an independent midwifery service met women's needs, its cost effectiveness and the extent to which the service met its stated objectives. Thirty clients as well as consumer groups and health professionals all regarded the service positively, particularly finding that the service was accessible to women and generally provided satisfactory continuity of care. Like the scheme researched by Flint and Poulengris (1987), women received care from a small group of midwives rather than one to one care. A few women felt because of this they did not receive the continuity of care they had expected and two reported a conflict of information.

Moloney (1992) used critical case studies of five midwives who had been registered for approximately a year to consider whether midwifery practice was empowering or controlling. She found that many conflicts arose between midwives in hospitals and independent practice as well as those who had been registered for many years and those who were comparatively new. Moloney concludes that despite the 1990 Amendment midwives were constrained by conflicting ideologies,

competing discourses and contradictions between belief and action. For midwives to reflect the professional ideals of autonomy and accountability, they must incorporate critical reflection and ongoing dialogue into their practice.

Conclusion

It may be seen from the literature reviewed above that both the research and non researched based literature has the potential to profoundly affect midwifery practice. As discussed above the findings from a number of research projects from a variety of disciplines are proving influential for New Zealand midwives in both practice and education. None of these studies, however, specifically offers an in depth look at independent midwifery practice, from either the perspective of women or midwives. This study aims to fill this gap.

CHAPTER FOUR

Theoretical Position

Any research which is concerned with midwifery practice must of necessity be grounded in women's experience and closely related to social change. This particular study seeks to actively engage a group of women (midwives and their clients) in a process of self-reflective inquiry, with the aim of problematising everyday experiences of pregnancy and childbirth and by so doing, offer a critique of what has come to be seen as natural in the world of midwifery. As over 99% of New Zealand midwives are women and they deal exclusively with women clients, it is appropriate, therefore, that a feminist approach be used to guide the conduct and analysis of this study.

This chapter first discusses feminist theory and its relevance for midwifery research. Strengths and limitations of a number of feminist theoretical positions are outlined and the relationship of feminist theory to critical social science and postmodernism is also addressed. A theoretical position, which remains women-centred but which draws upon each of these traditions and which will be adopted for the analysis of data in this study, is then outlined.

Feminist theory

Amongst feminist scholars it is generally agreed that there is no **single** feminist theory and any attempt to change this would be a retrograde step as "consistent and coherent theories in an unstable and incoherent world are obstacles to both our understanding and our social practices" (Harding, 1986, p. 649). The feminist movement is thus able to offer a number of positions which may form a basis for research into midwifery practice, and more specifically this particular project.

Expressed in simple terms, to undertake feminist research is to place as central to the inquiry the social construction of gender. Whatever the topic, feminist researchers see gender as "a basic organising principle which profoundly shapes/mediates the concrete conditions of our lives" (Lather, 1991, p. 71). Feminist inquiry argues that gender is central in shaping individuals' consciousness and skills and, more globally, the structure of institutions, power and privilege.

The overt goal of feminist research is to make visible women's experiences and, by so doing, reveal and correct the distortions which have maintained women's unequal social position. While feminist research initially operated within the empirico-analytic paradigm, over the last ten to 15 years feminist research has been more interactive using contextualised methods to search for pattern and meaning rather than prediction and control (Acker, Barry & Esseveld, 1983).

Although feminist research has tended to be somewhat marginalised by more traditional researchers, Harding (1986) has suggested that feminist theory has been successfully used to:

extend and reinterpret the categories of various theoretical discourses so that women's activities and social relations could become analytically visible within the traditions of intellectual discourse (p. 645).

It is through such attempts that four schools of feminist thought have come to be seen as "mainstream". Each of these is briefly discussed below, particularly looking at their strengths and weaknesses as a basis for this research.

Liberal feminism

Liberal feminism is based upon the assumption that all individuals are essentially rational thinkers. "Rationality" in liberalists' terms is conceived of as a property which emanates from individuals rather than

groups. In this way, liberalism is closely allied to the humanist movement of the eighteenth and nineteenth centuries in which human individuals were considered to exist outside of any social context (Jaggar, 1983). The liberals have accepted the mind/body split which derives from the Cartesian framework of the seventeenth century and, while not overtly committed to metaphysical dualism, the conception of rationality by liberals and humanists as a mental capacity possessed approximately equally by everyone, does make this distinction.

Liberal feminists believe that women suffer a variety of forms of discrimination which may be overcome by applying the above principles to women as well as men. Liberal feminists, therefore, take the position that there is no difference between male and female nature, indeed that there is only human nature. Women thus have the same capacity to reason as men, therefore are entitled to the same rights. By taking this approach, liberal feminists assert that from birth all people would have the same opportunities and so any unjust constraints of gender would disappear. Liberal feminists have focused on removing legislation and traditions that they believe are discriminatory against women.

Liberal feminism has been recently popularised in midwifery practice with Kitzinger (1987) espousing the concept of individual autonomy, both for midwives and their clients. Kirkham (1986) also adopts such an approach when urging midwives to consider each labouring woman as a rational, thinking human being.

In New Zealand, the campaign to legislate for independent midwifery practice (refer Chapter Two pp. 19-21) was also derived from a liberal feminist approach on the basis that the previous legislation favoured the male dominated medical profession over midwives who are predominantly women.

Despite the obvious successes of liberal feminism, the concept has several limitations which render it unsuitable as a basis for this midwifery research. These derive from the principle of "individual autonomy" which is grounded in the liberal conceptualisation of "rationality." By its focus on the mind to the exclusion of the body, liberal feminism ignores ideas of biology, in particular reproductive biology, which has contributed greatly to the social structures in which we exist. Further, liberal feminism makes the assumption that human characteristics are the properties of individuals without taking into consideration why these exist. The idea of women acting the same way as men as fully rational agents is now being disputed by research which shows that women conceptualise and reason differently from men (Belenky, Clinchy, Goldberger & Tarule, 1986; Nye, 1990). Liberal feminism, therefore, ignores the way in which women's beliefs, values and desires are socially constituted (Jaggar, 1983).

Midwifery practice is naturally deeply concerned with reproductive biology. Therefore, any research in this area cannot ignore this relationship without prejudicing the research itself. Further, if midwifery is to develop in a way which is different to the practice of general practitioners and obstetricians, midwives and therefore midwifery research must concern itself with the social and historical structures which are intrinsic to its practice.

Marxist feminism

Marxist theory emerged from the opponents of liberalism, who reject its metaphysical duality and thus the liberal conceptualisation of rationality. While there is some controversy over the continuity of Marx's work, it is his later work which appears to have most relevance for the feminist movement. Human biology is central to Marxist thought, as humans exist in a world in which it is possible for these

needs to be satisfied. They are prepared to transform their world in a conscious and purposeful way to achieve this aim.

Human biology and human society are thus related dialectically in that each partially constitutes the other. Each society, therefore, is constituted by its mode of production which "conditions the social, political and intellectual life process in general" (Marx, 1968, p. 29). Rationality is therefore expressed in action, which in turn is created through the history of each society. It is this dialectical relationship between biology and society which has led to the creation of classes and, which, under capitalism, serves to maintain the dominant ideology, with the ruling class defining production. Competition between individuals is encouraged and interdependence obscured, resulting in human alienation.

Although Marx himself did not undertake a thorough investigation of women's nature, Engels, an adherent to Marxist philosophy, argues that women's subordination is a form of oppression resulting from the institution of class society and currently maintained because it serves the interests of capitalism (Jaggar, 1983). Marxists believe that capitalism has produced truncated and distorted forms of human development and it is only by replacing capitalism with socialism that the full development of human nature may occur. It is because of this concern with critique and overthrow of capitalism, that Marxist feminists are interested in the organisation of women's productive activity and their social relations.

Marx and Engels (1970) assume that capitalist society is characterised by a sexual division of labour, which, while not initially oppressive to women became so with developments in the male sphere of production. Having acquired dominance over women with wealth, men wanted to

keep that wealth and so developed a patrilineal system of monogamy in order that they might bequeath it to their biological offspring.

Monogamy, which was initially tied to the ownership of private property, thus affected women of the bourgeois class rather than the working class. However, with the dominance of the bourgeois class, monogamy has in western society come to be seen as natural. With monogamy has come the creation of the nuclear family, with its specific division of labour which, "develops spontaneously or 'naturally' by virtue of natural predisposition (e.g. physical strength, needs, accidents etc.)" (Marx & Engels, 1970, p. 51). Neither Marx nor Engels attempt to discuss these natural predispositions, nor whether they can be overcome. Applying their writings to feminist issues, however, suggests that for women's emancipation, monogamy and nuclear families would have to be abolished, and this could occur with the eradication of capitalism. However, the problems of biology may not be overcome and women thus would have to take a compromise position.

Adopting a traditional Marxist approach such as that outlined above, may offer some explanation as to the twentieth century subordination of midwives by the medical profession. However, Marxist theory cannot provide an explanation as to why it is that midwives are primarily women. It also fails to provide an explanation as to the relationship between the "private" sphere of the work being done by women in childbirth and the "public" sphere of the work of her attendant, the latter of which has recently been recognised by New Zealand law.

Particularly important for this research, however, is that Marxism has tended to move into the realms of theory and divorced itself from

practice (Lather, 1991). Marxist feminist theory, therefore, cannot stand alone as a basis for this research.

Radical feminism

Unlike liberal and Marxist feminism, both of which have their roots in long established philosophical traditions, radical feminism is a contemporary movement, established less than thirty years ago. Radical feminism shows how distinctions of gender structure the whole of life and have created a social construction of "woman" serving to keep women subordinate to men. By understanding the system in which gender has maintained the supremacy of men, radical feminism seeks to overcome it.

In the short time of its existence, radical feminism has changed a great deal. Initially the concept of individual autonomy derived from the liberalist perspective was adopted by radical feminists whose aim was to create an androgynous society. Sex role language was used to suggest that human beings existed as actors who enacted roles that were appropriate at any one time but were discarded later. However, perhaps because of the static nature of the concept of "role" and the failure of androgyny to highlight women's struggle (Rich, 1976) this approach did not succeed in meeting the aims of radical feminists.

Radical feminists now concentrate on biology. From one perspective, biology has been seen as problematic to women, but from another it is seen as a strength. Women's subordination has been explained in biological terms by writers such as Brownmiller (1976) who highlights men's capacity to rape while women cannot retaliate in a similar manner. Sherfey (1970, p. 225) who, in discussing the "scientific discovery" by Masters and Johnson of women's capacity for multiple orgasm, speculated that men found it necessary to suppress women's "*biologically determined, inordinately high, cyclic sexual drive*" (italics in

the original). Neither Brownmiller nor Sherfey offer solutions to the problem of biology, but Firestone (1970) who also sees biology as problematic to women, has suggested that women may, through modern technology, overcome the root of their own subordination.

The idea of biology as the source of women's oppression has gradually fallen out of favour with radical feminists who are now choosing to celebrate its power (Rich, 1976; Raymond, 1979). Women are seen to be close to nature and, with this, to have special ways of knowing which emphasise feeling, emotion and nonverbal communication as opposed to the masculine emphasis on reason, and patriarchal ways of knowing (Belenky et al., 1986).

The issue of biology has been taken even further by some of the French feminists such as Cixous (1976), Irigaray (1985) and Wittig (1986) who begin to challenge the "naturalness" of the female body, of childbearing and sex difference. Wittig (1986) suggests that women have been compelled to correspond exactly with the **idea** of nature that has been established by society. The ideas of this group have yet to be fully developed through research but offer a different perspective in the development of radical feminism.

Radical feminism holds considerable potential for midwifery research, particularly from the popular perspective held today which is celebratory of women's biology and ways of knowing. The relationship between midwives and women at the time of birthing is often characterised by intuitive knowing or even by silence (Belenky et al., 1986). On a more global scale, the ability of radical feminism to politicise issues of childbirth must seem attractive to a midwifery profession that is trying to re-establish itself. However, its concern with biology is also a weakness in that, to date, radical feminism has taken little notice of any other influential factors such as history. Culture, too,

has tended to be dismissed by radical feminists as a male construct so giving the impression of sameness or universality amongst women. In other words, in problematising gender, radical feminism's sole concern has been with biology. For research which is attempting to problematise everyday understandings of women, this is too restrictive an approach, as biology, while fundamental to issues of childbirth, is only one of the issues which affects the participants.

Socialist feminism

Socialist feminism is another contemporary development which has tried to overcome the limitations of both Marxist and radical feminisms by synthesising concepts from each. Like other feminist perspectives, socialist feminism tries to discover the cause of women's oppression and by so doing, end it. It is committed to the basic Marxist conception of human nature as created historically through the dialectical interactions of human biology, society and environment. Socialist feminists consider the differences between women and men to be both physical and psychological, with the main focus being on the social construction of masculinity and femininity.

Socialist feminists such as Rubin (1975) have attempted to 'debiologise' Freudian psychoanalysis, claiming that our inner lives as well as our bodies and behaviour are structured by gender. A major task of socialist feminism, therefore, is to consider the relationship between individuals' inner lives and their social context, including the sexual division of labour. Eisenstein (1979) sums it up as:

None of the processes in which a woman engages can be understood separate from the relations of the society which she embodies and which are reflected in the ideology of the society. For instance, the act of giving birth to a child is only termed motherhood if it reflects the relations of marriage and of the family. Otherwise the very same act can be termed adultery and the child is labelled "illegitimate" or a "bastard." The term "mother" may have a significantly different meaning when different

relations are involved-as in "unwed mother." It depends on what relations are embedded in the act (p. 14).

Like radical feminism, socialist feminism holds considerable promise as a framework for midwifery research. It does overcome some of the limitations of the other perspectives, but is as yet incomplete in that it is still far from constructing a consistent and coherent account of women's subordination. It remains at present rather fragmented. However, as with the other approaches to feminism, its main limitation lies in the very fact that it is seeking **one** truth which will provide the answer to the problems of women's subordination. Midwives and their clients are working in highly complex situations which are influenced by many discourses and any research which ignores this would be at risk of failure.

Limitations of grand feminist theory

The above discussion has indicated that each of the theoretical perspectives outlined above is incomplete in itself as a basis for this research. However, to synthesise concepts from each perspective to provide an eclectic view fails to be true to the theory itself. As Finn (1982) says, theories cannot simply be doctored at the same time saving the theory, as the underlying philosophical system does not survive the doctoring.

One of the main limitations of the analytical categories outlined is the very categorising itself; the attempt by grand theories to search for a defining theme of the whole may lead to the suppression of the important, and often challenging, positions of those viewpoints which differ (Flax, 1987). In so doing, feminism runs the risks of repeating the tendency of patriarchal theories which assume that solutions offered by the theories are the only possible answers. Attempts to categorise have also led to outcries from those such as women of colour, lesbians, older

women, disabled women, who become marginalised in the attempt to generalise.

Despite its radical challenges to the epistemological foundations of western thought it appears, therefore, that feminist theory is in danger of falling into some of the very traps from which it is attempting to escape. Harding (1986, p. 647) suggests that "theorising itself is suspiciously patriarchal," as it inevitably assumes separation between the knower and the known, subject and object. This expands on a point made earlier by Cixous (1976) who states:

It is impossible to define a feminine practice of writing, and this is an impossibility that will remain, for this practice will never be thought, enclosed, encoded-which doesn't mean that it doesn't exist (p. 883).

With Cixous in mind, Harding (1986) suggests that because women and gender relations are everywhere, the subject matters of feminist theories cannot be contained within any single theoretical framework. She has proposed that feminist scholars should not attempt to create grand theories, but accept the fluidity and instability of the world.

Flax (1987) has built on Harding's argument suggesting that feminist theorists have a fourfold task to:

(1) articulate feminist viewpoints of/within the social worlds in which we live; (2) think about how we are affected by these worlds; (3) consider the ways in which how we think about them may be implicated in existing power/knowledge relationships; and (4) imagine ways in which these worlds ought to/can be transformed (p. 641).

It is with these aims in mind that I now turn to a discussion on the situating of this research.

The situating of this research

The above discussion serves to illustrate the complexity of undertaking research grounded in women's experiences. Since the aim of this research is for the participants to render problematic their everyday understandings of pregnancy and childbirth within the context of the midwifery partnership and by so doing offer a relentless critique of what has come to be understood as natural, the research is openly ideological with an emancipatory, praxis-oriented intent.

Rather than being limited to the constructs of grand feminist theory, therefore, I have chosen to draw on two other discourses, those of the postmodern movement and those of critical social science, while always keeping in mind the overt goal of the feminist movement of making visible women's experiences, revealing and removing the distortions which have maintained women's unequal social position.

There are many who would argue that the aim of the postmodern movement is to challenge the fundamental assumptions of the modernist legacy (Rorty, 1979; Heckman, 1990). However, there are also those who suggest that postmodernism is simply the latest stage of the Enlightenment. Sloterdijk (1987, p. 82), for example, sees postmodernism as a "twilight state" through which the Enlightenment philosophies must pass if they are to achieve their aim of transformation through rational consciousness. Derrida (1985), described in academic circles as a "postmodern", also cautions against description of philosophical breaks, and Foucault goes as far as to reject the label "postmodern" when applied to himself (Heckman, 1990).

The above debate will no doubt continue in the interests of developing analytical categories, but if the fluidity envisaged by Harding (1986) as necessary to feminist research is to be attained, such debates are of little

practical interest. Of much more importance is a clear understanding of the meaning of concepts which are central to achieving the aims of this research. Three such concepts are those of praxis, subjectivity, and knowledge/power. Each of these is now discussed.

Praxis

Central to this study is the notion of praxis described by Freire (1972, p. 52) as, "the action and reflection of men (sic) upon their world in order to transform it." In order to achieve praxis there must be a dialectic interplay between action and reflection; in other words theory must be relevant to the world in which it is situated and sustained by actions within that world, while the action is politically grounded in its own theorising. By its dialectical nature and emancipatory intent, the concept of praxis is comfortably situated within a modernist framework.

It is in Neo-Marxist (modernist) thought that the issue of praxis has become popularised, Gramsci (1971) urging intellectuals to become increasingly conscious of the interplay of their own thoughts and actions by developing a praxis of the present. It is this conceptualisation of praxis that was visualised by Habermas (1974) as he endeavoured to develop a critical social science that could be located between philosophy and science. Habermas was concerned with the qualities and values inherent in human life and sought to preserve these by developing the classical view of praxis with the rigour and explanatory power associated with modern science (Carr & Kemmis, 1983).

It was through such dialectical interplay of theory and praxis that Habermas believed that enlightenment would be possible, hegemonic structures overcome and that truth revealed. In developing Habermas' ideas, Fay (1987) believes that enlightenment by itself is not enough to achieve the practical intent of critical social science; this can only occur

when all three phases of a tripartite process of enlightenment, empowerment, and emancipation are complete.

The concept of praxis as conceptualised by Habermas has also been developed by Marxist feminists (Jaggar, 1983). Now, other feminist theorists such as Lather are becoming deeply concerned with the theory/practice nexus where the transformatory aim of feminism is deeply embedded in popular practice. For praxis to be possible, theory must not only illuminate the lived experience of the people but also be itself illuminated by their struggle (Lather, 1988). Praxis, therefore, implies a reflexive relationship between theory and practice in which each builds on the other (Grundy, 1987).

Carr & Kemmis (1983) point out:

praxis has its roots in the commitment of the practitioner to wise and prudent action in a practical situation. It is an action which is informed by a 'practical theory' and which may, in turn, inform and transform the theory which informed it (p. 165).

The emancipatory intent of praxis, however, becomes problematic to the postmodern movement which requires deconstructing the complex network of overlapping forces which constitute the environment (Heckman, 1990). To salvage the notion of praxis then in a postmodern climate is as Lather (1991, p. 12) puts it "an intervention of wilful contradiction." She suggests that rather than continuing to fuel the modern/postmodern debate, through a process of deconstruction using strategies of "displacement," the concept may be reconfigured and kept fluid. In this way the courage to think and act within an uncertain framework "emerges as the hallmark of liberatory praxis in a time marked by the dissolution of the authoritative foundation of knowledge" (Lather, 1991, p. 13).

For the purposes of this research, then, the concept of praxis remains central as, for midwives practising in a changing climate it provides an opportunity for turning critical thought into emancipatory action. The notion of praxis is also relevant for the clients in this study in order that they too may begin to move towards taking an active part in the birthing process and so overcome some of the dominant structures suggested by Berman (1989). Additionally, by reconfiguration of the concept it allows for the awareness of the potential of oppression found within the ostensibly liberatory forms of discourse associated with independent midwifery practice.

Subjectivity

While it is possible to reconfigure concepts such as praxis, its practical intent requires a thinking, active human being. This becomes problematic to the postmodern movement which appears to reject the notion of subjectivity. As Foucault (1984) says we are bodies totally imprinted by history. This implies that subjective experiences are determined by a complex network of overlapping forces of which individuals are only a small part. To understand society, therefore, requires deconstructing these forces.

It is this apparent renunciation of subjectivity that has caused much debate amongst philosophers interested in attaining a position of "postmodern feminism." Alcoff (1988), for example, states that if everything is deconstructed, an effective feminism could only be a wholly negative one as the postmodern critiques of subjectivity must pertain to the construction of all subjects. She suggests that such nominalism threatens to wipe out feminism itself.

Yudice (1988) also supports this stance and adds:

Surely it is no coincidence that the Western white male elite proclaimed the death of the subject at precisely the moment at which it might have had to share that status

with women and the peoples of other races and classes who were beginning to challenge its supremacy (p. 233).

This implies that by following the postmodern view of subjectivity, feminism is continuing to align itself with mainstream philosophical thought, an approach which is little different to that of the liberal and Marxist feminists.

The concept of subjectivity has also proved problematic to some nurse theorists. Humanistic theorists such as Paterson and Zderad (1976) have built their entire theory around the notion of intersubjectivity between nurses and clients. However, later writers such as Chooporian (1986); Stevens (1989); and Kleffel (1991); move away from subjectivity and instead focus on the concept of environment. They each suggest that clients' life experiences are dependent on environment which should be reconceptualised in relation to these experiences.

Environment is also central to the work of Belenky et al. (1986), who in their research into women's ways of knowing, suggest that life experiences of women constitute how they know and what knowledge is important to them. Faraganis (1989) goes further and states that:

individuals, men and women, are historically embodied, concrete persons whose perspective is a consequence of who they are; therefore in a society divided by gender, women will see and know differently from men (p. 288).

Environment and subjectivity are thus dependent upon each other and it is through this interlinking that new knowledge may be developed. This emphasis on environment is also supportive of the postmodern position of Foucault (1984), who does not renounce individual subjectivity but suggests that it is created by experience and history.

Despite assertions that the postmodern movement is posing a challenge to the modernist era, Foucault's position is not unlike that of Fay (1987).

In discussing critical social science, Fay asserts that individuals are frequently constrained by a sense of false consciousness and that by making them aware of this they will be able to reconstruct their environment and remove the constraints.

As with praxis, therefore, subjectivity has become the focus of intense debate. Whether subjectivity constitutes the environment or environment creates subjectivity will continue to be argued. This research, with its focus on midwives' and their clients' experience of midwifery practice, acknowledges their interrelatedness and takes the position that each constitutes the other throughout the duration of the pregnancy, birth and post-natal period. It also takes the position that it is through such interrelatedness that the concept of partnership may be explored.

Power/Knowledge

By acknowledging the subjectivity of participants involved in midwifery research, outcomes of this study will depend on how knowledge and power are conceptualised by those involved. To date, knowledge articulated by midwives through their everyday practice has mainly derived from a behaviourist perspective in which knowledge is produced in a place far from the students who are asked only to memorise what the teacher says (Freire & Shor, 1987). Midwifery education has been based on the necessity to accomplish a given number of tasks in a certain time period. Further, until 1990, midwives have been required to be supervised by members of the medical profession, who have been educated in a similar manner.

However, as discussed in Chapters One and Two, midwifery practice has recently undergone radical changes partly as a result of consumer pressure, partly in response to changing trends in society and partly because of the instability of the economy. Midwifery has become more

"women-centred" thereby rejecting the emphasis on technical knowledge and embracing alternative frameworks. This reflects a general dissatisfaction with paternalistic politics where men have claimed to know what constitutes women's nature.

While critical social science as envisioned by Habermas is also critical of technical interests guiding knowledge, his conceptualisation of emancipatory knowledge also asserts that there is one universal truth, which may be found by engaging in a process of "*ideologie-critique*" to uncover hegemonic structures (Habermas, 1974). The notion of hegemonic masculinity in which Connell (1987) outlined the insidiousness of masculinist beliefs on Western society goes some way to illustrating the complex nature of hegemony. Within the health care arena this not only creates and perpetuates the subordination of women as clients but also may divide female health care providers, such as midwives, amongst themselves.

This notion, however, is similar to that of the mainstream feminist positions outlined above, each of which assumes that there is one cause for women's oppression. By uncovering the myths and deceptions which are associated with this cause, truth may be discovered and the problem overcome.

Contemporary feminist thinkers, however, have rejected notions of universal truth. Hawkesworth (1989), for example, argues that:

knowledge is always mediated by a host of factors related to an individual's particular position in a determinate sociopolitical formation at a specific point in history. Class, race and gender necessarily structure the individual's understanding of reality and hence inform all knowledge claims (p. 330).

Other feminist scholars such as Berman (1989) have also discussed the notion of knowledge as an integration of an individual's experience and

her position within her environment while Belenky, Clinchy, Goldberger and Tarule (1986) offer a number of different "ways" in which women come to know. Each of these reject the concept of a universal truth which has also been attacked by postmodernists who argue that no absolute grounding in rationality or any other omnipresent is an essential condition of truth (Rorty, 1979).

Foucault (1980) argues that knowledge cannot be separated from power, both of which are fused in the practices of history. He is concerned with the plurality of discourse arguing that all discourses create subjects, objects and regimes of power and truth. All discourses are therefore characterised by different approaches to the power/knowledge nexus.

In New Zealand, while health care systems generally remain dominated by technical knowledge and the resultant power of the "knower," independent midwifery has broken away from this approach to knowledge, so creating a new focus for power and knowledge. While some feminist scholars such as Martin (1988) warn against the acceptance of Foucault's power/knowledge nexus, the issue has also been discussed by Webb (1993) who maintains that those who are more highly educated are more powerful. Most midwives are more highly educated in matters pertaining to birth than their clients, therefore, according to Webb must be more powerful. It was, however, primarily the power of the consumers not midwives (refer Chapter Two, pp. 12-21) which has led to the creation of independent midwifery practice.

The idea of "*différance*" which characterises Derrida's (1982) approach to knowledge and power may therefore be relevant to this research. *Différance*, according to Derrida, permits the articulation of both speech and writing in a way which rejects the binary oppositions which have structured modernist Western thought and therefore does not privilege

one over the other. This builds on the ideas expressed by Cixous (1976) which were outlined earlier in this chapter (refer p. 73). The analysis of the data collected in this study from taped interviews with reference to the literature on childbirth and midwifery practice examined in Chapter Three will bring the concept of *différance* to the fore in later chapters.

Foucault's and Derrida's thoughts on knowledge, therefore, have relevance for this research. Both employ strategies of deconstruction which are necessary before the practice of midwifery may be reconstructed to meet the needs of women in the future. Foucault's explicit linking of knowledge and power is valuable because of the way in which it acknowledges uncertainty and indeterminacy (Diamond & Quinby, 1988). It may provide the foundations for the exploration and critique of structures affecting midwifery practice of today. Derrida's conceptualisation of *différance* may also be valuable as both written and spoken discourses will affect the participants' beliefs about pregnancy, childbirth and midwifery practice. Such a conceptualisation also acknowledges the contribution of the unspoken or unwritten, a contribution found to be of great importance to Belenky et al. (1986) as they researched women's ways of knowing.

Conclusion

This discussion represents an attempt to situate this research in a constantly changing and unstable practice world. It does not offer a synthesis of ideas drawn from feminism, critical social science and postmodernism but seeks to reconfigure concepts which are at the heart of each approach. In most instances, ideas from feminist philosophical positions have been refined by drawing upon the other two discourses.

No attempt has been made to reach a conclusive position, but to utilise the commonalities and ambiguities of the various positions in order to define the politics and distortions inherent in independent midwifery practice and by so doing transcend them. At all times in the collection and analysis of data the feminist goal of making visible women's experiences has been to the forefront. Some of the ambiguities, in particular the issues of reciprocity and collaboration, are discussed in the next chapter which examines participant selection, data collection methods and the issues of reliability and validity as they have been reconstructed for this research.

CHAPTER FIVE

Methods

The previous four chapters have described this study in relation to past and present influences on New Zealand midwifery practice and published literature on midwifery and childbirth. A theoretical perspective which serves as the basis for both data collection and analysis was also outlined. This chapter provides an introduction to the data by outlining methods used for data collection and analysis.

Participants in the research are first described, together with an overview of the midwifery service which was the focus of the research. The main ethical issues which pertained to this study are next discussed, then reliability and validity concerns outlined. Data collection methods and analysis processes adopted in this study are then described to form an introduction to the data.

The participants

Selection and background of participants

The participants in this study were all *pakeha*⁸ women resident in one metropolitan area of New Zealand. It was an area which I had visited on only two occasions prior to undertaking this research and about which I knew little. However, through contact with colleagues in the locality, I heard that an independent midwifery practice had been set up where midwives worked together providing continuity of care for a designated number of clients. Subsequent pages refer to the participants as "midwives" and "clients." The midwives who participated in this study were practising on an independent basis (refer

⁸ non Maori New Zealander

Chapter Two pp. 22-25) and the clients are those women who sought care from these midwives and who agreed to participate in this study.

On visiting the practice, I found it operated in the manner suggested by Flint and Poulengris (1987). The three midwives provided care for their clients either independently or in shared care arrangements with medical practitioners. Births generally took place in the location of the clients' choice, with hospital births outnumbering homebirths by approximately two to one.

The midwives worked as a team in the provision of care, with clients having the opportunity to meet all three midwives during their pregnancies. A roster system was thus able to be organised so that each midwife could have regular times when she was not required to be on call.

While visiting the practice I discussed many practice issues with the midwives and we felt that the practice would make an interesting focus for this research project. To enable a richness of data to be obtained, I expressed a preference for client participants who could be part of the study from early pregnancy until the end of midwifery care rather than conducting one or two interviews with many clients at different stages of pregnancy. I therefore opted for including all clients booking with the midwifery practice who were due to have their babies over a two month period. Average client numbers at the time of my preliminary approach were about six per month.

During the course of the data collection several things changed. A drop in new clients booking with the practice, which the midwives attributed to the Frontline documentaries (refer Chapter Two pp. 27-29), was experienced. The midwives changed their way of practising to provide one-to-one client care. There were also personnel changes as the service

restructured in response to predicted changes in funding from government. Although client numbers were less than projected, those who booked with the service and who participated in this research generated sufficient data all of which was able to be used in the final report. Some further, more detailed information about the participants is provided next.

The midwives

In total five midwives took part in the study although secondary data was obtained from other midwives practising in the locality. Prior to the research being undertaken none of the midwives were personally known to me. The initial contact which was made through midwifery and nursing colleagues was described above and when later approached with the completed research proposal at this meeting the midwives appeared very interested and keen to be involved.

The midwives who agreed to take part in the study were from a variety of backgrounds but shared a commitment to midwifery. Two had children of their own. All were registered nurses for varying lengths of time prior to becoming midwives but all expressed a belief that midwifery was a profession separate from nursing. Some of the midwives described themselves as feminist.

Midwifery education, amongst the midwife-participants was varied as two of the midwives had undertaken their midwifery education in hospital programmes out of New Zealand, and the remaining three in New Zealand Polytechnics. Experience in midwifery practice ranged from 12 years to just over a year. Most of the midwives had been practising in hospitals prior to the 1990 Amendment. All were committed to a midwifery model of practice which was woman-centred in its focus (Rothman, 1982).

The clients

The clients in the study were five women due to give birth over two calendar months and who attended the independent midwives for all or some of their maternity care. In order not to break the confidentiality of the midwife/client relationship, women were initially approached by the midwives who told them briefly about the research and asked if they were willing to be contacted by me for a preliminary meeting and discussion about the research.

One woman whom I contacted felt unable to take part in preliminary discussions as she worked erratic hours and did not know when she would be available. The remaining women agreed to participate in the preliminary meetings and subsequently the research itself.

The majority of the clients who agreed to take part in the study were married and already had one or more children. One woman was single and one was expecting her first baby. One woman separated from her husband early in the pregnancy, before her involvement in this research.

None of the women in the study had completed any tertiary education although one was currently studying a short course at the local university. Three had left high school at age 15, the remainder at 17 or 18. Only one of the clients identified herself as feminist.

Two of the women had previous experience of midwifery care when they were followed up by community midwives following early discharge from hospital. All were attending independent midwives for the first time. Three of the women were also having some pre-natal care from their general practitioners.

The researcher

In feminist research it is important that in addition to the participants described above, the researcher also shares of herself. I came into this study as a midwife with 14 years midwifery experience in a variety of settings and in several different countries. Most of this experience was in hospitals dominated by the medical model of obstetrics, but in the last seven years an increasing interest in the feminist movement led to my seeking alternative ways of practice.

Community midwifery in a rural area mainly serving Maori women became the focus of my practice and as outlined in Chapter One (refer pp. 2-3) with the support of this community I became one of the country's first independent midwives in 1990 before taking up an academic position in 1991. Previous research in the women's health area has involved looking at community midwifery services in a large metropolitan area (Fleming, 1988) and determining how nurses could fulfil an advocacy role in a women's health care setting (Fleming, 1991).

My involvement in this study therefore necessitated my sharing this information with the other participants at the commencement of the data collection phase of this study. This and other ethical issues associated with this study are discussed next.

Ethical considerations

All research requires that the researcher undertakes certain procedures in order to maintain ethical standards. Prior to commencing this study the research proposal was presented to, discussed with and approved by members of the Massey University Human Ethics Committee. Following this approval it was then submitted to the local ethics committee, where, with minor amendments it was also approved.

The collaborative nature of this research implies the affirmation of the rights of individuals to autonomy and self direction. This means that the researcher is under an obligation to ensure that these capacities are not threatened. It also requires that the researcher ensures as fully as possible that the participants understand the nature of the research process and the intended outcomes of the study, in order that they are in a position where they may freely choose to participate or not. How this was done in this study is described in the next section.

The main ethical issues for this study, then, were the reflexivity inherent in the relationship of researcher and participants, the right to full information, negotiating the partnership and confidentiality. Each of these is now briefly discussed.

Reflexivity in the relationship of the researcher and the participants

The issue of subjectivity was acknowledged in Chapter Four (refer pp. 77-79) as important for this research. The development of a relationship between myself and the participants and the nature of that relationship is also intrinsic to how data was obtained and utilised in this study.

Established feminist researchers such as Oakley (1981) and Klein (1983) have suggested that, at the very least, a relationship of reciprocity between the researcher and participants should be established. This permits a two way exchange of information and promotes interaction between the researcher and participants and acknowledges the difference from traditional science which values detachment and objectivity.

Tripp (1989) suggests that the key characteristics of reciprocity are:

- (1) a shared commitment to the necessity of the research
- (2) the research agenda concerns topics of mutual concern
- (3) control over the research process is equally shared

- (4) the outcomes are of equal value to all participants in professional terms
- (5) there is fairness and justice amongst participants.

While I accepted that the degree of importance of the research would vary amongst participants, all agreed that it was meaningful. An interactive approach was vital to involve all research participants in the construction of meaning and the validation of knowledge. It was emphasised that each person had valuable knowledge which they could contribute to the research.

However, there are those who argue that such a two way flow of information is impossible to achieve (Ribbens, 1989; Webb, 1993) and that a one sided relationship in which the researcher holds the power is inevitable. The latter arguments are based on the premise that researchers have a different status from those researched as they are usually more highly educated and therefore more articulate.

Such arguments appear to present a limited conceptualisation of knowledge and attribute no value to experiential knowledge such as women in this study have gained about childbirth. However, they do highlight the dangers inherent in any qualitative research. As a means of overcoming these, Wasserfall (1993) has suggested that the kind of reflexivity proposed by some postmodernists may help to prevent distorted power relations and promote a more ethical approach to social science research.

Reflexivity, according to Myerhoff and Ruby (1982), is the process by which researchers understand how their social background influences their thoughts, beliefs and actions. The use of reflexivity during fieldwork, therefore, can dilute the distances between the two worlds of the researcher and participants. The midwives and clients

participating in the study were all aware of my midwifery and feminist background. Each knew that this study would be conducted and analysed using a feminist framework. The relationship, therefore, concentrated on aiming to achieve a maximal approach to reciprocity by negotiation of description, interpretation and principles (Lather, 1991).

However, I also had to seriously consider the extent to which I would be willing to answer questions from clients, in particular, concerning their experiences during their current pregnancies. This is also an issue raised by Webb (1984; 1993) and Oakley (1981). As with these researchers, I decided that while I would not raise specific issues, I would willingly engage in open discussion on any matter pertaining to pregnancy or birth which was raised by any of the other participants. By so doing, I felt that I would be offering something in return for the time and information given to me. In this way the research process also became the vehicle for ensuring maximum reflexivity.

Reflexivity is not only the province of the researcher, however, and considerable time was spent during the course of the initial interviews in exploring the background of the participants so that they too could begin to acknowledge this as relevant to the research. During the course of the study, by adopting this strategy, the research became more mutual as each came to know the other.

The relationship of the researcher and the participants thus became more of a partnership as the study progressed. Participants increasingly looked forward to my visits and during the course of these we shared and debated many ideas on midwifery and childbirth.

The right to full information.

The initial approaches to both midwives and clients have been discussed above. The first individual interviews, which took place with all participants were not taped and involved a full explanation of the study. The degree of participation in time and nature was fully discussed and explained to the extent possible. Implications and outcomes of research of this nature were also discussed and I emphasised that participants could withdraw from the study at any time without adverse consequences. Each interview began with a summary of progress to date, including a review of the transcript of the previous meeting and ongoing data analysis.

Negotiating the partnership

Although, as described above, initial consent to participate in this study was obtained from all participants, the responsibility of the researcher did not end there. For this study to be truly a partnership, consent was renegotiated at each interview. Ongoing consent as an integral part of the research process was obtained and documented on tape rather than in writing. All participants had the right to remove from the transcripts or data anything with which they felt had been misrepresented or which they felt should be retracted. In addition they also had the right to add anything which they felt was necessary for clarification.

In keeping with the feminist principle of reciprocity, I also gave draft copies of all the data chapters to each participant, so that they could see and comment on my analysis of their transcripts. At this stage any data which they felt was too revealing was able to be removed. Only one of the participants chose to exercise this right, though most contacted me with constructive comments and criticism (refer Appendix Two for an example of this).

Confidentiality

With permission having been given by all participants to audio-tape interviews it was emphasised that participants may switch off the tape at any time. Tapes were only accessible to me and to my supervisors and were stored securely when not in use. All of the interviews were transcribed by me, which allowed me to listen to each tape many times, thoroughly immersing myself in the data. On completion of the research tapes were returned to the participants involved. Transcriptions of interviews were only available to the individual concerned. In addition to transcripts, draft reports which used pseudonyms were available to all participants for comment and amendment as described above. All participants were made aware that selected excerpts from interviews would appear in the final report but that pseudonyms would be used to reference these excerpts.

Issues of reliability and validity

Efforts to produce social knowledge that will advance the struggle for a more equitable world must pursue both rigour and relevance (Lather, 1988), because as Acker, Barry and Esseveld (1983) state, an emancipatory intent is no guarantee of an emancipatory outcome. The acknowledgement of subjectivity and personal interest does not mean that emancipatory research should fail to connect methods with theory. Indeed, past efforts to limit all elements of subjective knowledge out of the research process have been seen as a contradiction in terms (Cronbach, 1980).

The concepts of reliability and validity thus need reconceptualisation if they are to sit comfortably within an emancipatory paradigm. They also require that researchers develop new techniques and concepts for obtaining and defining trustworthy data which allow critical examinations of the tensions and contradictions inherent in the research

design. According to Lather (1988), it is such self-reflexivity which will lead toward a paradigm where issues of bias are no longer held as all important in establishing scientific knowledge.

The reflexivity of emancipatory methods involving dialogue between participants and researcher, who together theorise about the issues, implies a distinctiveness about each situation, therefore replicability is not compatible with this paradigm. Indeed, Sandelowski (1993) warns that research participants often change their stories as they are retold as the telling itself may cause them to see events differently. She suggests that there is no reliability coefficient which can deal adequately with the analysis of qualitative data. However, the reporting of such narratives do provide an account and critique of the way in which the subjective understandings of the participants' world are developed and maintained at that time. By illuminating new possibilities for action, readers are offered a surrogate experience. Identification of similarities and differences may allow readers to engage in critical reflection of the conditions of their own practice and so enhance the potential for action. There is therefore a continually evolving process, with constant potential for action.

The validity of emancipatory research and the critical theories produced within them are testable only in action. Lather (1991) offers a reconceptualisation of validity which is more appropriate for research of emancipatory intent. First she considers a form of triangulation extended beyond the traditional definition of multiple measures, to include multiple data sources, methods and theoretical schemes. In this study, data from interviews with midwives was compared with that from clients, journalling and clinical notes used to supplement interviews and videotapes of some of the births added further means of triangulation.

At all stages of the research, negotiation amongst the participants concerning the meaning of statements and propositions and refining this where appropriate, met the condition of face validity described by Lather (1991). The concept of construct validity was shown by the self-reflexivity of the participants which revealed how a-priori theory has been changed by the logic of the data. It is the enhanced self-understanding preceding political action that will test the construct validity of this research.

Lather (1991) also adds a fourth test of validity, that of catalytic validity, which represents the degree to which the research process reorients, focuses and energises participants toward knowing reality in order to transform it. The evidence of enhanced self-understandings preceding action, again may be seen as the meeting of this criterion. However, like construct validity, some of these effects are not immediately visible, but may become so with the passage of time.

Data Collection

The preliminary meetings

Prior to the first meetings I had contacted all potential participants by telephone and each had the opportunity to study the information sheet (refer Appendix Three) and, if requested, the research proposal. The purpose of the research and the nature of the research process were more fully described at the preliminary meetings and each potential participant was given the opportunity to ask questions and express concerns.

It was important to hold these preliminary meetings on an individual basis as each participant had to feel comfortable within herself about her involvement, rather than agree because of peer pressure. At the end of this meeting, I obtained consent to participate and accept the use

of a tape recorder to record interviews. I emphasised that this consent was not a binding contract, rather it was for the protection of both parties and withdrawal from the study was possible at any stage of the research process.

At these first meetings, I outlined some of the characteristics of collaborative research, particularly the expected relationship between myself and the participants. Midwives were encouraged to talk about the research with each other and clients with the midwives. In order to protect client confidentiality, clients were not informed of other clients in the study. I gave my work and home telephone numbers to all the participants and emphasised that they could call me any time they wanted to discuss any aspect of the study. Three of the participants used this option.

Interviews

Feminist research has traditionally been undertaken by using data collection methods such as interview, ethnography, story telling and life histories (Shields & Dervin, 1993). While the concept of interviewing has been hotly debated in feminist circles and at times described as a contradiction of terms (Oakley, 1981; Webb, 1993), semi-structured interviews were the best means of data collection for this study. It is through dialogue generated from such interviews that a process of self-reflection will lead to deeper understanding of the social situation of the participants. It was through this exploration and deconstruction of the participants' social situations that distortions and contradictions could be brought to light and independent midwifery practice reconstructed. Interviews, therefore, were the primary method of data collection.

In addition to the preliminary interviews already described, four individual interviews were carried out with each participant. At times,

three way interviews involving midwife, client and researcher, also took place. These were at the request of individual clients. Some clients also chose to involve their partners in some of the interviews. A final interview was held with all the midwives together at their request. This was also audiotaped.

None of these interviews adhered to a set of structured questions, although a few key questions were asked of each participant. Questions generally reflected the participants' concerns within the broad focus of the research. The interviews were therefore conducted in an interactive, dialogic manner requiring self disclosure from both myself and the participants.

The interviews took place over a nine month period, with some participants speaking informally with me on the telephone or by letter between times. After the first interview, all interviews were audio-taped, the participants having the opportunity to turn off the tape recorder if they wished something to remain confidential. This was an option which was more frequently used in the initial interviews as participants were unsure whether or not to say certain things on tape. Each interview lasted between one and three hours with taped portions lasting from 30 minutes to two hours.

Audio-taping proved to be a satisfactory means of recording dialogue, with participants each having the opportunity to study their own transcripts and make amendments as they wished. For the most part, these amendments consisted of clarifying statements they had made and which were further discussed at the next meeting. Key points of the interviews were also noted by me for discussion at the next meeting.

Journalling and clinical notes

To supplement the information available in interviews, each participant was asked to write down any thoughts she might have that were relevant to the study. Five of the participants did this, the remainder forgetting or being too busy. This emphasises the importance of the spoken word as compared to the written (refer Chapter Four pp. 81-82) particularly as it pertains to women's ways of knowing (Belenky, Clinchy, Goldberger & Tarule, 1986). The data obtained from journals was mainly used to prompt discussion at the next meeting. For those who kept journals, however, it provided another record of their journey through pregnancy which contrasted with their clinical notes.

Clinical records of all care from midwives were held by each client and in some instances these were shared with me. Clients were encouraged by midwives to write in these notes, but for the most part did not. These notes were therefore professional factual accounts of interactions and mostly recorded data on each client's physical condition during the pregnancy.

Videotapes

Three of the births were videotaped and each of these women allowed me to watch these and provided a commentary as we looked at them together. In addition for this being a time for the woman to reflect again on her birth experience, this provided a further excellent source of data.

The process of data collection

To collect the data I travelled to a city several hours flying time from home, for one week per month throughout the year. During that week interviews were scheduled in advance each day at times which were convenient to the clients. Interviews with the midwives were arranged

once I had arrived in the area, as their hours of work were fairly unpredictable.

Despite these somewhat loose arrangements there were surprisingly few problems encountered in the data collection phase of this study. Only one interview, out of over 50 was cancelled. Both midwives and clients appeared to enjoy the process and freely shared much about themselves. In some instances clients would share problems about their pregnancies. Sometimes this was as a means of confirming discussions they had already had with the midwives but more often it was to try and find out if I thought it was important enough for them to report to the midwives.

Midwives, on the other hand, while using many examples to illustrate points they were making, were pleased to be able to talk to a midwife from another area who might be able to throw new light on experiences which they had been having. As the health services were changing rapidly during the period when this research was being conducted and midwifery itself was extremely political, we shared many lively discussions all of which were relevant to midwifery practice in New Zealand.

Data analysis

The concepts of power/knowledge, subjectivity and praxis as outlined in the previous chapter (refer pp. 75-82), together with that of reflexivity, form the main framework for analysing the data in this study. To enable this process to take place necessitates the reconstruction and reconceptualisation of the dialogue of the participants.

The use of audio tapes to record the interviews enabled the immediacy of situations and the intensity of speech to be captured. By transcribing these audiotapes myself I was able to begin analysing each interview on an individual basis shortly after it took place. This preliminary analysis formed the basis of our next interview.

Analysis, on a larger scale, however, took place after interviews were completed. The use of a qualitative research analysis programme such as "Ethnograph" or "Nudist" was considered but following discussions with other researchers and computer personnel, and a brief review of literature on such programmes I opted instead to carry out a manual analysis of data as I felt that this permitted more flexibility when categorising raw data.

Each transcript was studied in detail, with initial analysis carried out on each paragraph of transcript. Key concepts were noted and then each transcript was analysed in more detail, with each word being considered separately. When each transcript was complete these were considered and in some instances amended as I listened to the tapes again. This helped to prevent the text from becoming independent from its context and the speaker's original intentions. As Ricoeur (1981, p. 91) warns, it is possible for a transcription of dialogue to become decontextualised to the extent that "it transcends its own psychosociological conditions of production and thereby opens itself to an unlimited series of readings."

From each transcript's key concepts, common themes were generated and data reorganised under these guiding themes. At this stage, I listened to each tape again to check this for accuracy. Some of the data fitted within more than one theme and so when appropriate was filed under several headings.

Finally, the concepts of knowledge/power, subjectivity, praxis and reflexivity were juxtaposed upon each theme to establish "fit" and to form a framework for their analysis. It was during this final phase of the data analysis that the basis for the next four chapters, that of a journey of midwives and clients, became established.

Conclusion

This chapter has outlined some of the practicalities associated with carrying out this research. Interviews, journals, clinical notes and videotapes provided rich sources of data for both the participants and myself to use as a basis of reflexive critique. The evolving nature of my relationship with each participant encouraged the exploration and analysis of meanings that certain actions and events held for them. The relationship of the research methods and the conceptual framework for analysis were also discussed.

This chapter has provided the last of the background to this study and forms a link between the introductory chapters and the data which is presented in the next chapters.

INTRODUCTION TO THE DATA

Chapters Six to Nine contain verbatim data obtained from participants in this study. This is presented as undernoted.

Participants' speech recorded in *italics*.

Researcher's speech recorded in normal type.

Third person's (e.g. partner) speech recorded in ~~shadow script~~.

Loud speech recorded in **bold type**.

Following each extract the participant's pseudonym, interview number and page of transcript is recorded, e.g. Lesley, i2 p3 represents page three of "Lesley's" second interview.

Square brackets [] indicate the insertion of material to clarify points or to preserve anonymity of third parties.

Dots ... indicate that part of the quote is omitted or where pauses in speech occur.

CHAPTER SIX

Seeking Midwifery Care

This chapter begins to present data from clients and midwives. It looks at some of the reasons why clients have chosen independent midwives as their primary caregivers. It also explores some of the difficulties which have been experienced by clients as they seek access to a midwifery service and midwives attempts to become visible in a system of medical domination. The interrelated concepts of power and knowledge as discussed in Chapter Four (refer pp. 79-82) form the main framework for analysis of data in this chapter.

Past experiences: Knowledge for future decision making

All of the clients in this study had some previous involvement with health services although two were expecting their first babies. Each of these women drew on knowledge gained from these previous experiences to illustrate why they had elected to have independent midwifery care in their current pregnancies. As outlined in Chapter Five (refer p. 87) none had any prior experience of independent midwives and only one knew of a friend in another part of the country who had experienced independent midwifery care.

With one exception, however, the midwives did not refer to their own past experiences as reasons for their becoming independent (as opposed to hospital) midwives. The first part of this chapter, therefore, mainly focuses on data drawn from clients who first describe a variety of poor experiences.

Poor experiences with standard hospital care

I hated it, I absolutely hated it. I was just about in tears every time I had to put her on [the breast]. I blistered and I bled, oh it was horrible.

Chris, i1 p2

But when I got back to my room I can remember the same thing, I really wanted to get up and have a bath and I couldn't. I remember I didn't get bathed, or washed or offered anything, not even offered a shower or anything. I just got put in my room and left there sort of thing.

Yes, you said last time, that it was the first time you'd ever been in hospital and no one came and told you where the baby was, where the showers were.

No, but they hadn't even given me a shower after he was born. Even though I'd had an epidural and couldn't have got out of bed, surely I could have sat on a chair in the shower? Surely somebody could have helped me into a bath? Or even had a wash and put a fresh T-shirt or a nightie on. But I hadn't even had that. I basically had nothing. So I was... I remember waking up in the morning and it was light. It must have been really early, and the door to my room was shut. And I just sort of was lying there and I thought, "Will I get out of bed or will I not?" In the end I just sat there and about eight o' clock breakfast arrived, and at nine o' clock, the nurse finally came in.

Helen, i2 p2

Oh I was ready to leave... Someone on the other side of me and I'll never forget it, she was screaming and I could hear every word. I could hear what the midwife was saying and I heard the midwife say, "Oh, you're only seven centimetres dilated." And I was thinking I'd run away! I could hear it as clear as anything and I was actually thinking of asking to be moved because I still had a long time to go and I was just freaking out listening to this poor girl! I actually went and had a bath to get away! I really think they need to do something about it.

Karen, i1 p4

But I remember [in the hospital] the milking machine was away down that way and I was near the stairs to go up to the unit, but the milking machine was away down the other way.

And they left it there, they never brought it to you?

*Oh a couple of times, but you were sort of well and everything.
That was different too way back then, four years.
Margot, i2 p11*

These four extracts illustrate some of the frustrations experienced by clients who give birth in hospitals attended by midwives who are rostered on for eight hour shifts at one time. Only one of the experiences discussed was prior to the 1990 Amendment, but none of the others had been made aware that any alternative was possible since that time. Their experiences are similar to those described by Rich (1976), Kitzinger (1979), Oakley (1980, 1984), and Rothman (1982) who each describe the power and control that medicine has gained over the birthing process in the twentieth century. However, for the women who participated in this study, concerns were more specifically expressed in relation to four major areas; (1) not being listened to, (2) fragmentation of care and conflicting advice, (3) the need by midwives and other staff to be performing certain tasks and (4) being treated as the property of the hospital. Each of these themes is next discussed and analysed.

Women are not listened to

All of the clients expressed frustration at their lack of input into their own care and the way hospital staff perceived them as apparently unable to make decisions relating to their own bodies. Here Helen describes the sense of powerlessness experienced by her on previous occasions.

But I can sort of remember about 4 o'clock in the afternoon, I must have had a sleep and I woke up and I was, I felt like I was bursting to go to the toilet and this nurse just said to me, "Forget it, you're dreaming. There is no way you could feel that you want to go to the toilet." So I was... I got absolutely... I can remember getting hysterical with [my husband] and with her cause nobody... She finally...

...had your feelings but they weren't listened to.

But they weren't listening to me. And like about 15 minutes later she finally got a pan and I literally filled it. [My midwife] said to me, "You should have wet the bed." I said, "I just couldn't, I just could not." But she said I should have done, that would have taught her a lesson.

Helen, i1 p1

And I was so sore I could hardly sit...I had to sit on the edge of the bed with my arms around [my husband]. With my back curled like that and you know you are so sore in that area you can hardly place your bum on the edge of the bed. And then I can remember like really feeling, really excruciating pain and I think I must have moved because the first time she put the needle in my back she had to withdraw it and do it again. I said to the midwife, "I'm pushing." And she said, "Don't do that you're just making things harder for yourself." And then boom, my waters broke, the head was there, they got my feet on the bed as the baby slithered out and all I could say to her was, "That'll get you for not listening to what I'm saying."

Helen, i1 p2

Helen suggests that while on these two different occasions she knew what was happening with her own body, because it did not fit in with scientific knowledge and the medically defined norms such as the rate of dilatation of the cervix, and the effectiveness of epidural anaesthesia, her knowledge was not respected or even recognised by her attendant midwives. Midwives in attendance were accepting of the parameters laid down by the medical profession and made no attempt to move beyond these and consider alternatives. Alison expresses her frustrations with midwives being overcome by such structures.

I felt incredibly frustrated that midwives didn't have the power to do something they were very competent in doing.

Alison, i1 p2

While Alison alludes to midwifery, Helen is referring to the practice of individual midwives. The underlying notion in both the above excerpts is the espousal of an epistemology which is basically homocentric, and which perpetuates the ongoing dominance of the powerful structures in the childbirth arena (Heckman, 1990). The power of the institution over individual midwives is clearly evident, and while Helen made no

attempt to challenge what she perceived as the powerful position of the midwives, she takes some satisfaction from being found to be right.

Belenky, Clinchy, Goldberger and Tarule (1986) found that the tacit way of knowing expressed by Helen was common to many women in many situations. In that study, however, women themselves did not acknowledge this as a legitimate way of knowing and deferred to seemingly more powerful scientific knowledge which has, in turn, created certain discourses and practices which are considered legitimate. Women, in the present study, as in that of Belenky et al. also knew many things by intuition but as intuition is not quantifiable, this is generally seen as an unreliable source of knowledge by powerful groups such as medicine, thereby silencing women in the decision-making arena. In the next example this is summed up by Alison.

I just generally think that the spirit of woman and the spirit of life is very connected. I think that the system of medicine is very disconnected from the human soul and pregnancy to me is a very spiritual passage through life. And with medical intervention quite often, it could work hand in hand, hand in glove, but it chooses not to. It chooses to ignore those issues that women are saying. And because it does that women are totally unaware of it.

Alison, i1 p3

Fragmented care and conflicting advice

The frustrations expressed by the clients in not being listened to were generally spontaneous and were mentioned without being solicited by me. However the issue of fragmentation of care and conflicting advice was of concern to both midwives and clients. After it had initially been raised by one or two participants I probed the issue more deeply with both them and the other participants.

In the next examples Karen and Chris discuss aspects of their previous birth experiences which they both found fragmented and which left each with feelings of ongoing dissatisfaction.

But when it came to the birth, I was really disappointed because I saw about four midwives during the time, when they changed shifts, and the doctor just whizzed in at the end. You know, and got all the glory! (laughing)...

So that was... you had sort of fragmented care when you were in labour?

The last midwife I had, she knew about the independent midwives and it was actually her that told me about them. She was great and she stayed through the next shift so that she would be there for the delivery which was really good. So she's probably the one that I remember out of the lot. She worked hard, getting me pushing away and all that sort of stuff, then when it came to the good bit she ended up just having to stand aside.

Karen, i1 p1

With the changing of the midwives last time you had to feel like you had to get to know them all. And they would ask you the same questions and you couldn't just say, "Stop." Or whatever.

Karen, i1 p6

I noticed when I first went into hospital and I had a really lovely midwife, she was a real hard case, she was really neat and she got on well with everyone that was there. And when she left I had to re-evaluate everything again, I sort of had to change my ways to cope with the next one coming in.

So you had to change for them?

Yes, I certainly felt like that because they were all different people and it was just the first one I really would have liked to stay the whole time because we did, we clicked, it was neat. So, yes, it does make a difference. Whereas if you did just have the one you could cope a lot nicer, you know, a lot better.

Chris, i2 p1

Karen and Chris found that it was necessary for them, as newcomers, to mould into the well established hospital system. The midwives who practised within that system worked to a roster in which they were required to be on duty for eight hours at the end of which time someone else took over. This served to depersonalise midwifery care for clients whose labours overlapped two or more of these shifts. In this way, medical practitioners, who were generally rostered for longer

periods of time, were often the only people who provided a form of continuity of care for women when they were in labour. Both midwives and clients, then, were seen as subservient to medical discourse.

These findings are similar to those noted by Bassett-Smith (1988), whose research, although specifically carried out in a base hospital, found that women had no continuity of care in labour. Inevitably clients respond better to some midwives than others, and one of the aims of the 1990 Amendment was to overcome this limitation by allowing clients access to midwives of their choice who could provide continuity of care on an individual basis. The effects of continuity of care for the participants in this study are reported in Chapter Nine (refer pp. 191-193).

Changes in legislation, however, also have the potential to redress some of the imbalances of power created by the traditional regime. By women being able to choose their own midwives, and having the option to have no medical involvement in their pregnancies, the power of the medical profession in the area of birthing becomes diminished. This is further discussed in later chapters.

One of the midwives in this study was able to reflect on her experiences with the traditional health care system and express her concerns regarding fragmented care.

*Well, I was only involved with about three births as a student nurse and in each situation I was thrown in to meet this person in labour with, "This is a student nurse you'll have with you." I'd never met them before, didn't know a thing about them, so had very little power in the sense of how the birth eventuated and had very little knowledge about **anything**. Yet I was also that person's main support system, her support person, because the midwife was very...wasn't involved much.*

Sarah, i1 p2

Sarah's concerns reflect those of Chris and Karen. As a student nurse she felt powerless to intervene although she recognised that the women were not getting the quality of care to which she felt they were entitled. She knew, however, that although she had little formal knowledge of birth, she was able to offer some support to the clients she was allocated simply by being there.

In a system which was oriented to the medical profession, Sarah's status as a student nurse was only slightly above that of clients. Each appeared unable to change it though Sarah, through reading, was aware that birth could be different. In a later interview she reflects further on her experiences in relation to the fragmented care of her clients.

Yes, it was in a base hospital. I think it was just the way the hospital structures things really, their routines at the time and I don't know quite why. Because I hadn't really done a lot of reading or thought about a lot in a conscious kind of way that I somehow admired midwives for some subconscious reason and I was quite sort of shocked or disappointed when I saw you know, that it just didn't work like that here. I knew there was a ... that didn't inspire me to be a midwife in any way, although I did want to be a midwife because I somehow knew, I can't think clearly how I did know, but I somehow knew, yes, that midwives weren't like that everywhere it was just the way that place worked.

Perhaps because of just the medicalisation of childbirth? ... But it's horrible. As I said to you then and I still think about it, you know, some of my conditioning was like that, quite horrifying.

Mmm, I could never have fitted into that in the way that, I never did much as a nurse either, but I could never have fitted into that and then had to grow out of it, I just wouldn't have been able to do it, and at that stage I was reading books and things.

Sarah, i2 p1.

While Sarah's experiences relate to the time on delivery suite needed to ensure her registration as a nurse, she is beginning to look at the total care of a woman throughout the pregnancy, birth and post-natal period.

Such continuity of care was not a common element in midwifery practice in New Zealand at the time Sarah describes but had then been documented elsewhere in the world by such authors as Gaskin (1977), Rich (1976) and Rothman (1982).

Although fragmented care was most clearly articulated by clients in relation to the birth experience, reference was also made to the post-natal period. In the excerpt below, Helen reflects on her past experiences.

A nurse came back into the room at midnight and asked if I'd been seen to again. And I said, "No, nobody's been into do anything since he's been born." So all that time I'd been sitting in a pool of blood. They didn't give me anything to slow the flow down. They normally give you that injection straight after the birth. Nobody had thought to do that, nobody had thought to even change the bedding and when they got round to it they changed the whole bed, it was that bad! I mean they didn't change the sheets, they actually wheeled another bed in took that one away, that's how bad the bed was. And that nurse was appalled that I'd been left for so long. But it obviously just happens when they change shifts, one lot goes off and one lot comes on and they have to find out what's been happening when they get there.

Helen, i2 p2

In the final sentence Helen tries to justify the "nurse's" actions. She sees that the blame lies within the system, rather than considering the people who make up the system. The concept of the system is comfortingly anonymous and not concerned with the critique of individuals or groups of individuals within it. Capra (1981) sees individual anonymity as a strength of the biomedical model, and critical theorists such as Habermas (1974) and Freire (1972) have suggested that it is just such hegemonic structures which must be exposed and overthrown in order to achieve change. The lack of differentiation between nurses and midwives is discussed later (refer p. 117).

In terms of fragmented care it is the issue of breast feeding which remains one of the most problematic experiences for women who have babies in hospitals (New Zealand College of Midwives, 1992). Here one midwife describes a fairly common scenario and one client and her husband relive their own previous experiences.

Well this woman decided in fact to bottle feed and when I went in the next day and she said, "I've decided to bottle feed and I'm really happy about that." And she was absolutely sobbing her heart out at the same time. She obviously wasn't very happy with that at all but nobody had actually told her the alternatives. I suggested she could leave off breast feeding till her nipples had healed, till she felt better and could do a few more things, she could actually make her decision then, when she was feeling better, not when she was feeling absolutely ghastly. And that caused huge uproars.

Lesley, i2 p2

I felt very angry, she was in a lot of pain and no one seemed to try and help her or even tell her or show her or even tell her anything.

Yes and there was a lot of different information.

And then you'd get a different shift coming on and doing different things.

Yes, yes.

And then going back into hospital again and being told what you had to do. Them saying, "Oh you could breast feed, give it another go."

Chris (and husband), i3 p10

Post-natal wards in New Zealand are traditionally staffed by one or two midwives, registered nurses and obstetric nurses who have been educated in a number of different institutions. Through their formal education as well as from personal and professional experience they have each learned different ways of assisting women with breast feeding.

There are many ways in which breast feeding may be successfully achieved. This is a point which is emphasised by Jackson (1993) a lactation consultant, who advocates flexibility by both clients and midwives in regard to all aspects of breast feeding. However, as can be seen from the above excerpts, women seem to benefit little from the many approaches to breast feeding but to somehow become caught in the middle of competing professional ideologies.

In the instance described above the multi-professional approach of the hospital staff leaves feelings of confusion and turmoil amongst its clientele. It therefore becomes a more subtle manifestation of power as each midwife or nurse attempts to educate women as to "the one best way" to ensure successful breast feeding. As clients talked about these previous experiences of learning to breast feed the language which was used implied that it was a violent rather than a nurturing occasion. Chris provides an example:

This time I feel much more relaxed. There won't be all these nurses like there were in hospital ramming the baby on.

Ramming the baby on?

That's exactly what they were doing (shudders).
Chris, il p8

Again, however, although Chris has unpleasant memories, there is no suggestion of any blame. Rather, any fault is generally attributed to the system as a whole where nurses and midwives may be more anonymous and where time and client numbers often dictate their practices. In the past this has created an orientation to midwifery practice dominated by the tasks which had to be carried out. Task approaches to midwifery practice are discussed in the next section.

Task approaches to midwifery practice

Midwifery workloads in most post-natal areas have been reorganised in recent years to reflect a more humanistic rather than task approach to client care. This has been achieved in many instances through organising workloads by clients rather than tasks. However, heavy workloads ensure that many practitioners are still primarily concerned with efficiency than quality of care.

The example given above in relation to a specific aspect of practice, that of breast feeding, shows how midwives practising in hospitals may not be primarily concerned with health education for clients, thereby creating client dependency on the staff who are perceived to be more knowledgeable and consequently more powerful. This dependency in turn creates a need for hospital midwives to **do things** so that they can continue to perpetuate the dependency.

An example is provided by one of the midwives.

It's interesting where ward staff who are reputed to give good breast feeding assistance... I've heard people say, "So and so can get any baby to go on the breast, she can get a baby to go on to a block of wood"(laughter). She can, but she can't teach a mother how to do it. In fact the worst disasters we used to have come from her purely because, yes, she was able to get that baby on but that was only in the hospital when she was on duty, but when she wasn't there... it wouldn't go on.

Lesley, i2 p6

Further discussions with that midwife suggested that the nurse concerned would have no idea that she was acting in a way that exuded power, by creating client dependency and so maintaining the need for her own services. It is such subtle forms of domination as this that has given rise to the power structures in health services which independent midwives now seek to break down if true independence is to be realised (Foucault, 1980). Chris and Helen give examples of how actions such as those described by Lesley affected them personally.

Yes, well they were doing it. They'd stick her on and that would be fine, but as soon as she came off and I tried to do it we'd be back to square one. It was just hopeless.

There's a lesson in that, for midwives, for nurses, for folk that work in hospitals. You're certainly not the first one that's said that.

Chris, i1 p10

All week I had someone to tell me, "Bath it now, change it now, feed it now."

But isn't that part of the conditioning of hospitals?

Yes it is.

Helen, i1 p8

Clients, therefore, are seen as needing things to be done to them rather than preparing them for caring for their babies when they left hospital. Indeed, most of the clients in this study spoke of how so much was done for them in hospitals that they felt ill equipped to go home.

It was just so pressured, I just hated everything about it. The more, the longer I stayed the worse I got. I got really depressed and I didn't want to go home. I wanted to get out of there but I didn't feel confident to go home. I thought, "How the hell can I feed this baby?"

Chris, i1 p9

I remember with [the first one] the day we came home on the Sunday and I sort of got home and burst into tears, "Oh my god I'm so scared, I don't want to be home, what am I doing? And I've got this thing, what am I supposed to do with it?" ...

And that first time when you came home after the five days, you didn't have any one visiting till the Plunket⁹ Nurse came?

No one. No. And then she only came once a week. So I'd been home a week before she came and that's a long time.

Helen, i1 p9

⁹ Registered Nurses with specialist education whose practice is the care of under five year olds.

Experiences which Chris and Helen describe add to the undermining of their confidence and lead to the belief that any knowledge they might have is meaningless. As Belenky et al. (1986) state, this is a common feeling amongst women when confronted with ideologies which they perceive to be more powerful than their own knowledge and values. For the women in this study, confidence was undermined by means of the fragmented care and the necessity for midwives and other staff to be performing certain tasks, which abruptly stopped when clients were discharged from hospital. It is this task approach to care which has led to midwives carrying out their duties in a way which ensured the best possible use of their time rather than balancing the needs, values and desires of individual women (Bassett-Smith, 1988). It has also led to the invisibility of midwives within the culture of the hospital. This invisibility is now discussed.

Invisibility of women within the medical system

In various excerpts above, clients have described incidents where they have been required to adapt to the demands of a number of different health professionals. Here both midwives and clients provide examples from their experiences which show that adaptation by both is required on a broader scale. Previous excerpts (refer p. 105 & 111) have shown that clients refer to their caregivers in hospitals as "nurses" rather than "midwives." Further examples illustrate this

You talked about disrupting the Nursing Care Plan. Nursing care in a midwifery setting? Is that the type of care it is?

(laughing) I suppose it's referred to as the care plan. I would say it's actually partly because we've all grown up with the idea of the Nursing Care Plan and it's quite difficult to view a midwifery care plan... I remember in [another area] when the Nursing Care Plan was coming out and I remember us midwives discussing it and saying it really wasn't at all appropriate for midwifery. Particularly for a woman in labour. I think it's because nursing is dealing with problems whereas pain for instance is not necessarily a problem for a woman in

labour. It's actually so obvious though that if it is a problem what to do about it. Give pain relief.

As you say it's not necessarily a problem but the other thing I wondered about that word 'nursing' was that it seems to be a word used by hospital midwives.

Yes, I think that's probably right for me. I do think of myself as a midwife, I'm very much a midwife but maybe I see the hospital midwives as giving nursing rather than midwifery care.

Lesley, i2 p2/3

Midwifery then had not only been subsumed by the medical profession but also the culture of nursing. Hospital rituals such as nurses and midwives wearing the same uniform and the breakdown of client care into tasks has perpetuated this invisibility. Although the 1990 Nurses Amendment Act has gone some way to redressing this, there are those for whom the differentiation of nurse and midwife remains obscure and others for whom it is misinterpreted. In this study Karen gives an example of this latter perspective:

[My midwife] came in every day. Apart from that the nurses were there when I need them but I didn't really need them. But they popped in and introduced themselves on their shift and that sort of thing.

Karen, i4 p.5

Karen differentiated between her midwife and the staff in the post-natal wards whom she saw as nurses. While technically this is true, as all were registered nurses, the institution concerned made a point of employing all midwives in the maternity unit. The midwifery philosophy of practice articulated by the New Zealand College of Midwives (1992) is clearly different from any nursing model but the clients in this study were unable to recognise this.

Likewise, clients at times also appear to be invisible within the hospital system. Pamela, for example, recalls her experience as a student midwife:

*That was it though, women didn't feature in my training.
There was a pregnant body but nothing about her.*

Pamela, i1 p10

Clients attending the hospital were divided up into their respective parts for the purposes of midwifery education. Education, like the clinical experience described above, focused on tasks to be done, and until recently in New Zealand it was a requirement of the Nursing Council that to register as a midwife certain **numbers** of abdominal palpations, vaginal examinations, and deliveries were essential. Clients of the system unwittingly provided these numbers for student midwives, and for other students such as doctors, nurses and ambulance officers. As Donley (1986) has said, the 1938 Social Security Act ensured that there was plenty of clinical material available for medical students. The domination of medical science over midwifery curricula ensured that for the experience of student midwives women were also required as clinical material rather than as part of the decision-making process regarding their own care. Lesley reflects on the meaning of this and presents the scenario of a midwife (or nurse or doctor) who is admitted to hospital to have a baby.

*And as midwives and nurses we have a double dose of all that,
not only from going into but also working in that system.*

Yes, you're right. How often do we have a client who's a midwife or a nurse or a doctor and they're seen to relinquish that knowledge as they're "only a patient?"

*Yes, and there's a huge amount of pressure on them when they
are a patient to behave themselves... I hear about the midwives
who when they're pregnant say, "I hope I don't make too much
noise... I hope I... I hope I behave myself." Like there's this
huge pressure on them as well to conform and it's just not on.*

Lesley, i2 p7

The situation which Lesley describes is a reality for many midwives who have undertaken a technical training in which clients have been used for clinical material as described above. So when they are

pregnant themselves, there is a feeling of having to relinquish the knowledge which they have and yet to provide the medium for others to acquire that knowledge and experience.

Lesley also suggests that there is a fear that if these midwives are not seen to be relinquishing their knowledge and conforming to the rules of the institution then their care could be jeopardised. This matter of fact suggestion does not allude to the hegemonic structures within the hospital, which subtly maintain the status quo, until challenges are made from those whom it affects (Geuss, 1981). Rather, these structures are implicitly acknowledged, and whilst not liked are somehow seen as immovable.

Instead of directly confronting such structures midwives have made changes to client care regimes in both hospital and community settings (refer Chapter Two pp. 22-27). However, these have failed to substantially overcome the structures. These structures are also recognised by clients in this study. Here Chris recounts her experiences and like Lesley, although recognising that there are some power structures, does not suggest a way to overcome these. Instead, this time, through choosing midwifery care she has found a way to get round the obstacles she found in hospital.

Whereas then I just did what I was told. You know I felt like this solo mother that didn't know what to expect and they didn't know how she was going to cope, whereas I did have my support.

Chris, il p8

Margot, however, sees herself as isolated from any decision making, which is up to the health professionals. She sees that they are the ones with the knowledge and therefore are those qualified to make decisions about her pregnancy, even although she has had previous experience of childbirth. Berman (1989) has suggested that attitudes such as

Margot's are common amongst women and are part of the hegemonic structures keeping medicine in its powerful position. In a discussion in an early interview concerning how shared care between midwife and doctor was working for her she expressed this.

But you're quite happy with the way they work in with each other?

The doctor is very happy with the way they work in with each other. He thinks it's good.

Margot, i2 p3

Alison, however, had some awareness of what the difficulties could be. She sees doctors as the main power brokers in hospital services and by raising issues of safety, they are able to maintain their power.

However, it's a bit different than what the doctors are saying. They'd be saying, "Well we're going to be laying down these rules." So that you can be sure you'll keep your baby alive. Well, they can't and I don't want it to be like that.

Alison, i2 p4

However, in a later interview, Alison suggested that it would be almost impossible for a client to take any action which would serve as part of the counter-hegemonic struggle, required to change the structures of maternity services. This is consistent with Freire's beliefs that a critical mass is required for any purposeful action to occur (Freire, 1972).

It's women complaining about the medicalisation. Two different lots of women I guess, the feminist movement but also the traditionalists who want to get back to family birth and together they've successfully challenged the medical establishment. So it takes the complaints. And sure it's like the whole world's against you, but it's **you** that's in the wrong.

*The whole essence of it is that it's **you** who's the 'unmedical' person and you're against the doctor. And unless you've got a doctor presenting your evidence, standing up against another doctor it's very difficult. I mean it's really hard, almost too hard, to think about. The assumption is that I don't know anything.*

Alison, i3 p11

However, it is through the articulation of feelings of frustration which Alison has expressed that led to the establishment of a critical mass in the 1980's. It was this critical mass which ultimately presented the challenge which led to the 1990 Amendment and the re-establishment of independent midwifery practice which was the method of care sought by women in this present study.

Having considered some of the reasons why women were seeking a change, the second part of this chapter now examines how midwifery care was accessed by both the clients in this study and other women. The experience of clients families in response to the selection of midwifery care is also briefly discussed.

Access to midwifery care

As outlined in Chapter One (refer p. 1) midwives have been able to practise independently of medical supervision since August 1990, and since then increasing numbers have been so doing. Despite this option, however, three of the clients in this study who have had previous pregnancies since that date were unaware that such an option was possible. One midwife describes it:

I think when it comes to... most women if they said to you, "I think I'm pregnant." And you said to them, "Who are you going to go and see?" Most of them would say their doctor and I think they just see that as normal. Maybe it hasn't reached them that midwives are doing it, they're out and about in the community, not just in the hospital dealing with labour and things. So, I think it's a matter of women being aware that there's midwives there and thinking, "Oh, I think I'm pregnant so I might go and see a midwife."

Yes, yes. A woman's just said to me this morning, "Oh, can you just go to midwives?" And I said, "Well, yes." And she said, "I don't know that I'd like that."

Yes, they see it as being dangerous or risky or just not safe. I hate that word "safe." I think there's a lot of stuff said in the name of safety.

Julie, i1 p4

Julie expresses her doubts as to the accessibility of midwifery services to the general population of women in New Zealand. As outlined in Chapter Three (refer pp. 36-39) the medical campaign for control of childbirth was based on the issue of safety. It is a concept therefore, which tends to have negative connotations for midwives in this country. Julie's doubts as to accessibility are partially shared by Fiona who spoke of her early hopes for setting up an independent midwifery service:

We were pretty sure that once women knew about it they would be pretty keen but we live in a society where I'm pretty sure that women are born believing that they need a doctor [at the birth of their baby].

Fiona, i1 p5

Fiona believes that women in New Zealand have come to expect, and therefore to need, a doctor to be present when they are giving birth. It seems at times that the hegemonic structures were so firmly ensconced that to make a break from such traditions through a process of *ideologie-critique* (Habermas, 1974), still requires major changes. Despite the action which had brought about the 1990 Nurses Amendment Act, power structures remained basically unchanged.

Moloney (1992, p. 80) suggests that it is **midwives** who are with women throughout labour and therefore it is midwives who have, "tacit understandings of the nuances in interpretation, a kind of communication that takes place among familiars." This concept of mutual understanding is one on which midwives have sought to develop the basis for independent practice. However, evidence in the present study is suggesting that women still believe that a doctor is needed to supervise pregnancy and birth as shown. Hence, the

midwifery approach to the total pregnancy and birth needs to be more visible.

In this study, I asked midwives how they were contacted by clients and clients were asked how they were able to locate midwives. Some of their responses form the basis of the next section of this discussion.

How do they actually get access to that choice? [of midwifery]

Word of mouth [mainly]. Other women tell them what's available. We receive lots of invitations to speak at Plunket groups, La Leche, Parent Centre etc., so we broadcast the choice as widely as we can. We distribute our pamphlet, [one of the midwives] has spoken to the media, has had articles in the newspaper and whenever that happens, there is a flood of enquiries but from our survey last year the major source of information was from a friend who had used the service. Some doctors are telling the women. Some doctors who don't do obstetrics will conscientiously recite all the choices to women and that's what we encourage because that's brilliant.

Fiona, i1 p10

Fiona firstly expresses that most clients who approach her come without having seen any advertising about independent midwifery. She recognises the potential of advertising, however, not only to increase the client base for her practice but to ensure that women have access to all the choices which are available in the locality. Indeed the midwives in this study and elsewhere in New Zealand have all expressed the importance of women's choice and how they endeavour to ensure that this has the potential to be as fully informed as possible.

Fiona overtly praises the doctors who offer women who approach them the full range of choices. Although not explicit, the suggestion is there that many doctors do not offer the range of choices to women, preferring instead to keep control of their own clientele. Control is manifest in limiting access to independent midwives by the simple means of restricting the amount of information available to their clients.

Controlling of information through silence is one of the most powerful tools able to be used by the medical profession to maintain their position and prevent independent midwives from practising. One midwife did, however, explicitly state that doctors were not doing all they could to offer women the range of services.

Oh I'm sure that it is, there's a lot of women that have no idea. And I don't think we can rely on the first person whose door they walk through, who is usually a GP. I don't believe despite what I've heard over recent weeks that they actually provide choices for women. I don't think they sit down and say, "Yes, you're pregnant now and here are all the choices. Here's the hospital and here's me and those are all the different things that are offered." That's not a reality. I think, the Area Health Board is supposedly putting out some booklet or other that supposedly gives the choice without pressure one way or another. I think the Health Department needs to do something like that.

Yes, it's got to be a supposedly neutral body I think. But still the majority of pregnant women will go to a doctor first.

It's hard but we really need to get to them before that. We try to put our pamphlets into the Family Planning Clinics and we try to have them in the GP's rooms, especially the ones that don't do obstetrics because they're far less threatened by us because they know we're going to send the women back to them. And the ones who do do obstetrics have been threatened by what we've done. Some have even employed their own midwives because it keeps them very much more under their control and they don't have to share the power in any way.

Pamela, il p6

Pamela has outlined a phenomenon which is becoming increasingly common in New Zealand, that of doctors employing midwives or entering into other business relationships with them so that any other practitioner is excluded. In this way the medical profession remains in control of childbirth as women are referred by their general practitioners to the midwives of their choice who sometimes may only see clients once before labour begins. Other doctors prefer to retain those clients whom they see as easy and are using midwives as a

medium to refer clients whom they see as problematic, through poor social circumstances or poor attendance at pre-natal visits.

You know, you're really surprised that they'd end up finding... well now doctors are starting to you know, like doctors are starting to refer women who are in difficult social situations or, you know, or bad histories and things.

Sarah, i2 p3

While the midwives speculated in general terms, however, the clients gave more definite reasons for choosing midwifery care.

So what made you choose to go to a midwife? Was it that experience?

No, it wasn't. Even before I considered having another baby, my sister... she's right into home birthing and all that sort of natural stuff anyway... and there was a meeting at the Plunket, at least through Plunket and there was a midwife there and someone who'd had a homebirth and there was another lady, I can't remember who she was now. I said to [my sister] "Well, do you want to come?" Because they don't mind if you take people along to these Plunket meetings and she said yes she was really keen to go along and listen and that was when it triggered to me that anyone can do this. So that set me thinking that maybe it was an option for me. And it wasn't till later when I did get pregnant and I decided, "Well yes, I will, I will have this baby at home."

Chris, i1 p3

I heard about the independent midwives from [a midwife] before it was set up, I think they were just planning it. Then I went to a Plunket AGM and one of the speakers was one of the midwives and that's what really sold me on it.

That's interesting because a woman I was talking to yesterday was saying the same thing, she'd been to a Plunket meeting and off she went...

Yes, it's really interesting. When I went along to it I thought, "Oh, I wish I had that when I had my baby." So this time I decided that's what I wanted.

And do you find that in the Plunket circles a lot of women didn't know about it till they came?

Mmm, yes, even now I think a lot of people don't know about midwives. I keep telling people about it and selling the idea.
(Laughing)

Karen, i1 p2

So how did you find out about them?

My mother.

Oh, tell me more.

Um, it was something in the paper that she read, in the local mid-weeker, that she read.

So what did she do? Waggle it under your nose or had you been saying to her that you wanted something different?

No, no. She told me about it and she said, "Well?" "Oh I'll ring up and find out about it." And then they rang me, we made the appointment and here we are.

Margot, i1 p2

Each of the clients quoted above was able to find out about the existence of independent midwives through some form of advertising. Advertising of midwifery services is something which has not been discussed in previous research studies in this country, and is generally a concept which has been foreign to New Zealand midwives in the past. However, with the need to compete with medical practitioners for clients, and in some cases with other midwives, advertising is obviously necessary if midwives are to succeed in independent practice. Advertising would not only inform women of choices available but also serve as a medium for individual midwives to promote their own practices. Increasing the visibility of independent midwives through such advertising may be seen as part of the counter-hegemonic struggle within the childbirth arena.

One client who knew of the existence of independent midwifery found it difficult to access a specific service, even though that was the care she wanted in her pregnancy.

You were just saying about the early difficulty in finding a midwife. How did you try?

I asked actually three health professionals, males. And none of those felt that there was a good system here. As you know there were two, and on a course I went on for a herbalist lady and I asked her if she might be in contact with that kind of thing and she said she knew there was one somewhere but she wasn't sure whether there was a group here. So she said it would be under the yellow pages or white pages or such and such. So I perused the yellow and white pages.

Read the telephone book!

Read the telephone book page by page and no there wasn't. Well in all accounts I thought, "No, there is no midwifery." Several months after that I was three and a half months pregnant at that stage and still deliberating and people were saying, "You really have to go to the doctor, you've really got to do something." And I said, "I don't want to go to the doctor."

... So you got to three and a half months and you still hadn't been to a doctor.

No, I still hadn't and I was starting to get concerned myself because I felt I should be learning something... I came across a newspaper at a party. I was bored and started reading the newspaper and all of a sudden this ad just popped out at me. It said, "Midwives wanted." Hence I made an enquiry and I went through four different phone numbers and got hold of my midwife. So I was still passed on and I was amazed at how completely difficult it was to access something that is my right as a woman and in the end we just totally under-emphasise the fact that the woman giving birth is our future, is our world.

Alison, i1 p5

Although Alison had specifically sought help from three health professionals regarding midwifery care in the locality, they were unwilling or unable to provide her with that information. In a later interview she speculated on some of the reasons:

(Sighing). Well options, and information. How do we step into the networks? Well, we need to stand back and see what knowledge we want, what knowledge we do have and what knowledge is available. The thing is it's just so dammed difficult to step into it... there's GP this or hospital that, a real

anti feeling about anything else. They really push other people's male buttons but will only half pie push their own and the other half is that people will actually control what information goes to you and keep you in ignorance. I keep on thinking it can't be as basic as that but there must be multiple reasons. But why is that information not available to women? I don't know. There should be things about it on the radio. But all you hear about is golf clubs and organisations like the men's Lions clubs and it just goes on and on, there's no information about women's health or women's issues. You have to go to all women's clubs, to alternative medical practitioners. I mean it's all just so alternative and it shouldn't be so alternative it should be available information.

Alison, i3 p10

Alison suggests that midwifery is still seen as something which is outside the mainstream of health services in New Zealand. Her frustrations are expressed by the use of the word "alternative" which indicates that a medical practitioner is still the person who would provide normal care by right to all women. As Oakley (1984) notes, this assumption that medical practitioners should assume responsibility for women during pregnancy, labour and the birth, has only come about very gradually since the concept of pre-natal care was introduced early this century.

Midwives as alternative practitioners

In New Zealand, it only became every woman's "right" to have medical supervision of her pregnancy with the passing of the 1938 Social Security Act. As noted in Chapter Two (refer pp. 7-10) this right became compulsory through legislation in 1971. It is perhaps because of the comparative recency of these events that medical practitioners are reluctant to give up what has become a lucrative as well as powerful business. Because of medical determination to maintain their position of power, midwives will have to advertise their business for some time to come, although some women are beginning to explore the types of care which suits them best.

I was just talking to a woman today on the phone and she'd been referred by her health centre to us because they don't do deliveries. And I asked her whether she wanted to go straight ahead and book or whether she just wanted to discuss what we had to offer and whether that suited her needs. Because she may not be aware that other midwives offer different things from [what we offer]. Whether, for example, it really was one to one care she wanted and she said, "That's exactly what I want." And I said, "Well we offer that under these conditions." And explained about the other midwives and she's still keen to come and talk to us. Hopefully I've given her the idea that it's not automatic. Just because the doctors have referred her to us that does not mean she has to come. She has to find out that it's us she really wants, it's no good her thinking that if the doctor has recommended them then they must be OK. But then she begins to have these worries and go through a whole pregnancy...

Fiona, il p10

Yes a lot of them ring up and say, "What is it about?" And usually they go on to book. We had one woman who wanted to come and meet us all and she was meeting the other independent midwives before she made her choice which I thought was great. So some of them are shopping around and some of them aren't. Some of them are coming by word of mouth in which case they've already made their decision, they know what they want. It's very rare that women in fact decide not to book once they know what's available.

Lesley, il p11

However, while the midwives encourage women to look at alternative practitioners or forms of care, none of the clients reported exploring alternative midwives in the locality. They made their choices from the advertising that was currently available.

So you've gone along to the independent midwifery service, rung them up. Then did they give you a time to go and see them?

Yes, I made my first appointment for [my husband] and I to go along and just to start things rolling.

Just to suss them out?

No, I'd made my mind up even before I'd met them all, even before I'd gone to the place that that was what I wanted because I couldn't have my doctor anyway. So I thought, "I'm going to have to meet someone new, so it might as well be them." And as soon as I got there I thought, "Yes this is it."

Chris, i1 p4

However, some of the clients were also concerned that choosing midwifery care could jeopardise relationships with their general practitioners and took pains to ensure that this would not happen.

I went to... my first ante-natal check was with my doctor, the one that delivered her. I said to her, "Now what do you think of homebirths?" And she said, "Well, I don't do them." And she said, "Why, are you thinking about it?" And I said, "Well yes, I am." And I said, "What would happen if I have one?" And she said, "Well, I can't be with you to deliver your baby anyway." Because she's having a baby in January. So she couldn't be with me, so that made me even feel quite content because I really like my doctor, she's wonderful, she's an excellent person. So I thought, "Well, if you can't be with me then I don't need a doctor at all and I'll just have a midwife, or two midwives."

Chris, i1 p4

So, you know I'm really pleased I've decided to have, I'm having shared care. So I'm still seeing my doctor. I actually saw my doctor today. So I've seen, 18 weeks and I've seen [my midwife] initially when I sort of booked in to have midwifery care and I've had one visit with [another midwife] and I see my doctor. And he's, it's funny... I wasn't sure how, it's like you don't know what doctors are going to think about it. No, he seemed all for it. It wasn't a problem as far he was concerned and he thought it was a really good idea. I should have thought, he was the same when I wanted to come home early. It was no big issue, he was quite happy for me to do what I wanted basically. So he's the same this time.

Helen, i1 p4.

Chris and Helen see ongoing relationships with their general practitioners, whom they have each known for several years, as necessary. This supports a point made in a British report which suggested that GPs should become more involved in labour and birth as they are often the professional whom women know best.

(Department of Health, 1993). The clients in this study also see their GPs as being powerful people whom they cannot afford to upset. Neither thought that they could change general practitioners if they wished to do so. Alison, however, was less concerned with her ongoing relationship with her GP though she found it was a good working relationship.

I went to my GP who I like and is a male and I feel very comfortable and this is to do with my kidney and not my pregnancy. He doesn't actually practise obstetrics, but I wouldn't use him even if he did... He's a lovely guy. He doesn't ah, he's a lovely male and in a sense he's a fatherly, has a fatherly role and I very much need that in my life so that's lovely. But as far as a person to go through the birth experience with, no he's not the appropriate person for me.

Alison, i1 p8

Margot was the only one who said that she enjoyed her visits with her general practitioner and the benefits she was able to get from these visits which she could not from her visits with the midwives.

It's nice at the doctor's and you can hear the baby, hear the noise.

Margot, i3 p2

As shown in the above excerpts, the dominance of the medical profession over midwives and their clients is thus still very evident as they continue to retain their clientele. Although not addressed in this study to any great extent, Margot's word reflects the views of other writers (Bassett-Smith, 1988; Fisher, 1986) which suggest that women are enticed by technology which is recommended in the interests of their safety. Technology is thus a powerful weapon which is used by doctors with expert knowledge to maintain this dominance.

Confrontational strategies which were being utilised by the medical profession to retain their power were discussed in Chapter Two (refer pp. 28-29). Alternatively, some doctors were entering into a partnership with midwives and would refer their clients only to those midwives, who would practise shared care with them, and subsequently both

could claim the maternity benefit. This problem is currently being addressed by funders of maternity services (Coopers & Lybrand, 1993).

A more immediately effective event was the screening of the "Frontline" documentaries discussed in Chapter Two (refer pp. 28-29). These were used by families and friends (unsuccessfully) to discourage the clients in this study from continuing with midwifery care.

It's amazing the people that have said to me, "Did you see that programme? Maybe you shouldn't be going to a midwife." I mean look at all the pills that they hand out and blow the budget. Do you ever see them making videos about that?

Alison, i2 p 3

While unsuccessful with regard to these and other clients who were already booked with the midwives, at the same time as the programmes were screened there was a considerable reduction in new bookings with the independent midwives. However, as Geuss (1981) states in order to maintain domination through hegemony many tactics such as this will be employed. In order to maintain this increase, however, midwives must continue to market their services, and ensure their accessibility, especially to women in their first pregnancies.

Conclusion

This chapter has examined how midwives and clients overcome some of the structures and access each other. The next chapter looks at the formation and development of partnerships both between clients and midwives and amongst health professionals.

CHAPTER SEVEN

Developing the Midwifery Partnership

The previous chapter demonstrated ways in which this research enabled clients to ground their present experiences in the past. By uncovering experiences related to the health services and, more specifically, maternity services, clients in this study articulated some of their reasons for seeking independent midwifery care in their current pregnancies. Both midwives and clients expressed their fears and frustrations over the continued invisibility of independent midwifery as an option for all women who are pregnant.

This chapter presents an overview of partnership in midwifery practice. As outlined in Chapter Two (refer p. 21) the concept of partnership has been a key issue for the New Zealand College of Midwives since its inception in 1990. Partnership arises between midwives and clients through mutual respect for each others' beliefs and values.

However, the issue of partnership amongst midwives also needs to be addressed, and the first part of this chapter will consider some of the issues which were relevant for the midwives in this study. The second part of this chapter will then examine the more widely expressed concept of midwife/client partnership as it applied to the women in this study. The concepts of subjectivity (refer Chapter Four pp. 77-79) and reflexivity (refer Chapter Five, pp. 89-91) form the main framework for analysis.

Partnership amongst midwives

As stated in Chapter Five, midwives who participated in this study worked together as a group, providing support for each other where

required and sharing office premises. By working together in this way midwives were able to provide assistance for each other in both formal and informal ways.

Fiona and Lesley express their feelings about working with a group of like minded colleagues:

This is what I find stirring and challenging and exciting and very, very satisfying as well. I still have heaps and heaps to learn, lots of ground to cover before I will feel completely autonomous. I lean very heavily on my colleagues and that's how I thrive... Certainly I couldn't have managed otherwise. There are one or two obstetricians who also are open to teaching and they understand the concept [of independent midwifery] and they're only too happy to support us and bridge that gap between being able to hand over all responsibility to a doctor and being able to handle some of that responsibility yourself.
Fiona, i1 p14

I think it's an excellent thing, I guess it's one good thing which is really good about being in a group practice that I've always got the others to bounce things off... And that's really good support.

Yes. So just someone you're a bit worried about you'll go and say, "Look I've got this, what do you think?"

Yes, or even things like you think, "Maybe I could have handled that better." I go and talk to them about it and sometimes we decide, yes I could have and sometimes we decide, no it's been done the best way.

And you get that in return from them?

Yes.

Lesley, i2, p7

Fiona and Lesley both state that they thrive on the support and guidance of their colleagues. Each feels she is constantly learning and that in the environment of independent midwifery, working with the support of like minded colleagues has created the opportunities in which this learning may occur. In addition, Fiona's statement expresses

a strong and positive subjectivity but in turn that subjectivity is shaped by her colleagues. Lesley expresses a feeling of reciprocity; while on some occasions she may be able to give advice and assistance to her colleagues, on others she receives their support when dealing with tricky situations.

The idea of talking to other midwives as a means of learning is important in both of these examples. Chinn (1991) speaks of learning through the medium of gossip, which she found to be a common occurrence amongst nurses, and which is also relevant to the midwives in this study. Such occurrences may further be linked to the feminist concept of consciousness-raising which encourages collaboration and interaction amongst women and which facilitates alternative frameworks for knowing (Cook & Fonow, 1986).

Another midwife who joined the practice reflects on her own experiences:

It's been great. I've come in with... and I have been trusted with my work. Because we work in a team practice where there's three midwives and we're all seeing people ante-natally, we're all finding out what's going on. It's not like one person's mine so that they have to come to me and ask me what's going on. They can see at the next ante-natal if I've missed something, or if I've over reacted to something and ordered a scan when I've not meant to or something and bring me up on it. So I'm supervised in that sense but it's a really subtle supervision. But it still makes me act and feel like I'm totally accountable for what I do. And it's not... in a birth situation, for example a homebirth, if something goes wrong, I'm just as accountable as the experienced midwife. I can't say "Well, the experienced midwife would do so and so..." It's never been like that and I would have thought it would have been more like that. I'm not disappointed at all, I think it's great because I feel quite clear about when I don't know things and when I need help.

Sarah, il p7

Sarah refers to the idea of supervision and how the idea of a group of midwives sharing the care of a woman can provide supervision in a way which is supportive rather than directive or punitive. Later in the interview she refers to reciprocity in a manner similar to that indicated by Lesley but also expresses the importance of environment. In this case Sarah sees the necessity for the environment of midwifery to be facilitative of open communication.

Yes, that's one of my battles, learning to trust my own knowledge and when you should listen to the other thing. And I feel that sometimes I am a bit big-headed and trust my own knowledge where perhaps I should listen. There's never actually been any situations where there's been conflict like that. There's been subtle things that are easy to let go of or else... We've got a relationship of communication where we can say what's on our mind and over time they've come to say to me, "I hope you bring me up on things too." ... It's good that it's not just one way and I've always appreciated the way I'm getting used and not getting over supervised or whatever. I mean I'm just as respected as the rest of the team for my knowledge.

Sarah, il p8

Sarah, in this instance, is articulating a more formal approach to knowledge, that of procedural knowledge. This idea is also developed by Julie who describes some of the differences in ways of practising between independent and hospital midwives but acknowledges the need for continuing education and regular, formal meetings to discuss issues of importance.

It's totally different. You're encouraged to be innovative and you get quite a lot of support from other midwives about things going on and what would be a good way to tackle things and stuff like that.

So do you have regular meetings?

We try, when we're all around, to have weekly meetings with just us. And we try to have meetings every fortnight with the other midwives [in the area] to find out what's going on. And it's quite interesting to find out that and feed back from us to them about issues we've had. Like we had one meeting about

students and who should be doing their assessment, whether it should be the tutors or the midwives, and stuff like that. Our own education is important, too, and I'd make sure I took time out for that.

Julie, i1 p2

So midwives in the practice and in the locality generally met more formally on a regular basis to discuss any issues which were considered relevant to their practice. Formal review of practice was also a key issue for the midwives in this study. The midwives saw this as another means of support when it was carried out by a panel of midwives and consumers.

Do you have a peer review system set up with the College as well?

That's our main thing... I'm quite happy to go along and have this year's practice looked at, that's fine with me. I think it's really important... And I wouldn't really want to wait too long before I was reviewed. And it gives you credibility as well. They let you know how your peers see you. And consumers as well, because they're there too, and that's really important.

Julie, i2 p1

The above excerpts all show the advantages of working together and the support that may come from such collaborative approaches to practice. The process by which each of the midwives looked at her own practice with a group of constructively critical colleagues facilitated the creation of an environment of trust and support and which was mutually constitutive of each other's interests and practices.

The clear links between the individuality of each midwife's practice and the practice environment goes some way to supporting the position of Foucault (1984) who suggests that individual subjectivity is created by experience and history. However, in this instance each midwife brings to her practice her **own** experiences and history. It is therefore the interweaving of each of these midwives' subjectivities created by their pasts with the present which creates and shapes both subjectivity and

environment. In other words subjectivity and environment are mutually interdependent.

When taken together, however, both subjectivity and environment create the potential in which reflexivity may occur. As Myerhoff and Ruby (1982) state, reflexivity will occur when a person understands how her background shapes her thoughts, ideas and actions. It is therefore this process of reflexivity occurring amongst the midwives in this study which has led to the strong sense of a midwifery identity, and which, as will be shown later in this chapter, also assists in the formation of strong bonds between midwife and clients.

However, interaction between midwives is not always strongly positive. In this study, midwives articulated some feelings of negativity between themselves and their colleagues in hospitals. This theme is explored next.

Rivalry amongst midwives

Moloney (1992) pointed out that while traditionally doctors have held positions of authority within maternity services, since the 1990 Nurses Amendment Act permitted expanded midwifery practice midwives have battled for position intraprofessionally. Participants in Moloney's study were midwives who practised within hospital settings and who saw the potential for conflict between themselves and independent midwives. One of her participants felt that when women were transferred into hospital and were cared for by hospital midwives, "a breakdown in relations between midwives can happen. It's a them and us sort of situation and it shouldn't be so." ("Ingrid," in Moloney, 1992, p. 114).

Moloney's findings together with the informal comments by midwives in a number of parts of the country suggest that conflict between independent and hospital midwives was a fairly common occurrence. In this present study, therefore, I deliberately sought evidence of such conflicts. At first there was the suggestion that relations between hospital and independent midwives were generally unproblematic except on the part of a few individuals.

When independent midwives are to come into hospital with a woman is there good sort of rapport between the hospital midwives and the independent midwives?

Depends how well known she is by hospital midwives and there's a wide range of attitudes among the hospital midwives so she may strike a group [on a shift] who are totally supportive and helpful and she may strike a group who perhaps have had a negative experience or who have a personal philosophy that doesn't encompass what independent midwives are trying to do and there's not quite the same degree of cooperation. But again we've been awfully lucky, we really are, in that the bulk of them are tremendously supportive.

Fiona, il p12

Certainly if I've got a hospital birth which is totally midwifery I don't get another person there although the hospital staff don't like that, they want you to have two midwives in the room, but we have agreed that we don't need to do that now. If we have a major problem we press the bell and they will come to our assistance and the vast majority of them are really very good.

Lesley, il p10

Fiona and Lesley both suggest that a spirit of cooperation between themselves and their colleagues in the local hospital exists in most instances. However, each of the midwives in this study articulated areas where there was potential for conflict or that conflict did, in fact, occur. Lesley, in response to a question first answers in a general fashion and then a specific example from the same interview is given.

With regard to that, do you see much evidence of midwives putting down other midwives in terms of midwives perhaps advocating for the system rather than for the clients?

Yes, I actually do see that and I also see a division between midwives which saddens me. And there are times... I think it's really important that there are good, strong midwives in this country.

Lesley, i2 p9

I suggested she could actually make her decision then, when she was feeling better, not when she was feeling absolutely ghastly. And that caused huge uproars.

Why?

Because ... I was pressurising the woman. In fact all the staff went to the woman to check that I wasn't putting pressure on her and she said, "No, this is what I want to do." It was really very difficult and in fact the woman's comments after was that she was feeling very vulnerable at that time. She's actually a very strong woman, had worked in the health system and those sorts of things. She actually felt that she needed protection and I was able to give that at that time. She knew all the politicking that was going on and certainly the comments the staff were making about her just didn't fit in with the woman that I had known.

So you had come to know her in her pregnancy?

I had come to know her really well and when the staff said, "Oh she's very precious." And, "She's just a pain." I knew this was just not her at all I was very concerned about her and nobody else was. I actually found that really difficult, I had to sort of step back and decide whether I was being over-protective or just being supportive.

Lesley, i2 p2

Fiona also gave an example of conflict which had arisen early in her experience in independent practice.

I mean I've expected people to understand some things because they know me and I've fallen completely flat on my face because they've chosen not to, or they've chosen to forget or they too have chosen to make particular assumptions... You feel like you've explained yourself totally and it gets mangled about. It gets misrepresented and the person on the receiving end gets the wrong picture altogether and you're in a bad odour all over again. One particular instance relates to a woman who was referred to me by a midwife up-country. She had planned a homebirth but her doctor had decided that she needed inducing and she should come into hospital. And this woman was

determined to at least know the midwife in attendance throughout her birth. We took on that case at short notice and that was fine. The woman's attitude was ideal and her antenatal education was spot on. She proceeded with the minimum of interference to a normal delivery and she had continuity of care from me and the doctors understood and were totally cooperative on the whole... but still misunderstandings took place. There was talk of writing a letter of complaint. Things were leapt upon and exaggerated and I had a lot of bother soothing down people's feelings. I had to go and explain, I had to go and challenge people about things that were said. You know I had to go and contact, registrars involved and I had to go and talk to both of them very quickly and they pulled back and denied and put the blame back on the midwives that were there. "It wasn't us, it was the midwives," they said.

You mean using midwives against midwives?

This was when we'd just begun basically and I thought that the staff in the hospital who knew me would never have jumped to those sorts of conclusions but they did! So I had the feeling that there was something else political going on. I felt terribly upset about it. I don't feel able to give all the details more clearly except that it gave me a terrible shock but fortunately I was able to speak to the right people and clear it up and those people haven't given me any further problems.

It's not nice, though.

I was in a state of total disbelief for a while. Just what I was accused of doing, and that these were my colleagues who knew I would never in thousand years do these things. That's what I thought but you can never be certain about those things and people might have other motives for jumping on you and it's probably not you they're jumping on, it's the ideals.

Fiona, il p13/14

Both the examples of Lesley and Fiona show evidence of reflection into their own practice, and its aims. They felt that part of independent midwifery was to act as advocates for their clients by working with them to achieve the best possible experience as well as outcome for them. However, in some instances, including the two scenarios described above, this brought about a conflict of ideals leading to polarisation of ideologies held by the midwife and the hospital staff

respectively. Each of those people at either pole would believe that they have the interests of the client at heart.

Literature on advocacy goes some way to describing many similar situations occurring in health services throughout the Western world (Fleming, 1991). Arguments are presented both for and against the notion that those who are employees of hospitals or similar institutions can advocate for clients when this may place them in oppositional positions to those of their employers. As a profession, New Zealand midwifery has not debated this issue but many individual midwives do so on a day to day basis. Reflecting on her own practice, Lesley sums up the major issue:

When it comes to dealing with tricky situations when I think a woman isn't getting what she's entitled to then I just stick my neck out. If it means I'm not liked, then so be it. I see myself as advocating for the patient and, yes, I guess I'm not the most popular person in the hospital system because of that.

But do you feel, as an independent midwife, rather than a midwife attached to a hospital or whatever, that that's something that you can truly do?

It is much easier to do when you're not part of the hospital system because in fact they have, they don't have much control over you. A hospital system is a very hierarchical system. It has a trickle down effect and regardless of what we have to say practice is still limited by the fact that there are endless power structures and you have to survive within that power structure. The things I do sometimes for my clients, I stick my neck out for them by not being in that structure.

Lesley, i2 p1.

I never wanted to be a hospital midwife. I never saw myself fitting with the hospital way. I never did believe it worked for the consumer... I had a certain faith about the naturalness of birth and all my kind of ideas about that. I didn't want to get tainted by the whole hospital system which is quite fearful for them.

Sarah, i1 p2.

Conflicts, then, generally seem to be focused around specific issues of client management and reflect some of the discussion in the previous

chapter (refer pp. 107-114) in which clients expressed their frustration with conflicting advice they received from the different health professionals who attended them. However, both Lesley and Sarah express some of the ways in which conflicts of interest have the potential to affect them as hospital midwives. Each believes that she will not experience similar conflicts in independent practice, though as shown later, this is not always the case. At present the only situation in which this could totally be avoided is in a homebirth in which the midwife is the sole health professional involved. However, it is interesting to note that in this study although I asked clients who gave birth in a hospital about conflicting advice, none reported it as problematic. Karen and Margot sum up the experiences of the clients:

So just a question that comes up for me now is in the post-natal ward who would be doing most of your care? Was it your midwife or was it the hospital staff?

My midwife. She came in every day. Apart from that the nurses were there when I need them but I didn't really need them. But they popped in and introduced themselves on their shift and that sort of thing. But apart from that [my midwife] did all my checks...and his.

And all was well with both of you the whole time, was it?

Yes, a box of fluffies¹⁰!!!
Karen, i4 p4/5.

OK, and in that time, how much of your care was done by your midwife and how much by the hospital staff?

Em, well no...they were very, very slack [quiet] in there so they got the temperature first and they did my tummy and that as well. Only because they had nothing to do. And that was why they were doing that. They got on really well... So, that was really good. These nurses knew who they were, so there was no muck up or conflict or anything like that. They were there to help and they only did it because they had nothing to do.

So they happily helped out..

10 colloquial expression meaning perfect or wonderful.

Happily, yes.
Margot, i4, p8

The above excerpts could indicate either that both of these women were confident enough in their own input into their care so that minor discrepancies were not seen as important, or that if there were any points of disagreement these were resolved away from the clients so that no evidence of friction was presented. The relationship which had been established between each of these women and their midwives is also likely to have had a bearing on their perception of their post-natal care. It is this concept of partnership between midwife and client which forms the second part of this chapter and which is discussed next.

Partnership of midwife and client

As indicated in Chapter Two (refer pp. 21-22) the New Zealand College of Midwives was founded in a spirit of cooperation and partnership between midwives and consumers. As Fiona stated (i2, p4) "*I think its because of women that midwives have got where they are today.*" This reflects the work done by consumers and midwives to enable the law to be changed.

However, the concept of partnership is not merely appropriate on a broad philosophical basis which is divorced from practice. For the concept to be applicable to individual midwives it must be relevant to their way of practising. For the midwives and clients in this study, partnership was a key issue. The remainder of this chapter will discuss the themes defining the boundaries of the relationship and support of midwife and client for each other. The next chapter will then discuss the partnership in action.

Defining the boundaries of the relationship

Alison was the only client to talk in general terms about her expectations of the relationship between midwife and client. She also found it important that her trust in her midwife was shared by her partner.

I think it is very important to have a rapport with someone that you are going to go through something that could be incredibly scary or feel incredibly powerful experience. And if you have set your trust. It's maybe like sex for the first time, if the trust factor is laid down, if you know that person intimately. All those things, then it's not scary it's wonderful. And it is a very major, major thing that not only affects one person, but affects two really or three. Your partner, your child and you.
Alison, i1 p8

Fiona endorses the concept of trust by describing the necessity of not taking over clients' pregnancies by dictating to them what must be done. Rather she adopts an attitude of responding to their individual needs so that, in turn, as they come to trust the midwife, the clients will reveal more about themselves.

We spend time in being responsive. She comes up with whatever it is that she needs information on or that she's worried about and you respond to that as quickly and as efficiently as you possibly can and they relax. You can see them relax during the session and then they reveal more. They ring you, they get to know that if there is anything to do with their pregnancy that they would contact the hospital, they let you know as well. It's something we try to achieve with the shared care clients. With total midwifery care you are their source of information and their support and they will refer to you if something crops up. That's the source of the relationship. Educating, providing resources, providing lists of ante-natal classes that are available to them, the social welfare set up.

Fiona, i2 p5

Julie takes Fiona's point a step further:

the partnership business, the midwife and woman. How do you see it now, that you've finally made it to independent practice? How do you see it working for you?

Well, I see, I hope that I see it as a level, sharing thing and me as being a source of information and somebody to discuss things through. As well as doing all the physical checking of pregnancy, I see it as learning to be a support person. To a degree. I don't know that the midwife ought to be the one who's rushing in and rubbing the backs and doing that whole main thing because I think that's quite important that that's the partner or the family or whoever. Because they're the ones who are going to be there, you know after six weeks or whatever and it's nice for them to be able to think, "Oh, I helped out there and I was involved in that." That makes it help and a bit more special for that family and helps them to bond and things like that. So maybe I see myself as a bit of a facilitator really... to sort of help that woman feel free enough and able to let go with her body and go for it. And stuff like that. And to keep an eye on things make sure they're on track and if they're stepping off the track to help.

Julie, 11 p7

Julie strongly reaffirms the normality of childbirth and the importance of family involvement. However, she also acknowledges that sometimes things can deviate from the expectations. Here she is prepared to step in and assist. This does not necessarily mean that the pregnancy or labour becomes abnormal, but that the woman's response may be different from her own expectations and the midwife can support her to regain her power and direction. Affirmation of the client by the midwife is also a key issue for Lesley and Sarah.

Each person is an individual who has to be taught what suits them. Our job is to do that. Everyone needs affirmation that she's a good mother.

Lesley, 12 p7.

It's one of my very strong beliefs, that is one of the backbones of midwifery. While the biggest thing that a midwife should be doing is affirming the woman the whole way along, I've seen so much in the past, people in the situation where because they've trained, think they know more than the woman... Well the huge things that I feel, that's one of my big philosophies about how I work. I don't go in there telling women what they should be doing, what I think they should be doing at all. And I do that to an absolute minimum. I don't ever show anyone how to bath their baby or to breast feed unless there's problems. And I think to do things in a way that is very affirming and to

let people make their choices. I mean it's just so important to me.

Sarah, i1 p12

The scenarios outlined above represent a different situation from that described by Moloney (1992) who found that although the midwives in her study strived for a more equitable distribution of power between themselves and their clients, in general the hospitals in which they practised were found to be authoritative giving clients "little or no opportunity to become involved in their experience as knowing subjects" (Moloney, 1992, p. 84). Lather (1991, p. 28) describes this as a "cult of expertise" in which professionals take for granted their authoritative knowledge in their interactions. It was suggested by the midwives in this present study that this image of the authoritative professional was creeping into midwifery practice. Sarah describes it.

I was talking with a student midwife and she was saying things like, "You've got to make yourself look really professional." And, "You've got to make people see you as really professional." And I said, "But what's looking professional if you're not?" And she said, "But you've got to look competent." And I said, "Looking competent doesn't mean anything." I personally feel it's better to share your own inadequacies with people so they know when you don't know something or they know when you're unsure, where you think you're good and that sort of thing, because she was saying that sometimes we looked slack and we've got to look professional. The whole idea was looking.

What does looking professional mean?

Oh, because you look really smart and the way you talk is that you put yourself on a pedestal and talk about being professional, so that people have this false confidence in you because of how you appear. People have, you know she didn't trust that people have just as much confidence when you share your lack of knowledge.

Sarah, i1 p16

In a later interview Sarah suggests that in order to achieve a true partnership this image of professionalism needs to be broken down, and what is needed is simple honesty.

...isn't it better to just be honest about the areas where you're not so hot and stuff like that you know, and not having to sort of look this way and act the part. And that's where I think it's one profession where women can be very honest and it can sort of break down that professional image of what you have to be to be a nurse or something, to sort of be ...Yes, because midwives ...traditionally we're just another woman in the village, nothing special about them, they're just another woman in the village who have knowledge and experience and knew about different herbs and different things, whereas now you can just sort of feel like... we can't just be another woman down the street.

Sarah, i2 p5.

Sarah is concerned that midwifery may come to be seen as elite and all knowing in a way similar to that of the medical profession if steps are not taken to rectify this. She suggests that her own ideals of midwifery are tempered by society's expectations and midwifery practice which is grounded firmly in the needs of the clients is one way in which this may be avoided. She believes that the midwives in this study are trying to achieve a client-centered focus.

However, by grounding their practice in the needs of their clients, midwives sometimes feel that the distribution of power which they would expect to be equitable tilts away from this to almost untenable situations. Two examples are given below.

We had a woman last year who didn't feel it was necessary to have anything at all. She did actually have some booking bloods done so that we knew her blood group and rubella status and didn't have any more after that. I was actually quite happy with that, it was her choice. She would be very unusual, she was a woman who was very confident in her ability to give birth. She felt that everything was normal and so why should she endanger her baby. Basically, she only came to us because she knew that she needed to have a midwife or someone there. And yet she probably did want us to actually catch the baby. And everything was on her terms, and she lived away out of the city and was due in the middle of winter. She wouldn't come in for any of her ante-natals, we always had to go to her. And in fact in her evaluation she emphasised that. She felt that all ante-natals should be done in the woman's own home and things like this which was totally unrealistic.

Lesley, i3 p6

We had one woman recently who was overdue, going into her third week overdue resisting very firmly any suggestion that we should closely monitor the baby. We passed on the advice from the consultant that she shouldn't deliver at home since she was so overdue as these were the risks to the baby and we had a discussion and she lived 15 to 20 minutes away from the hospital if anything did go wrong. So every single aspect was gone over and we began to feel like we were putting enormous pressure on to her. We felt very uncomfortable because she was resistant and could not accept that anything could have gone wrong. Anyway she laboured at home and she delivered at home. She had two midwives present on the understanding that they were there and it was against their advice. And it just felt so wrong to put her under that strain. And I was part of all that, part of my advice to her was a suggestion that she make an appointment with the consultant. I wasn't actually there at the birth, I actually had to go and see her afterwards to get rid of that awful feeling that we had acted counter to what our philosophy is. I also couldn't see any other way around it because I truly believed that it wasn't safe for her and I documented page after page with all the things that were explained and she still kept to her plan and I said, "I have to say that I admired you." Because I did. In the event the baby was not that overdue. Obviously it was not that overdue. But that is almost besides the point, it isn't really the issue. We supported her with those reservations and she was well aware of our reservations and she wasn't... over the top sort of person, she was obviously a person who was determined that this baby was to be born at home and she wasn't accepting anything else other than what she believed. But we wouldn't accept that with all our documentation we had done our best to get her into an obstetrician. The obstetrician herself said, "That woman would have delivered alone, she was so determined."

Fiona, 12 p9

While, in each of these incidents, the outcome was satisfactory for the woman and baby, there was not such a feeling of satisfaction for the midwives. Another midwife in describing how she felt about the second scenario above said:

It was a really awkward situation and to talk about it today, three months later, it's sort of like, it still feels like, "How could I have managed that situation differently?"

Sarah, i2 p5

In terms of the ideal of partnership expressed by the New Zealand College of Midwives, when considering the above situations this could not be said to be happening. Just as in the past midwives and feminist writers (refer Chapter Three, pp. 39-43) have described the abuse of power by the medical profession, today there is the potential for power to be abused not only by midwives but also by clients. This presents an oppositional side to the scenario which is suggested by researchers such as Ribbens (1989) and Webb (1993) who maintain that two way situations are impossible to achieve and one party always holds the power. Ribbens and Webb each referred to research situations in which they saw the researcher as being the powerful party, but as discussed earlier, this situation is like the midwife/client relationship.

For midwives the dilemma is manifest in incidents such as those described above in which they have to balance issues such as the safety of one or more women and babies against the expressed wishes of a woman. In most cases any incongruencies are sorted out early in the relationship but as in the above two illustrations they were not, so causing the midwives considerable distress.

The notion of advocacy described earlier in this chapter (refer p. 142) was relatively clear cut for midwives in independent practice but in situations where the midwives' judgement differs from that of their clients, the actions midwives must take become blurred. In the above two examples the midwives drew on the support of their colleagues in assisting them to make the best decisions but still felt several months later that there may have been a better way to handle them. One way of overcoming these notions of one sided approaches to power may be the negotiation of description, integration and principles at all stages in the relationship.

None of the clients in this study, however, considered acting in ways which would challenge the boundaries of their partnership with their midwives. However, knowing my background as a midwife, at times they also sought information and advice from me. I had considered the possibility of this happening and discussed it with the midwives. As had been the case with Webb (1984) I felt it important to give something in return for all the time that was being given to me. I made the decision, therefore, to talk openly with clients about any issues which were concerning them. This is discussed next.

Clients seeking reassurance from the researcher

As discussed by Bergum (1989) women who are pregnant often become enveloped in that pregnancy and constantly seek advice and support from a variety of sources. At times I felt privileged to be one of those sources but I was also mindful of the need for these women to discuss issues with their midwives in order that informed decisions about ongoing care could be made.

Most of their questions related to symptoms which had developed in the interval since they had last seen their midwives and all felt that these were too trivial to initiate a special call. Examples from Helen and Karen indicate the most common types of questions I was asked.

so she'll make sure she's got a couple of good painkillers and to make sure I've got plenty of panadol in my cupboard.

Even panadeine, because in my experience, she's right, they tend to get worse as you have more babies.

(laughing) thanks a lot!

Well, they do go away... What usually happens is that with each baby you have, your uterus gets a bit more distended so it's got a wee bit more clamping down to do.

So, that's what does it? Great! Just as well this is the last.
Helen, i2 p5

Hopefully, too it will be a bit quicker, a lot quicker. It should be, eh?

Yes, it usually is. I mean you might not even notice it so much at first either. Quite often you can be well on before you're actually aware that you're in labour, whereas with the first one you tend to feel every contraction. Apart from that though, with the first one, there's an awful lot of work that needs to be done by contracting all the muscles of your uterus to get the baby out. Hopefully this time you'll find it much more pleasant.

I hope so, it would be easier all round!
Karen, i3 p3/4

Both Helen and Karen were seeking reassurance in ways which allowed me to support rather than oppose anything their midwives may have said. Questions such as these may also have been asked of their friends or mothers but the addition of some technical point which I was able to include may have helped their understanding. This was especially noticeable in the case of Margot who was concerned that she would not recognise the signs of labour.

So, I've assumed that if the baby went down any further then she'd break the waters.

Not necessarily, because say that's your cervix (shows) and that's her head. If she goes down, what happens is the further she goes down the nicer and more snugly she fits into the cervix. So there's more water behind her and less in front.

Oh, right.

So, there's less chance of her breaking the waters, the further she goes down. It's usually when they're not sitting quite so nicely that the waters break because there's not that sort of protecting, more goes down and so like a balloon it bursts.

Right, so what happens about the show, how does that come into place?

Well, the show's in slightly different a place. Let's look at the cervix. (Draws). That's your cervix there and that's the baby.

Yes.

And in the cervix you've got two parts to the opening. There's an outside part called the external *os*, here, and another one here called the internal *os* and the show is in between these two openings. It stops infection getting up there when you're pregnant.

And the show is all mucus?

It is more or less, there's a wee bit of blood when it peels off. So when this outside *os* starts to open a bit, then it falls out.

That comes first?

Often first, but not always, nothing's sure in this game! I worked with a GP once who said he reckoned the show was a 48 hour warning of labour. He was often right but he got some women worried when he wasn't.

Margot, i3 p2/3

For me each of the above three examples, as well as being of use to the person concerned helped establish my credentials as a midwife. They also exemplify one of the principles of feminist research as outlined by Duffy (1985) where it is suggested that research should be of use to both researcher and participants. In this small way I was able to attend to some of the minor day to day needs of the participants without causing them to displace the boundaries of their relationships with their midwives.

Conclusion

The themes described above outline some of the ways in which the concept of partnership was relevant for participants in this study. It showed the benefits, for midwives in maintaining close relationships

with their peers. It also demonstrated the rivalry that exists between some midwives.

This chapter also showed how each midwife/client partnership entered its formative stages and how the parameters of these relationships were defined. The material presented sets the scene for the data introduced in the next chapter where the concept of praxis is used as a means of analysing the working relationship of midwives and clients.

CHAPTER EIGHT

Feminist Praxis: Working Together

The previous chapter has demonstrated how, through the medium of independent midwifery practice, women (both as midwives and as clients) have come together in partnership to counter the hegemony of the medical profession in the childbirth arena. However, while setting up a relationship grounded in an ideal of individual partnership is a relatively straightforward process, it is the partnership-in-action which determines the success of the relationship, and to some extent, the success of independent midwifery practice. This chapter and the succeeding one consider the success of independent midwifery practice firstly from the point of view of individual partnerships in action and, in Chapter Nine, from the perspective of independent midwifery in its broader socio-political context.

Midwifery knowledge

In any situation where women seek advice from health professionals there is a potential for that relationship to be directed from the health professional with the woman complying with what is seen as the accepted wisdom (Wilshire, 1989). As Bassett-Smith (1988) said, women in her study were socialised into believing that their doctor would take charge of the whole experience of pregnancy and birth and were disappointed to find that was not the case. Likewise, some women in this study had similar experiences in previous pregnancies. The legislative changes of 1990, however, permitted these women to seek alternative forms of care, one of which was independent midwifery whose philosophy enabled a sharing of knowledge and power to take place. **How** midwives and clients work together within the

knowledge/power nexus forms the basis of the partnership-in-action and it is this which is discussed first.

I don't see myself as much different from a support person they might bring along. It's too easy to think that because you know a wee bit more then you can direct the play.

Yes it's a really important trap not to fall into, that's what's happened to obstetrics, the knowledge gaps of the woman are there and there and there.

But even in a natural birth where there isn't it still can happen so easily.

However, you do know more in some ways, but a woman knows her body in a way which you will never know.

We do know a lot more, and that's why they need a midwife. And it's very valuable and you're always using your experience and your knowledge, but it should still be seen as working with the woman.

Sarah, i1 p15

Sarah outlines how she feels that her specialist knowledge as a midwife blends with the unique knowledge each client has of her own body so that the two might work together in a way which is mutually beneficial and so that each may grow and learn from the experience. Each respects the knowledge of the other whether this be knowledge gained from public places which may be verified or whether it is a less tangible form of knowledge which does not focus on separate details and is gained in less formal ways (Belenky, Clinchy, Goldberger & Tarule, 1986). Lesley also focuses on an integrated approach to knowledge and describes this in the context of her experiential knowledge of being a woman which has become inseparable from formal knowledge learned as a student midwife.

I don't know that I can actually separate midwifery out because I can't actually separate the midwife from the woman. It's an integral part of me.

You being a woman and you being a midwife? The whole issues of sexuality and reproduction.

Being a midwife. It's just so many things and I can't say, "That's the midwife part of me and that's the woman part of me." What I find is my own experiences come up in my practices anyway... I've had a lot of similar life experiences to many women and those experiences affect how I practise.

Definitely, yes, and it's nothing to do with your age. It's your experience. I mean how many women do you see that have been midwives for years and years and have had children but in your book would be bad midwives.

I don't think you need to have had a baby to be a good midwife.

There are those who would argue that.

Oh, a lot of woman believe you need to have experienced giving birth to be a good midwife. I think it's special if you've got that as well, it can be, but it can also be quite damaging if you have a poor experience of giving birth. I actually know of a midwife who had a very bad birth experience and the way she relates to women in labour to me is not good at all and I feel very sad about that because the system failed her but now she is, you know it's quite damaging for some clients and instead of being... I've also found they've been criticised by other staff instead of it being dealt with in a much more caring way and I find that sad but there's nothing much I can do about that.

Lesley, i1 p12

Lesley then sees her life experiences as integral to her present day practice as a midwife, a feeling that was shared by Sarah.

I was really into it all then, but it wasn't until I could be in a situation of being a midwife that was an advocate for women and everything that independent midwives are nowadays, no I couldn't see myself being any other kind of midwife.

So you brought all that to your training, your midwifery training and then to yourself as a registered midwife. I mean you weren't coming in as a new graduate, like a 22 year old new graduate would have been.

No, no. I don't think I could have got through without my own personal experiences, because I used to be really involved with discussion groups and we used to talk about... all kinds of issues. You know, experiences like women have when they have kids, all kinds of things.

Sarah, i1 p5

In the next excerpt taken from a later interview, Sarah attempts to define how her knowledge now that she is a registered midwife is different from that of her clients.

Yes, sometimes you can sort of feel that you know something and trust in it, you don't necessarily recognise exactly why, like you might not look back and think, "I remember these experiences that make me feel quite sure about this now." Because everybody's experience is so different anyway even though there might be common factors and sometimes it might be just because you're... you know. For some reason that you know something, and you can't necessarily quantify it, not in any magical, far out intuitive way, but just for some reason that something seems pretty logical or commonsense or you know, whatever. You can work it out in that fashion too. But to some, well I don't know whether I'm quite on the right direction, but sometimes I can think of experiences that have made me teach things which have made me realise that I should involve others in working out how things should be managed. And other times I'm ignorant and I learn again yet another thing where you know I assumed something was OK and I should have done this, or something like that, so it's a whole variety of things. Because some things you can just accept and trust straight away, you don't question whether you should involve others otherwise you'd spend your whole life questioning whether you should ask others, so, it's like when you're slightly doubting I suppose that you start to think now, "Should I just... am I correct in this or should I ask somebody else about it?"

Yes, yes. I was in a situation where they were quizzing me on this intuition, what do you mean by intuition, and I said that I didn't think it was fair of them to ask me because I wasn't sure what I meant, like you tried to define it, it doesn't carry much credence.

It doesn't. In a number of, where people depend on definitions to be sound you can't sort of define some things and where women have always had the disadvantages you know over male patriarchy, isn't it, to not be able to define? I mean it's something that everybody should recognise is there's some things you just know and you don't know where you get your knowledge from, but you know it and get a sense of rightness or security in that knowledge. Sometimes you doubt it when you have a sense of doubt for whatever reason sometimes you don't know why you're doubting, sometimes like the old scenario of expecting someone to have a difficult labour and

you've got nothing to substantiate it. So you don't put them into... you don't tell them to go to hospital or anything because you can't find anything to substantiate your sort of feeling, and half the time you're wrong! And half the time you're right!

Do you often find though that your feelings are in tune with the woman's? One woman. If you're maybe thinking you know, like there are some odds say against her having a normal birth or a straightforward labour, some scientific evidence such as two previous prem births or something like that, but you feel that everything's going to be all right, do you think she may feel the same at times, or...

Yes, I doubt if ever I would trust a feeling of mine that was different from the woman's you know, like if the woman felt something strongly and I felt something the other way, no it's definitely a factor, what the woman's feeling is definitely a big factor isn't it? Because you know, I could never say to someone, "Oh no, this one's going to be terrible." When they were quite sure it was going to be right. I've never had that feeling myself or vice versa.

Sarah, i2 p2/3

Sarah expresses the difficulty felt by feminist philosophers who argue for recognition of ways of knowing which are outside the parameters of male thinking which have dominated the Western world since the time of the Enlightenment (Heckman, 1990). Midwives, in attempting to practise within a framework which is different from that of the dominant medical model of birth, and which is accepting of the woman as a partner in her own experience, are, as shown above, basing their clinical judgement on knowledge which does not come from traditional Western epistemologies. Here, postmodern thought which rejects the dualisms of the Enlightenment is useful. In particular, Derrida's conceptualisation of *différance*, highlights the difficulties in escaping from the power of the written, dominant discourses over the spoken. According to Derrida (1982, p.15) *différance* would allow deconstruction of meaning which took into account the "play of differences" within language and so celebrate these differences.

In this study, differences between the written word and the spoken were clearly evident when clinical records were examined. Alison's clinical records show a fairly typical picture as shown in one entry:

All progressing normally. Uterus = 30 weeks = dates. Slight swelling of ankles in the evenings. Advised to elevate feet when sitting down. Blood Pressure slightly down at times. See again in two weeks.
Alison, clinical notes.

Yet in the first interview I had with Alison she gave a very clear picture as to why she preferred a female primary care giver:

Men cannot intrinsically understand and feel what it is like to be pregnant and have a child, to do those things. They do not have those life experiences. They can empathise and in my belief they don't try very hard to empathise. But they can and that is possible. But they cannot understand, they can not do the same things that another woman can.
Alison, i1 p6

The qualities which Alison suggests are those which Bassett-Smith (1988) and Moloney (1992) suggested were important for midwives. Alison saw no conflict between her expressed beliefs and the entries in her clinical notes, the clinical notes were simply "for the bureaucracy" (Alison, i3, p12). The clinical notes of Alison and other clients, however, do suggest a certain amount of routinisation of care in the pre-natal period. This is supported by Lesley:

Although we are stuck into certain ante-natal investigations being routine. The weighing of the women at each visit, well I always say to them, "I really don't know why we do this, it's been shown to be not terribly useful, it's whether the baby's growing that is important." And I say to them, "It's just that we feel negligent if we don't do it." That's the thing. But if I'm actually doing somebody's ante-natal visits at home then I don't get them to step on the scales I just write, "At home." And I'd like to feel brave enough to just stop doing it altogether. For a lot of women it's the thing they hate the most... And the blood tests as well, I think you do need some of that information and they're repeated at 28 weeks. Do they really need to be repeated at 36? Isn't once enough in the middle of those two times?
Lesley, 13 p4

Although questions were beginning to be raised, this research really only scratched the surface of some of these issues. Midwives in this study were concerned mainly with the sharing of their knowledge and power with their clients. However, as Sarah pointed out, it is not merely the acquisition, recognition and dissemination of midwifery knowledge which is important, but that the knowledge of the midwife is seen to be in tune with that of the client. Moloney (1992, p. 73) has described a concept of "meshing" in which the midwife and client are able to maintain a harmonious relationship. This builds on Bassett-Smith's (1988) notion of balancing an individual woman's needs, values and desires with the views of the midwife. Sarah's words, however, suggest that meshing is more than simply the maintenance of a relationship; it is the positive blending together of knowledge from two women's experiences and intuitions. It is meshing in this latter sense which forms the basis of individual midwifery partnerships. Alison, drawing on prior experience from working as a hospital aide,¹¹ concurs with this saying that she could begin to tell from simply being with women what experiences and progress was occurring during their labours.

I started working with women having children I start listening to them, how they feel about their birth, they are a lot happier to have midwives rather than doctors. You hear it over and over again. There are lots of things, you could say cues, you pick up those as well. It's very hard to put words to

Yes, to instinct isn't it?

To women's feelings. You see the pain on their face. You see them first delivery, second delivery and you see what's happened for two and there is all this information. And then again it could be a pure bias on my birth experience. But I just generally think that the spirit of woman and the spirit of life is very connected.

Alison, i1 p3

¹¹ an untrained hospital employee who performs certain duties delegated by nursing staff

Meshing, as described above, allows the midwife and client to be sensitive to each other's needs and recognise both the formal and less formal knowledge that each possesses. Lesley outlines a specific scenario:

Any midwife or nurse or doctor who is in labour, then we need to take into account that they do have that knowledge so we talk to them in the way that we normally would do to them but at the same time if it's a doctor you must remember that she may need to be taught how to change nappies because that's not the sort of thing that they do. She will still need affirmation and reassurance that she's a good mother and that you can't just leave them entirely to it. Nurses and midwives may need lots of help with breast feeding because they may know very well how to put someone else's baby on to someone else's breast, quite different to putting your baby on to your breast. And at the same time if it's a midwife you don't need to show her how to bath her baby.

Lesley, i2 p7

The conflict between different ways of knowing, however, and the power of the dominant discourse, is better described by one of the clients who reflects on her experiences during her labour during which time, although she had been in hospital for two hours with her midwife in attendance she had not had a vaginal examination to assess her progress in labour.

The reason I asked that was that it tends to be a midwifery thing where vaginal examinations aren't done so much, and it's a thing that's become common with medicine taking over and I wondered if that was the way it was for you. Sounds like you've hit the nail on the head, she was happy with the way you were going...

And the doctor had to see, he wanted to know where you are. It was quite good though. Because I wanted...to be told that I was still only four centimetres and we could be looking at least another two hours. OK sure, it was only one, but it might have been two and I couldn't have gone for another two hours, I couldn't have gone for another hour on my own. And we all knew then that I couldn't.

Helen, i3 p8/9

During the pregnancy Helen and her midwife had come to know each other and feel comfortable in each other's presence. When in labour the midwife's assessment of Helen's progress through this knowledge, her previous experiences and intuition suggested that there was no need for a vaginal examination (V.E.). However, on the arrival of the doctor, such an examination was immediately carried out by him.

Surprisingly, Helen welcomed this examination because, as she stated, it allowed her to **know** how much her cervix had dilated. What it did not do however, was give her any indication of how long she would have to go in labour. The midwife describes the same occasion:

He just had this look about him of wanting to do a V.E.

The need to do something!

Exactly, and she'd actually been wanting to push, hadn't been doing something really effective about it, not like a pushing, pushing. And her membranes were bulging and he didn't rupture them which I was quite impressed with. I mean there was no need for him to do the V.E. I feel because she wasn't doing any harm to her cervix. She was pretty half hearted and baby was OK and stuff. And so, but when she found out where she was she got quite upset, because she was four centimetres and we were thinking she was a bit further along the track than that... And she was talking about not wanting to have it any more, not have any pain any more and he said, "Well, how about an injection?" And she'd said earlier on she wanted to have either nothing or an epidural so I thought, "Oh, em..." I didn't hold out much hope at all for this pethidine, but it actually worked beautifully. It was just what she needed. It just seemed to take the edge off them so that she could...it knocked them back a bit, she caught her breath and she just did absolutely beautifully, and an hour later the baby was born.

Julie, i2 p13/14

The technical knowledge which measured Helen's cervix to be only four centimetres dilated caused her some distress as she felt that she still had a long way to go before the birth of the baby. In fact, the midwife's less technical means of assessment had suggested that Helen was in transition and labour would not last much longer. Here, however, the

partnership of midwife and client was not strong enough to resist the pressure from the established knowledge of the medical profession which has developed a very standardised approach to supervision during labour. It is the singularity of this approach which needs to be rejected by both midwives and clients for progress to be made in the development of a midwifery model of practice which is recognised as different from the medical model.

However, in exploring the concept of partnership and because of incidents such as that described above, it must be acknowledged that, like doctors, midwives have the potential to use their power as health professionals in ways which may not only best serve the interests of their clients but also provide inaccurate measures of progress. How power was seen to have been used by midwives in this study is explored the next section.

Power in the midwife/client partnership.

Until the advent of independent midwifery practice, midwives, like their nurse colleagues in hospitals were a group who were relatively powerless in the hierarchial system. Power, therefore, in the masculinist sense (French & Raven, 1959) is something into which midwives have been thrown with the enactment of the 1990 legislation. However, by the reconceptualisation of power as indicated in Chapter Four (refer pp. 79-82) power may take on new meanings. Sarah provides a good example of this as she describes a scenario in which she sees midwives as acting powerfully in a situation where, using more traditional analyses they would have been seen to be subservient.

You know, the male obstetricians have been the most powerful ones who feel the midwives should do what they say. So I think that in the delivery suite that's how midwives find their... use their power. They don't... it's not like they're empowered and they're up there sort of battling with the doctors, but they find their ways of getting around it to get the results that they

want. For example, directing women, if a woman's told to get up onto the bed for example by the doctor and the doctor's telling the midwife to get the woman onto the bed or something and then the midwife can say to the woman, "Do you want to get up onto the bed?"... Finally getting around it, so, I think they can, just round doctors, be strategic. I mean I think that women often use a lot of quiet strategy and manipulation to get the result that they want for the woman.

Sarah, i2 p4

This supports the findings of Moloney (1992) who described the midwives in her study finding ways around obstacles which would act to their clients' advantage. A similar scenario, which was researched in a nursing setting, was described by Hutchison (1990) as acts of responsible subversion. Faraganis (1988) warns, however, that we need to be accountable for our actions and therefore act in ways which are open to public scrutiny rather than appearing to be underhand. This returns to the issue of how power should be conceptualised within midwifery practice.

In this study, none of the midwives spoke of their own power until I specifically asked. Generally midwives viewed their own power from a traditional (masculinist) perspective. They each felt they had, or potentially had positions of power. Julie's response to a fairly general question is indicative of others.

What power do you think that midwives have?

I think that midwives probably have the potential to have quite a lot of power because I think...I think women and family having babies, especially first babies it's quite a vulnerable time. And it's often the way life is that people don't know a thing about having a baby or what they can or can't have; they've never really thought about the things they might like or not like to do. They're quite ignorant even of their own bodies. So we've got quite a power. It's how we practise I guess, a bit like a GP or we can make it a really good learning time for a woman or a couple or a family really. And I think there are midwives who are using it well, I mean it would be a nightmare if midwives got out there and practised like GPs,

because then women would still not be getting anything even though it's midwives so there's still lack of choice in decision making and involvement.

Julie, i1 p5

Julie sees the power of midwives occurring in relation to women who may be less knowledgeable about the processes of pregnancy. At this stage she is not able to link the knowledge of clients with that power. Lesley and Sarah, however, do articulate this.

We believe that midwives empower women, is that how you see the practice here?

*That's an essential part of the practice. I believe that women are perfectly capable of making choices for themselves and taking responsibility for their own health and their babies' health whether it's *in utero* or *extra utero* provided that they're given the information that they need in order to make those decisions. I guess I get my warm fuzzies in helping them make these choices, them saying, "This is what I want." So in fact the less I do the better I think it is for the women.*

Lesley, i1 p3

I'm glad I'm not having to deal with that you know, and obvious power games and things, that hospital midwives have to deal with.

I don't know, I mean I keep having my doubts and I don't work in a hospital so I don't know; I mean I haven't got first hand information, but from what I hear I sometimes think, "Oh my god, you know, why don't you just step out of it, look at yourselves and find things still very very medicalised still."

I think it's the old thing, I was in a conversation the other night, it's the old thing that the way that women find their power or find their way of getting the results they want in comparison to men.

Sarah, i2 p4

While Lesley and Julie each considered themselves to be in positions of power they were both concerned with the dissemination of that power to their clients. While this is essential in developing the midwifery

partnership it reinforces the notion of power/knowledge as hierarchial. This was clearly illustrated in relation to some of the screening procedures carried out in the pre-natal period.

I tend to feel that childbirth is fairly natural. There's lots of signs that tell me all's well, like the baby moving around and I feel good, the urine's good. And all that's important information. They do get carried away on all these tests, everything needs a test to prove that you're OK, not that something's wrong... Ideally for me tests, well all my tests have been given to me and my file has been given to me which is wonderful.

Do you write in it?

No, I don't write in it. I write in a journal separate from that. But I'm quite accepting of what... it's interesting to see what someone else has written about your moods and so on. So I keep mine separate. But any information that comes back regarding tests, I can see at the time and if I choose I can look up in books to see what it means and what it doesn't mean. A lot of women, pregnant women I know haven't got access to their test results, neither do they know what they mean, nor do they know whether they're important or not or relevant. They haven't even thought about the relevancy, they've just gone along which is part of the power play of the whole thing... I'm taking your blood and you're lying on your back and... you know. But what was I going to say? (laughing) Oh, it would be nice when you got your test results to have a little computer printout, which would be nothing to set up, actually explaining what these things are and how they worked. Instead of being just available to the medical half, unless you want to go through textbooks and look things up, heaps of abbreviations and medical terms, it would be nice just to have them in layman's terms.

So you're relying on the midwife to translate them for you?

Oh well, she translates them very well, but I usually look them up in a book. The section in the book that's got all the little symbols and things.

Alison, i3 p6

Despite a rather self-contradictory statement, Alison is accepting of whatever tests that her midwife deemed necessary and she relied on her or a textbook for their translation. Although she had access to her notes she felt that they were not her property and thus she could not contribute to them. Alison also describes her midwife as a "medical person." I asked her about this:

Now why do you call them the medical team?

Em, well they are a team... the team... medical team. Well that's something I've just picked up in the last few days... it must be something my father said. He said, "I understand you're having the medical team that you've chosen around you." He went in for an operation recently. The birthing team? It's just the team of women I've got. I suppose it's just kind of... in a way... suppose they're just as medical as you know a hospital would be.

Alison, i3 p5/6

Alison's description of midwives as part of a medical fraternity was significant in that it possibly indicated a more widespread view of clients' perceptions of midwives. In this study this was substantiated by one other client. Chris expresses her views:

Now, you're going to have your family around, your husband and daughter. What are you expecting the midwife to do?

I suppose... I won't need her for support! (laughter) I'll have enough of that. She'll be there just to do the medical side of it I suppose. Just to make sure everything is progressing the way it should be.

Chris, i2 p8

Because of comments such as these I also asked midwives as to how the medical view of childbirth influenced their practice. Lesley talks further about the need for midwives to carry out a number of tests in the pre-natal period.

Yes and perhaps one of the biggest reasons is we've all been taught this is what you do for ante-natal care and not to do it makes us feel negligent. And then you start thinking, "Oh, no have I done the right thing? What if something happens? What are they going to do to me? They're going to kill me!"

And all those sorts of things come in and I know that the pressure of doing things to people and for people is absolutely huge on midwives and, in fact nurses, and that's one of the most difficult things to do when you actually start empowering women. It actually means not doing things for them. It means supporting them so they can do things for themselves and if you take a backwards style sometimes you're accused of being lazy or negligent, something like that. And I really only learned to stand back and let women do them when I was in a very small unit where I didn't have all these people constantly watching what I was doing and I was able to say, "Well I don't think you need me to do this I think you could do this yourself." And they could.

Lesley, i1 p4

Here Lesley initially justifies the actions of midwives in terms of their relationship with the powerful policy makers, many of whom are obstetricians. However, she is beginning to move away from this perspective of power and instead talk of empowerment. In feminist terms, empowerment is more than simply disseminating information but is constitutive of women's interests and making these flourish (Bordo, 1989). Julie is working within this framework when she says:

But what we would maybe see as important that women know and things like that, a woman might not put so much emphasis on it. But that's maybe because of where we're coming from, whereas maybe we see women being kept in that powerless position. So maybe if we give them that information then they might be able to say, "Well, hey, that really annoys me."

Julie, i1 p7

From the above extracts it is obvious that there is still some difference of opinion on both individual and more general levels as to what is important during pregnancy. While some aspects of pre-natal care have been examined by a multi-disciplinary group of health professionals and new guidelines issued (Department of Health, 1992) questions posed by Rothman (1982) regarding the necessity for many of the procedures carried out by doctors and midwives generally remain unanswered. For the experience of pregnancy and birth to reflect a genuine power sharing and partnership of midwife and client some of

these will have to be urgently debated in the near future and the emphasis on the importance of clinical notes reviewed.

One issue which was of concern to midwives in this study was the potential for abuse of power which midwives have. In the excerpt below, Lesley is discussing a client whose care she felt had been less than optimal.

How do you deal with that sort of thing and turn it to the woman's advantage?

It's a very tricky one and I suppose what I'm always aware of is that as much as midwives have the potential to empower women we also have a huge potential to have absolute control over them and they're very vulnerable and a lot of the time you may not even realise you're doing that. Certainly I know that I can very well sway what a woman's choice is by the way I put something across. One of the difficult things is making sure it's what the woman wants to do not what I think she should be doing.

Lesley, i2 p1

Lesley here, like the other midwives in this study, is well aware of the responsibilities that accompany positions of power and in general found the issue of power to be problematic. To assist in the dissemination of this power the midwives made every effort to pass on information to their clients. This is reflected in the extract from Fiona who is discussing some of the issues associated with shared care.

It's still ten times better than meeting her for the first time when she walks in in labour even to have had one or two antenatal visits with her. There is already a relationship; there is already an understanding; there is already some memory of what her plan was so it's just more comfortable.

Fiona, i1 p11

However, when I asked clients about power the issues appeared more clear cut.

It's very much **your** decision then?

Well, yes, I feel that it is. It's my experience no one else's. And while I'll be getting help and support, it's ultimately got to be me that makes the decisions.

Karen, i3 p5

I'm staying in for a week, I want to stay in for a week. It's very hard organising the children, that's the only problem. I can stay a week in self care. It depends where the baby is too, how early the baby is or how big the baby is.

Margot, i2 p4

Both Margot and Karen expressed in straightforward terms what they would be doing when they were in hospital. They expected that it was they who would be in control of their experiences and make decisions which were relevant to them even though previous experiences had not permitted this to happen. Power, then to these clients was not seen to be of great importance at this stage. However, one of the midwives shared an experience she had with a client who was not part of this study. This midwife felt that the client was extremely powerful and used her power to good effect.

Yes, some people want, like that woman who had me as second best was also shared care with her GP and I knew very clearly from the way she talked about her GP that it would be him that she was wanting to deliver. And we got to the hospital and it was a good hour later even though she was fully dilated at the time... she had a lot of work turning the baby around. And I just left her to it with her pushing and I thought that she'd come to it. And I did another V.E. I'd done one before we left home so I knew that she was fully dilated and that and I didn't want to rupture her membranes. And you know how it takes some women some time to get into their pushing and that and it was taking her some time, but it didn't worry me and I thought, "Well, she'll come to it." And it was her second baby and she knew what she was doing so I didn't tell her what to do and that. But her GP does do that. And he had done it with her first baby and she had really liked it. So I knew that this baby wouldn't be born till he got there.

Julie, i2 p8

Each of the examples given above shows how power was used in a traditional sense by clients. Although clients are generally considered

to be at the bottom of the hierarchy in the health care system, perhaps they felt confident enough in their relationships with their midwives to express these examples of their own power. The idea that they may be powerful, however, was not verbalised on tape, and nor was the discomfort that one client initially felt with her midwife. Belenky et al. (1986) discuss the non verbalisation of women's experiences and suggest that it is common amongst women to show rather than verbalise ways in which they are powerful. One client, however, did consider the issue of power to be relevant though felt that both she and her midwife were powerless in a system which was dominated by others.

What about the women, what power have you got?

Right at this moment, Val? (laughing) None at all. Well, it depends on what power you're talking about.

It depends on how you see power, I guess.

Em, normally I do have some power, but that's only because I've gone out of my way to find a network which was supportive, but the rules still function. I mean we all still know the rules. [My midwife] still operates on a system of power too. I have to accept that...

You've got more power, so what's your midwife got?

Because I'll be working in [Alison's] home as far as I can see Alison is the one that will be more in control of the power, and what she wants goes. I mean even if she's doing something, I mean if she wants to continue along a path which I think is risky. Because I've given her the information and she still chooses to make that choice. The real power lies with her. We could carry on with a fairly rigid routine but it comes down to what she wants. She could choose to have this or that or even do things which I think are risky and I might not like it but as long as I give her that information it's ultimately it's her choice. But I don't think we'll be in a situation like that.

Alison, (and midwife) 12 p4

Here, midwife and client are discussing their positions relative to each other. While each agree that the rules are still set by a certain ruling

elite, within these rules midwife and client could work together in a way which was mutually engaging and suggested the beginnings of a reciprocity in the relationship. For a partnership to be truly reciprocal, however, clients and midwives need to ensure an attitude of reflexivity in their relationship. How this occurred for participants in this study is discussed next.

Reciprocity and reflexivity in the midwife/client partnership

As outlined in Chapter Five (refer pp. 89-91) as well as being necessary to develop this research in a reflexive manner, midwives and clients as they develop a relationship during pregnancy often also use a reflexive process to overcome the power differences. As Wasserfall (1993) notes, this is a "strong" interpretation of the concept of reflexivity which encourages midwives as well as clients to reflect upon influences of their backgrounds and the extent to which this shapes their beliefs and actions. By so doing midwives and clients would be placed upon the same critical plane and able to work together with increased understanding. Both midwives and clients in this study have used the concept of self-reflexivity at times to enable this to occur.

I don't think I could have got through without my own personal experiences, because I used to be really involved with discussion groups and we used to talk about... all kinds of issues. You know, experiences like women have when they have kids, all kinds of things and I wrote a booklet about experiencing childbirth and I used to run ante-natal yoga classes, so I was really involved with that kind of thing. And with having children myself, I was making choices about vitamin K and immunisation and whether I got to see Plunket Nurses or whether I didn't. Whether I had my stitches, stitched or didn't, sore nipples, all those sorts of things. I had a lot of my personal experiences and those of my friends intimate experiences. So I don't know if I could have come as a new graduate to independent midwifery if I didn't have that. Because that has taught me almost more than the course has.

Sarah, il p6

I feel that through working with women and through my own experiences it's really helped to make me a better midwife with more understanding.

Julie, i2 p5

Sarah and Julie each draw on their life experiences to contribute to their present day midwifery practice. They each draw clear links between themselves and birthing women in order that understandings may be shared and midwifery practice be validated as an appropriate model of care.

As shown in Chapter Six, (refer pp. 103-121) clients in this study also reflected on previous life experiences which had led them to seek care from independent midwives in current pregnancies. However, when asked to consider what expectations of midwifery care they held on this occasion, the same degree of self-reflexivity could not always be seen to have been occurring. At 38 weeks pregnant, for example, Karen told me:

I don't actually know what decisions I'll be making now. I won't know until the time comes.

Karen, i3 p5

At the same period of her pregnancy Alison was also uncertain:

Some days I think I know what I want but on others it becomes less... certain. I think that during labour and afterwards, too, I'll rely on [my midwife] to tell me what to do.

Alison, i3 p9

Oakley (1981) has suggested that one way of overcoming such concerns is through "knowing." However, midwives in this study have stated:

However, we do get women less sure of what they want who are sent to us by their friends.

Oh, I get it.

They don't really know what they want but they've been told to come to us. Basically I give them a fairly routine explanation of the choices available to them and request that

they go, home and think about it and let us know what they decide.

Fiona, i2 p5

Well, we usually do talk about having a birth plan. And often when we ask them they'll say, "I don't know." And that gives us the chance to go through these things like, "Do you want to be active in labour?" "Had you thought about analgesia?" "Do you want to use the bath?" "Do you want your waters broken or not?" "What about syntometrine?" We explain what it is and how it's given usually. In fact our tendency is not to give it so if they want it to be given routinely then we have to make a note of that. Vitamin K we discuss.

Lesley, i3 p1

Fiona and Lesley's words reflect what Wasserfall (1993) describes as a fairly common problem, discrepancies between goals of two groups. Here it may be that midwives' goals for their clients are somewhat different from those of the clients themselves. Julie recognises this:

Because sometimes they come out and say to you, "Well, what do you think?" And sometimes your expectations aren't all that great, sometimes you just pile all that information on to them that they don't want or need and make it a whole confusing issue.

Julie, i1 p6

Julie's words are in accord with the earlier section (refer pp. 166-167) which considered how midwives attempted to empower their clients. As can be seen from the following extracts from Helen and Margot, Julie's concerns were reflected by the clients.

Midwives will always do what you want, but I think at the end of the day they're quite reluctant with pain relief and things. I think they like to get you as far as they can without anything.

Helen, i3 p12

It [the pain] was all in my bottom and I just sat on it and it went away. But I still can't get any information from them or from the books about pain in the bottom! There's nothing at all.

Margot, i3 p5/6

Pain then was obviously a key issue for clients but less so for midwives in this study. It is clinical issues such as this that need further discussion in venues such as joint midwife/client workshops which respect the knowledge of both clients and midwives so that some of the insights gained by midwives in relation to results of studies such as that by Flint and Poulengris (1987) may be debated and change made where the aims of the midwives are not necessarily the same as the aims of the clients.

However, with regard to the overall midwife/client relationship a sense of trust was seen to be developing as the partnership strengthened during the period of the clients' pregnancies. This sense of trust was what allowed issues of power generally to become less important as the relationship became more one of reciprocity. Chris, Helen and Margot describe this feeling of trust that each have developed in their midwives.

And what about the relationship you've developed with [your midwife] up till now? How has that made a difference?

It definitely has. It's going to add to my confidence.

What do you think?

Oh yes, I think it has. It's something I've seen for so many years now that knowing the women beforehand gives them a better labour and a better birth experience. And even if things go terribly wrong during the labour, the fact that they know the midwife and trust her may just tip the balance.

Chris, (with midwife) i3 p11

You know it just sort of I guess knowing that if I've got a problem you know the midwives are there, you know you can ring them any time. If something happens or I'm in labour, they'll come and check on me at home I won't have to go into the hospital. I'll ring them and say, "Well things have started and I'm fine." And they'll say, "Well, I'll just pop out and see you." Just sort of knowing things like that. That they'll come

to me, I won't have to go to them. No, but they'll make time in their day to come and see me and if I feel that I'm getting to a point where I'm not going to come back, then I'll just have to ring someone and they'll be there.

Helen, i1 p7

Yes, I guess they've been keeping a close eye on you. So do you feel it took a while for this trust to build up?

No, not really, she was always happy to spend time with me and talk to me, just talk, that's the difference. Like, I suppose it could happen to her too.

Margot, i3 p7

However, Karen felt that it wasn't until she was in labour that the feelings of trust actually began to establish themselves.

Looking back on it now, how do you feel that worked for you?

Very well, much easier to have her coming up. Especially since she was the one at the birth, that's the time I felt that we built up quite a relationship, and trust. I actually only had two visits with other midwives.

Karen, i4 p4

Reciprocity in the relationship was occurring, then, as the midwives and clients worked together in planned and committed ways. However, when the midwives were asked as to how empowering the clients were of them there appeared to be some uncertainties. Lesley's position was like most of her colleagues.

How do you think the clients are actually empowering of midwives, or are they?

It's not something I've given as much thought to as the other way but it's definitely a two way thing.

You're busy trying to unleash that burden of power, to share that power with women. Some professionals do hang on to that power though.

Yes, but the women definitely give us power as well. The fact that you, particularly if it's a woman who knows what she

wants I can speak for her if she wants that and it means that you're much more likely to stand up... I mean it doesn't harm me because I will stick my neck out for the clients. If it's an issue involving clients and staff or whatever. I would never do that for myself.

Lesley, i2 p8

Conclusion

Partnership-in-action, then was a developing process for participants in this study. For participants in this study the issue of power remained unsurfaced in relation to midwifery practice, although this had previously been discussed by both midwives and clients in relation to the medical profession. The concept of power therefore was still generally visualised from a masculinist perspective.

When specifically raised with the midwife participants, each appeared to be conscious of issues of power in relation to their own practice and anxious to overcome some of the perceived imbalances. While such actions effectively helped midwives to divest themselves of their power, their narrow conceptualisation of power appeared to put some limitations on the utilisation of a reflexive process to develop a reciprocity in the midwife/client relationship.

At times, too, the aims of midwives for their clients and the aims of the clients themselves appeared to differ. Although this did not cause any obvious strife for the clients in this study, midwives need to be aware that, if they enter into a true and balanced partnership with clients, some of the issues discussed in this chapter need to be further addressed.

However the notion of independent midwifery is still relatively new and the midwives in this study were investing considerable energies into disseminating power to their clients with the aim of creating a

partnership of equals. As time passes and further research which, like this study, considers socio-political and gender issues in relation to midwifery practice, is carried out, more progress may be made.

CHAPTER NINE

The Partnership Evaluated

The previous three chapters have examined the midwife/client relationship from its beginnings through to one which is praxis-oriented. For clients in this study the major focus of interest in the pre-natal period was towards labour and the birth while after the birth their interest was mainly directed towards motherhood and the baby. Bergum (1989) describes this transformation as a phase which occurred in all the women she studied as they became mothers. I noticed similar trends occurring with the clients in this study in the post-natal interviews as the incidents they described as important for them were related to their experiences of labour and subsequent motherhood. Until I specifically asked about the midwife/client relationship during and after labour this was not raised as an issue by any of the clients. Rather the type of picture painted by Karen is typical:

I'm not looking forward to the birth but I am looking forward to having the baby though. I was saying to my mother the other day that it would be good to have something that wipes you out so that you can't remember it. The first time ignorance is bliss but this time I start thinking and remembering, "Oh god that's right!"

Karen, il p5

Midwives in this study tended to concur with this picture as they stressed the importance of the pre-natal period for getting to know their clients. It would appear that for most midwives and clients, the birth of the baby also signals the beginning of the winding up of the partnership as clients assume the lifestyles associated with being mothers. This is despite each of the midwives visiting their own clients several times in the post-natal period.

As this study is focused on the concept of independent midwifery practice the developmental processes associated with women becoming mothers has not been explored. Rather, what was examined and is analysed in this chapter was the success of the midwife/client relationship from both midwives' and clients' perspectives and the determination of when that relationship should end. As labour has been consistently seen as particularly important for the clients, the discussion in this chapter focuses on the expectations and review of the labour and birth experience. In addition, the overall midwife/client relationship from the specific perspective of the clients as well as a more generalised commentary from the midwives is presented. It then turns to some of the highlights for midwives and clients of midwifery. Finally some discussion on terminating the relationship is included.

Expectations of labour

Clients who had experienced birth before generally had expectations that their labours on this occasion would be similar to past experiences. For me, this was unexpected as they had chosen a very different form of care from what was available to them in previous pregnancies. These expectations did not seem to change despite the increasing intensity of the midwife/client partnership in the latter stages of pregnancy and the developing sense of trust which, in most cases, grew with the relationship.

However, as Bleir (1984) has pointed out women are trapped in an androcentric world in which language and meaning have generally been constructed around androcentric discourses and goals. What is viewed as legitimate, therefore, is a limited range of activities and enterprises. Although the clients in this study had mostly enjoyed very different experiences with their pre-natal care in their current pregnancies, until it occurred labour remained an unknown entity in the

new partnerships and therefore was still viewed in ways which could be operationally defined by the medical profession.

Within the biomedical framework, labour and birth comprise several features such as rates of cervical dilatation and descent of the baby's head, frequency and intensity of contractions, fluid intake and output, blood pressure, pulse and fetal heart rates. These features provide a visual representation of labour which can be conveniently documented on a partogram¹² and so provide a ready reference point for the attending physician.

There is no place for qualitative assessment of pain or mobility with documentation such as the partogram, yet to women it is often memories of bad experiences during labour which linger after the event. For clients who were part of this study that was certainly the case, and it was these memories on which they were basing their expectations of their forthcoming labours. Some of the clients express such feelings in response to questions I asked concerning their thoughts about labour.

I know what's happening to my body and what it's going to be like and what the pain is going to be like and with the first you don't. It's funny I was scared of going, I guess I had always felt I'd had such a rotten time with the first I was scared of it happening again... The pain is just as intense and horrible, but that really excruciating pain I'm sure I don't even remember an hour of it. That got to that point where I felt like I was going mad. You know felt like I had lost control.

Helen, i1 p7

I'll probably, last time I just stayed in this little, wee room. I had to wait a long time for anything to happen, because my waters broke early and nothing happened when they said it would. And so I went home and then when I went back it still took a while to get going and once it did it was right.

Chris, i1 p7

12 a one page visual representation of labour viewed from a medical perspective.

I presume I'll be the same way this time when I'm in labour and the pain gets bad. As long as they can go along with that then I'm quite happy. As long as people don't think that they have to struggle with me!
Karen, i2 p2

So yes but even then, I was still scared about what was going to happen. I worried about it for weeks, weeks and weeks before he was born. I dreaded it, absolutely dreaded it. The thing is, with the first it was the fear of the unknown, you don't know what's going to happen, where with the second one it's because you know very well what's going to happen and how painful it's going to be, but you still...
Helen, i2 p8/9

None of these women can visualise her labour as being any different this time than in the past. They did not feel that trust in their birth attendants and the fact that they would be there whenever they mutually agreed was necessary would make a difference. Although each of the clients had developed some form of birth plan with their respective midwives the initiative for these had come mainly from the midwives concerned. This is in keeping with beliefs that the professional possesses expert knowledge and reflects the power of the hegemonic structures still inherent in maternity services of New Zealand.

While as seen in previous chapters, midwives are trying to counter some of these hegemonic structures, the medical profession have worked at retaining them through a process of benign paternalism which serves to maintain their power and relegate both midwives and clients to subordinate positions of acceptance. Some obstetricians, for example, suggest to women that safety for themselves and their babies will be enhanced through technology which only they have the power to prescribe.

While the passing of the 1990 Nurses Amendment Act legally removed midwives from such positions of subordination much work still needs

to be done before such power structures may finally be overcome and clients are in a position to reconceptualise labour. Indeed, as Karen notes, in reflecting on her first birth experience, her visualisation of labour left her totally unprepared for its realities.

Yes, because you build up a picture of what's going to happen but you don't put pain into the picture so... my delivery wasn't anything like what I planned it to be. I was not going to have my baby on the floor, but as it turned out I couldn't get myself off it. And all these things. Like I said, "I'm not going to do that." And as it turned out I did and my husband thought, "How embarrassing, how can she do that?" But all the inhibitions fly out of the window.

Karen, i1 p5

Karen felt that the first time as she was not sure what was going to happen she was prepared to go with the flow. She had not had the opportunity to share her expectations with her primary caregiver or the midwives who attended her in labour. She did not consider herself taking any affirmative action to shape her labour to meet her expectations. Consequently, in subsequent pregnancies she considered labour as a somewhat evil necessity to go through for the sake of having children. Chris, however, towards the end of her pregnancy began to speak of her plans for the impending birth.

Because last time my waters broke and nothing happened for six hours and it was six in the morning when that happened. So it'll just depend on sort of how it all comes around really. Then I'll just start getting in contact with people so that they know it's happening and they can get organised...

OK, so that's the family organised, you'll do the ringing around. When are you going to get in touch with your midwife?

When I start thinking I need support from her...

Yes, we'll let her know it's going to be some time soon but not to hurry.

Does that seem different from the last time? I guess you had to ring the hospital that time.

Yes and they told me to come down because my waters had broken. When I got there they sent me home so I thought, "Well, that was a big waste of time."

Chris, i3 p6/7

Chris is beginning to move to a more participatory model of care in which she has some responsibilities. She sees her active participation as being vital to the successful outcomes of her labour. She also expresses an interest in the **process** of labour in which her family and the midwife are also key participants. This is supportive of the work of Bassett-Smith (1988) whose grounded theory suggested that the involvement of family and friends would enable women to experience labour in a more relaxed fashion.

During the course of her pregnancy, Margot, too began to anticipate her baby's birth and made plans accordingly.

*You don't get a chance [with prems] to look forward to the day which is a very big part of it. I'll be able to see **this** baby straight away and we've talked about staying in the room, the birthing room in the hospital after the birth and the baby will go straight on, and I'll have a shower. And we'll all stay in that room till it's time to go down to the ward. It sounds really, really good. And all my friends, we're all going to stay right there. It sounds really neat!*

Margot, i3 p2

While appearing less actively participatory than Chris, Margot had made considerable advances since our first meeting and was happy to make some decisions concerning the management of herself and her baby. It was Alison however, who unlike most of the women who had previous experiences of birth, used the pre-natal period to share many of her thoughts and plans with her midwife.

Some feelings which I think... I think... I hope to think that the more we talk, discuss this stage the more trust I'll have in my midwife, and with that trust the more at ease I'm going to be. And I think the more ease you're going to have the easier the birth is, on both of us and for everybody else. I think it works for the midwife too. I mean if you have got a woman that

trusts you and you can work together with that trust, you can make something tremendous happen. But if you have got someone fighting against you in a state of panic. I know what that's like. It takes a hell of a lot of work to get it back and you don't often have time in delivery.

Alison, i1 p11

While Helen and Karen were unable to visualise labour and birth from a different perspective to the biomedical model, in which the woman's job was to comply with instructions and be delivered, Chris and Margot had to some extent moved beyond this. Alison, however, had entered into a relationship with her midwife which reflected the essence of the partnership inherent in the midwifery model. This was to come later for Margot as she began to visualise labour as a "*powerful woman's experience*" (Margot, i4 p7).

However, as mentioned above, it is not just clients who have had to move away from the biomedical model of birth. Midwives in this study all had some experience of birth in a biomedical setting where neither the midwife nor the client has any power.

In fact the first birth I saw as a student nurse and I was there watching and I thought, "God, death is far more peaceful." It was only when the baby was actually given to the woman that I thought, "Oh no, that's nice."

Yes that's what I thought. I thought the baby had a heart defect. I had just come from the baby unit where I nursed the babies who did have a heart defect and it was so purple and I thought, "Oh my god it's another one for us." No, I still see a huge amount of dignity with labour and birth now and I get, I just get so angry.

Lesley, i1 p13/14.

You say when you were a student nurse, that birth was a horrific experience or something like that, whatever you just said. What do you mean by that?

Well, I was only involved with about three births as a student nurse and in each situation I was thrown in to meet this person in labour with, "This is a student nurse you'll have with you." When I'd never met them before, didn't know a thing about

them, so had very little power in the sense of how the birth eventuated and had very little knowledge about anything. Yet I was also that person's main support system, her support person, because the midwife was very...wasn't involved much. I'd always admired midwives up until then and wanted to be one myself and was quite shocked about the role of the midwife in those situations. The woman was left to labour on her own, she was petrified by the pain, the support she was given... well it was just really scary. And then she was, there was a great loss of dignity with being moved in second stage. One older woman who hadn't had a child for 11 years and was in a new relationship was really scared of having a baby. She had terrible sciatica and couldn't open her legs and was just forced to, she was totally abused really. The focus was on the student doing the training, not on the woman. And the doctor who was training the student... it was all sterile, it was just absolutely awful... The woman was absolutely... it was a horrific experience for the woman and I just in those cases refused to catch the baby. I just felt totally frozen by the situation. So that was when I started getting really interested in homebirths.

Sarah, i1 p2/3

Lesley and Sarah both expressed their horror about how birth, which they saw as a dignified, woman centred event, could be transformed into such a medical occasion. In their present practice both felt that they were working within their own philosophies of birth and that this would only occasionally encompass components of the biomedical perspective. For the most part, however, they felt appalled by the abuse that was experienced by women (both as midwives and clients) dominated by a medical philosophy of birth. The type of partnership and sharing of power that was outlined in the previous three chapters and was consistent with the midwifery model of practice (Rothman, 1982) was a means of overcoming this. How successful this was is discussed in the next section which focuses on clients reviewing their experiences of labour shortly after the birth.

Reviewing the birth experience

According to McKay and Barrows (1992) a woman's memories of her labour come from her own memories supplemented by information from family members and caregivers during labour. In this particular study I sought only memories from clients of their perception of their midwifery care. However, inevitably this turned to a discussion of their birth experience. Chris whose expectations were outlined fairly clearly in the preceding section, reflects on the realities.

So how did it all work out?

Completely different.

Completely different... this is no good!!

(laughing) Well, the birth was wonderful, it was really, really good. But it happened that fast that half my support team wasn't there, they didn't make it. The big one was my husband, he missed out!... It all happened over the weekend I had niggles then on the Monday, I thought, "Yes, it's going to happen." Something was brewing up. But I still just carried on through the day. I went to [the supermarket] and stocked up on all the food, and did a few things around the house. And in the afternoon I got hold of [the backup midwife] because mine had been at a birth the night before and was tired. So she came up and said it was all softening up and was going to happen and we were all going to get organised... That was about six o'clock when things were really starting to happen. And as soon as he got hold of this guy he thought he would go and fill the car up with petrol and get everything organised while he had the chance. And as soon as he walked out the door things speeded up. As soon as he left it was all on. My sisters and my Mum made it. They arrived, just half an hour in time. And when they arrived I was just sitting in the lounge with a hot water bottle on my stomach.

You sound quite relaxed about the whole deal.

Yes, that's all I did. I was sort of rocking through the contractions. And the midwife was just sitting there... I suppose she was just watching what was going on.

Were you a bit sorry that [your primary midwife] couldn't come?

Well she did eventually arrive, so she did come. And it was when she arrived... that's right... that I wanted to go to the toilet. So I wanted to go to the toilet and I decided that I was quite comfortable on the toilet. So I was in there all by myself. And she was just about ready to go and have a nap, and the student midwife who was here also, said, "Do you think you should?" She knew something was going to happen... she had this inkling that it was all going to happen. Then the midwife came through and I was on the toilet and my sister was running me a bath. And she had one look at me and said, "There's not going to be any time for a bath. Get hold of [the husband]. Get him back here." And the next minute they had everything set out here, and I had him. Just like that!

Just one push?

No, it took 20 minutes to get him out, it was quite intense. Everyone was terrific. [My daughter] was incredible, she was just amazing saying, "Are you all right, Mum?" And rubbing my back. And then the midwife actually took over then, she was really wonderful. She took over throughout the whole birth.

But until you got to that stage the midwives were just quietly in the background?

Yes, they were just sitting there talking among themselves, but as my mother said I really made it easy on everyone because it happened so fast.

And you were cool, calm and collected by the sounds of you.

Well, I suppose I made a bit of a roar!! But when you think back... yes, it just happened and it was fast and the next minute it was all over and [my husband] wasn't here. He made it in time to cut the cord. He couldn't believe it when he walked in the door.

Chris, i4 p1/2.

For Chris the midwives were available when she needed them, and stayed in the background until they were required to play a more active part. Chris, however, was aware that they were observing her, ready

to become more active when required. The verbal account by Chris was endorsed by a videotape of the birth in which the two midwives could be seen sitting quietly at first talking to each other and observing the action. Even when the birth was imminent there was no flurry of action, although Chris' three year old daughter was clearly enjoying the action and kept coming to stand under her mother's legs and look for the baby!

The practice of the midwives here is consistent with the midwifery models outlined by Rothman (1982) and Barrington (1985) in which the midwife's contribution to the partnership is described as supportive of the woman and participative as required. It is also the perspective which has been adopted by the New Zealand College of Midwives (1990) whose philosophy states that, "midwifery care is delivered in a manner that is flexible, creative, empowering and supportive."

The provision of midwifery care in the above manner also takes cognisance of the knowledge the client has of her body and the changes occurring therein. As Ginzberg (1989, p. 71) states, such an epistemology of interconnectedness is achieved through, "careful attention to the dynamics of living systems as pieces of a larger and more awesome natural world which is constantly responding to, and responsive to, itself." As long as this is occurring the client will remain the more active partner, with the midwife adopting a supportive position. However, as labour intensifies and the client begins to move away from her sense of interconnectedness then the midwife becomes more active.

This toggling of the partnership was also expressed by other clients. Like Chris, Helen and Karen felt that although they each had birth plans, when they were in active labour others should make the decisions for them.

You're saying that you're in quite a lot of pain and for them to do something. Their response was to say, "What do you want?" How did you feel in that sort of acute time being asked what you want?

Oh, I can't remember what I said. I think I said, "I don't care, I just want something." I wanted it to go away completely.
Helen, i3 p5

This time you say you felt a wee bit out of control. Did you feel you need the midwife or somebody else to actually direct you? Were you waiting to be orchestrated so to speak?

Yes, it was... compared to [my first baby's] birth I had a lot more... I had more to do with people, which I was really quite surprised about.
Karen, i4 p2

The comments from Helen and Karen suggest that perhaps the notion of making birth plans in the pre-natal period is of little practical use when in strong labour and it is up to the midwife to be more directional at this stage if required. The building up of the relationship in the pre-natal period to an extent where it involves a feminist praxis of the nature outlined in Chapter Eight would allow such a relationship to happen on a more regular basis with both the midwives and the clients maintaining a sense of balance in the relationship.

For such relationships to occur, there needs to be a developmental aspect inherent in the partnership. In the previous extract from Chris (refer p. 188) I had referred to the non availability of her primary midwife. Although she had not been able to come initially, this did not seem to be a matter of concern to Chris. Karen who did have continuity of care from one midwife (with a backup midwife visiting once) expressed similar thoughts to those of Chris.

Looking back on it now, how do you feel that worked for you?

Very well... Especially since she was the one at the birth, that's the time I felt that we built up quite a relationship, and trust. I actually only had two visits with other midwives.

Karen, i4 p4

The thoughts of Chris and Karen raise some questions for midwives who support the practice of one to one continuity of care from conception until after the birth, a practice which has been suggested by the New Zealand College of Midwives (1992) as enhancing and protecting the normal process of childbirth. While the Department of Health study (Scotney, 1992) supported this and suggested that one to one care was essential for client satisfaction, the findings of that study appear to be somewhat insular and do not indicate a balanced partnership in which midwife and client support each other.

What appeared to be more important than one to one continuity of care throughout the pre-natal period for the clients in this study was that whichever midwife provided the care for her during her labour would be giving all her attention to her and not working between several clients or going off duty later in the day. Helen expresses it:

What is a midwife going to do for me this time that's going to be different? She's not going to rush away, hopefully, because she's not the midwife that's got to cover the whole hospital, she's there for me. So, hopefully, I mean she's going to come and see me at home and we'll go to the hospital later. So just more support, I think. You know she's going to do exactly the same as what the midwives in the hospital do, she's going to be there and she's going to be there to help deliver the baby but it's more than that because she's not going to have to keep coming and going, like they just come in and out because they've got two or three other ladies having babies at the same time. She is there for me and will be till my baby's born. She won't go away, but it might be the luck of the draw, if she had to be with someone else that day, I'll have someone else, but whoever I end up with will be with me for the whole birth and they won't keep running away and they won't keep coming and going even like the doctor does.

Helen, i2 p9

Helen's thoughts reflect those written by Chris in her diary which she did not talk about on tape. I asked all the clients in this study if they could tell me if there was one moment when the midwife's being there was important. For Margot, in intense labour and needing to leave for the hospital, it was appreciation of the one to one care of the midwife.

But half past four we had to leave. So it must have been a quick phone call. But it was only to the midwife, that was really good. We didn't have to ring the doctor or the student midwife, or the hospital, it was only to the midwife. So it wasn't ring this, ring that it was good. I had it all spaced out.

So she took care of the rest?

She took care of the rest.
Margot, i4 p2

And for Helen the moment she describes appreciating the midwife was two hours after the birth when she wanted to go home.

We got up and walked out! She said my blood pressure was high but she felt it was because of the labour and nothing else. She said she felt that if she was concerned about it she'd have made me stay for a couple more hours and we would have monitored it but she was quite happy to let me go. And so we just sort of parted ways at the car. She said she was coming out straight home with us. I wasn't getting loved and left sort of thing.

Helen, i3 p8

The midwife/client relationship then was important to all the clients during labour although client needs were expressed in different ways. However it is not only in labour that trust and partnership were expressed as important. The concept of mutual support of midwives and clients for each other was expressed at various times throughout the research process and in relation to a variety of situations. This is discussed next.

Midwife/client support for each other

As was shown in Chapter Two, tension has existed between the midwifery and medical professions for many years and continues to do so. As with the situation described by Vosler and Burst (1993) the health care system now provides for consultation between midwives and obstetricians and referral where required. In addition many protocols for maternity services in New Zealand are still developed by the medical profession. This continues to foster midwife dependency upon obstetricians to some extent and as with Moloney's (1992) study, midwives here felt at times they had to "protect their backs." Here their clients were very supportive as Lesley indicates:

I know I have to watch my back all the time. And yes, there's been a couple of times where I've thought the mother's looked incredibly small but I actually felt their babies felt a normal size, but just to be sure I've sent them for scans and I know that was to protect me and all I could say to them was, "I'm actually doing this to protect me. I do not feel that there is a problem with your baby. We're in a vulnerable position and you know it would help me but you don't have to do that if you don't want, but it would help." And in fact both mothers were quite happy to do that, they realised that we were in a tricky situation.

Lesley, i1 p4/5

And I found it quite hard in some ways, I really didn't like myself at times. Sometimes I would just shut up about things and not inform people just because of knowing who their GP was and knowing the fact that what I said didn't make a stuff to him and he'd say, "This is what's happening." So, I sort of shut up in an effort not to put the woman and the family into conflict. Because I had that happen a few times and the end result was that the family ended up in quite a bit of conflict and just didn't know who they should be looking at and taking the knowledge of and the fact that I was a hospital midwife and I hadn't been involved with them prior and they had a relationship with their own GP and they were going back to him. And especially if they'd known him.

Julie, i1 p8

However, it is not just in tricky situations that this support comes to the fore. I asked the midwives how they saw clients as being able to offer them support and here Julie describes what she believes to be general feelings of women.

Do you think that women, on the whole, are supportive of midwives knowing that they need holidays and things?

I think they are. They recognise... sometimes I think that they recognise the work that... the hours and the on call and the commitment that we have. Others maybe don't have a very clear idea of it and only realise it when they're in labour and see all the time and work you put into them then and you've got the rest of your work to get on with and stuff like that. But on the whole I think that women are pretty supportive of midwives and realise that you've got to have your holidays and that you've got to be able to give... you've got to have a bit of time out for yourself because you've got to be able to give so much and you can't do that without having time out for yourself. I think they are pretty good about that.

Julie, i2 p6

I was feeling good about having sort of got to know my midwife, and I was a bit sad when she had to go on holiday and I was sort of... well, I didn't really know how I felt actually...'cos I understood, they have to have holidays and unfortunately it was just the way it went.

Helen, 13 p1

Julie's and Helen's words suggesting that women would be accepting of midwives' needs for holidays and other time away support the previous excerpts from Chris and Karen. However, this is possibly because the midwives endeavoured to arrange at least one meeting with another midwife, so that in the event of the primary midwife being unavailable for the birth, clients did not have to meet a total stranger, so recreating some of the difficulties they expressed in relation to multiple care givers (refer Chapter Six pp. 107-114).

The meaning of midwifery support for Lesley, Sarah and Alison was expressed on more broad terms and is presented below.

It's important that I know where my limit is and for that woman I put her in touch with a support service and they were able to find her good counselling which came from a feminist base, help with child care and housework and also put her in touch with the patient advocate

Lesley, i1 p2

You have to prove yourself as a new mother, and I'm sure lots of new mothers feel like this, you have to prove yourself by doing everything right and to teach them that most things don't matter... so many things don't matter and to learn about what really matters and to just relax and be calm is hard. And a midwife coming in and saying, "I think what you're doing is obviously the right thing." Or teaching people to work it out for themselves, I think that's extremely important.

Sarah, i1 p13.

It's very interesting... it grows. I don't seem to have relationships with people who have a ... I don't think I'd work with a midwife where I didn't feel close, I didn't feel in a sense intimate with. I would not have chosen one where I would feel tense, uncomfortable and I mean the very nature of having a child... I mean it's something where you have to feel very comfortable with someone and if you're going to be in that situation you tend to make friends and develop bonds and so I feel, personally, I've got very close to my midwife. So I'm lucky. I don't think... I didn't anticipate going for a midwife where I didn't have that feeling.

Alison, i2 p5

Alison clearly states her expectations which generally relate to the midwife's being there. However Alison expects that the partnership which develops is not simply that of a professional and a lay person, she expects a more intimate relationship with a midwife than she could expect to have with her GP for instance.

We are not at that level of intimacy that I think women find very easy to be at and men find very difficult to be at. And it cause all kinds of ethic (sic) problems when you do get that kind of intimacy with a male and female. Whether be in a surgery or a friendship situation society. Women can cuddle, they can kiss, they can ...

Be together?

Yes. There's a hell of a lot more intimacy there. But if you did that with a male doctor there would be all sorts of ethic (sic)

issues and it would be... If I cry, the midwife will put her around me, if I cry my GP would pat me on the shoulder.
Alison, i4 p8

Helen and Margot also allude to the notion of intimacy which developed during their pregnancies:

I knew that I was going to get to know the midwives. But I didn't really know how well... or how like... how... No, how much time they really are prepared to spend with you. And when they are with you, you have their undivided attention. They are not thinking about the next patient or the patient they have just seen. They are thinking about you and they are automatically asking questions about you and things like that and with the doctor it's kind of like... Well it was, he wrote something quickly but only because I took in my midwifery notes so he could see what they had written. I was in and out in five minutes!
Helen, i3 p10

Yes, and it would have been... well, it wouldn't have been woman to woman but all women. It had that special relationship for starters. There was a bit more to it. Giving birth was the end result of it, but there was more to it.
Margot, i4 p10.

Intimacy is a concept which has as yet had little discussion in midwifery or feminist literature. Two of the midwives, however, referred to the necessity for physical intimacy in midwifery practice.

It's really abuse you know. When you work with these things all the time to think that these women's breasts are your property just as much as they are hers, or that her fanny is or whatever.
Sarah, i1 p14

And I think that there's actually another side to the problem in that we're also all trained as women that in a certain situation we have to allow people to do certain things to us. So what happens is that say in a hospital situation, in a post-natal ward you're not supposed to have any problem with going around and handling women's breasts and doing things in the genital area. You just, it's supposed to be your job, you just do it. In fact if you feel uncomfortable about doing that then you start thinking you have a problem and that problem is labelled then as being sexual. So you just sort of used to do it. At the same

time when we're in that situation we're just expected to accept it being done to us.

Lesley, 12 p6/7

Both Sarah and Lesley see the potential for abuse or other problems inherent in a relationship which involves physical intimacy. Yet, a feminist model of intimacy as conceptualised by Dimen (1989, p. 47) in which each creates the other through "knowing, sensing and intuiting the other at the boundaries between the two" would allow less of a feeling of unease in such interactions. In addition, such a model appears to highlight the essence of midwifery practice as it is visualised in New Zealand. It indicates a willingness to commitment and involvement from both the midwives and clients and it is perhaps a concept which could be utilised to identify the unique partnership of midwife and client. This concept needs to be addressed in more depth in further research into midwifery practice.

However given that a relationship of partnership has developed over a relatively short period, how that partnership is dissolved also is of importance to independent midwives and their clients. This final theme is discussed next.

Dissolving the partnership

At present the law allows midwives to take responsibility for a woman throughout her pregnancy and up to six weeks after the birth of her baby. After this period the client will be discharged from midwifery care. In instances of shared care the discharge from midwifery care may come earlier if the woman chooses to return to her GP for a final examination. Dissolving the partnership may mark a transition to full independence of the woman as suggested by Bergum (1989), although other agencies such as Plunket and the GP are likely to have some ongoing involvement with the woman.

In this study, I asked both midwives and clients their thoughts on dissolving the partnership. Although most of the women felt that they had developed a special relationship with their midwives they found it easy to let go as they concentrated on the full time job of motherhood. Margot, however, who had not initially expressed great enthusiasm for midwifery care found it to be especially hard.

So then we got handed over to Plunket. And I still can't believe it's over, it's one of the things... it's just over.

Having developed that strong relationship, you mean?

Yes, and it's over... weird.

It's a good point, you're right, suddenly it's an end to what has been a real intensive period in your life.

It wasn't coming up to an end... it just ended. And I didn't even have time to think about it. And, you know, I'm not going to see her again and it felt weird.

Margot, i4 p7

The notions of closure expressed by Margot were not specifically mentioned by any of the midwives. However, in the excerpt below which relates to a situation which had been complicated, Sarah expresses similar feelings of frustration when appropriate steps had not been taken to dissolve the partnership.

It was a really awkward situation and to talk about it today, three months later, it's sort of like, it still feels like, "How could I have managed that situation differently?" There's all these protocols and guidelines put in place and basically I think to protect myself I'd have to tell someone to do this but I know in myself that's the choices I'd want her to make.

Sarah, i1 p11

Sarah mentions the need for ongoing dialogue in relation to a specific incident but which could also be relevant in most instances in which a strong midwife/client relationship is developed. The need for flexibility is thus seen as vital to both midwife and client in the above examples and although the goal of independence for the clients should always be

shared by both midwife and client, the time at which that independence should occur must have some flexibility. Julie sums it up:

Yes, what about terminating the relationship. Let's just finish with that one. How difficult or easy do you find it?

Sometimes it's quite hard really, especially with the ones who cut off earlier than you would think. And you sort of think, "Oh, OK they can do it all by themselves, sort of thing." To a degree and you think, "Oh." And you tell them they can get you if they want you but you also tell them that everything's fine and they're doing really well. And I saw one woman once and had a few phone conversations and she seemed surprised that I was ringing her up. So with some of them it's no drama at all and others... well from the woman's point of view they might go, "Oh so this is the last one." So often it's the time to talk over a few things and stuff like that and say how much you've enjoyed it and wish them well. And with these other women lately we're going to have a morning tea and I've personally told them that it would be really nice to see them there. It is important to have cut off boundaries but not too make them too rigid. There was one woman with whom I'd had a very professional relationship and she had her ante-natal class reunion at the weekend and she invited me to go out for a while. So I went out and that was a good thing to do because they'd discharged themselves quite early so it was nice to have a bit of a yarn at the things that go on and have a really good laugh about them.

Julie, i2 p10

Julie defines the concept of boundary marking and the need for flexibility. Again this relates to the necessity of individualised care in which a sharing of knowledge and ideas occur and which reflect feminist beliefs about knowledge which were outlined in Chapter Four (refer pp. 79-82). These recognise the strengths inherent in ways of knowing which have not derived from Western epistemologies but may have relevance to midwifery practice.

Such ways of knowing highlight the need for a move away from policies which are set in concrete and which have dominated the biomedical model of birth. This move to more flexible guidelines has been strongly encouraged by the New Zealand College of Midwives

(1993) and was also suggested in a recent British report (Department of Health, 1993).

Flexibility in termination of the midwife/client relationship could mean that the end of the partnership need not occur suddenly, that women can still telephone midwives if they are unsure of what they should be doing or if they have an emergency. Coffee mornings too as mentioned by Julie offer a means of ongoing contact and may also form the nucleus of a support group should this be needed by the clients.

Conclusion

This chapter concludes the journey though the midwife/client partnership. It has considered some of the expectations in relation to the realities of the clients as both midwives and clients reflect on the partnership. Some contradictions have been revealed in relation to midwives' expectations of clients' labours and clients' own expectations. It has also shown that both midwives and clients see their relationships as intimate experiences. As such, some greater degree of flexibility in the termination of these relationships is required.

CHAPTER TEN

Discussion, Recommendations, Conclusion

The previous four chapters have shown how midwifery in New Zealand is practised in the context of a wider society in which the social system continues to favour dominant groups such as, in the case of this research, obstetricians. Despite this, however, this study has demonstrated that midwives, together with their clients, were gradually creating a system which was more sensitive to individual clients' needs than the more structured biomedical model currently offers.

While it has been emphasised that the participants were not a sample representative of a larger population, the findings of this study nevertheless do have implications for midwifery in New Zealand. Internationally, too, where midwives are attempting to move away from a biomedical view of childbirth towards a partnership orientation to practice, this study may offer some insights.

This chapter first examines the findings of this study in relation to its stated aims. Next, implications for midwifery practice and education are discussed. Limitations of this study, in relation to the theoretical framework, are then identified and discussed. Finally, and in relation to the above areas some recommendations for future midwifery research are made.

Revisiting the aims of the study

The aims of this study (refer Chapter One p. 4) were to engage a group of midwives who claimed to practise from a midwifery model of care with their clients, in a process of self-reflective inquiry in order to examine how together they co-created and shaped their mutual

experience of pregnancy and childbirth. By adopting a critically feminist theoretical framework, this study also aimed to focus on the conceptualisation of partnership within the midwife/client relationship. Further, through the use of this framework it aimed to examine how midwives perceive and utilise power in their relationships with clients.

The findings from this study met these original aims. In writing the original proposal I used the word "co-create" when introducing the idea of exploring both the midwives' and clients' experiences of pregnancy and childbirth. The use of this word was to indicate the assumption that both midwife and client would be active participants in a process of partnership which was praxis based. Further, its use proposed that independent midwifery practice provided a very different framework of care for pregnant women than that which had preceded the advent of independent midwifery. This was in keeping with the midwifery literature which suggested that partnership of midwife and client is the pivot on which midwifery should be based (Flint & Poulengris, 1987; New Zealand College of Midwives, 1990).

The empirical evidence which emerged from this study demonstrated that both midwives and clients were highly reflexive and, to a degree, critical of the structures which dominated the arena of childbirth. How this was achieved in relation to the themes forming the theoretical framework (refer Chapter Four pp. 75-82) is now briefly discussed.

From subjectivity to intersubjectivity

The interrelatedness of the respective subjectivities of clients and midwives was acknowledged in Chapter Four (refer p. 79). I took the position that each constituted the other throughout the pregnancy, birth and post-natal period. The beginnings of this interrelatedness were found in the early interviews in which past experiences of participants were being explored. Here the strong theme of partnership began to

emerge from the data. Analysis of interviews and journals supported my initial assumptions that the participants had made clear deliberate choices in their move away from previous experiences in the biomedical perspective of childbirth to co-creating present experiences, although this was not apparent from the clinical notes. Although, as stated in the aims, I was looking for examples of partnership in the midwife/client relationship, I had not envisaged such clear evidence of its existence throughout the period of data collection.

This research also showed that the initiation of the midwife/client relationship was in itself often subject to the patronage of the medical profession who remain the primary point of access to the majority of health services. Most women, on becoming pregnant, still have their pregnancies confirmed by their general practitioner before continuing with care from them or seeking referral to other health care providers. The medical profession, therefore, are still able to influence a woman's decision to seek alternative forms of care and often withhold information about midwives unless it is specifically requested. Evidence of this withholding of information was reported in this study by clients and has been shown in Chapter Six (refer pp. 124-125).

So, although the law changed in 1990 to permit a midwife to take full responsibility for a woman throughout the period of pregnancy, women in this study for the most part seemed unaware that they could contact a midwife without being referred by their general practitioner. The one woman who did attempt to do so found that midwives were hard to locate and it was only by chance that she eventually did so. Midwives in this study also found the issue of medical control of access a problem and although they had made concerted efforts to advertise their services through attending Plunket meetings and similar events, clearly this was not sufficient especially for women who were expecting their first babies.

In order to become more visible, midwives therefore must continually actively market their services to make contact with potential clients. In some instances this may involve midwives making contact with women's groups which are not usually associated with pregnancy and motherhood in order to raise awareness amongst their members of the potential services midwives may provide.

Once independent midwifery care was selected by clients, individual midwife/client partnerships based upon collaboration, trust and intimacy gradually began to emerge. As shown in Chapter Seven (refer pp. 145-154) clients had clear expectations of their relationship with their midwives while midwives took care to ensure that "*all the information*" (Fiona, il p10) was available to women so that they could make an informed choice as to what various caregivers, including a number of different midwives, could offer.

Partnerships occurred on individual bases with some dyads establishing feelings of mutual trust and even intimacy early in the relationship while for others it was not until the advent of labour that a sense of trust emerged. For midwives, the relatively autonomous situation in which they worked provided the vehicle capable of accommodating such diversities of practice. The strength of the midwife/client partnership found in this study is similar to that proposed by Kirkham (1986) who suggested that this was the basis for feminist midwifery practice.

Although the midwife and client dyads in this study had each negotiated satisfactory working relationships in which various degrees of trust and intimacy were expressed, there was no evidence of this in the clients' clinical notes. This would appear to suggest that while concept of the midwife/client partnership was a key issue for the New Zealand College of Midwives in the establishment of independent

midwifery as yet this has not been researched or developed to an extent to which midwives can therein totally ground their practice.

As Ginzberg (1989, p. 79) has suggested, this supports the view that "midwifery is an incomplete, undeveloped, less successful and less scientific approach to the same scientific problems" that obstetrics is trying to solve. It also reinforces the notion of *différance* within midwifery which traditionally has been practised as an oral rather than a written tradition. This notion is in itself supported with a lack of texts concerning the essence of midwifery practice. More research is needed in this area so that midwives are able to celebrate women's ways of knowing as an essential part of their practice and oral traditions come to be valued. However, in acknowledging the power of the written word, midwives should be encouraged to document the essence of their relationships with their clients and, through this, create a written body of midwifery knowledge.

Power/Knowledge

By midwives and their clients focusing on an individualistic approach to the concept of partnership, there is an opportunity for producing the environment in which some midwives could become extremely powerful and use this power to benefit themselves rather than the clients in their care. Midwives acknowledged this potential and the data presented in Chapter Eight (refer pp. 164-173) suggested that all the midwives in this study attempted to divest themselves of this power by empowering the clients. However in some instances this may have had the opposite effect of its intentions. By trying to explain or justify the seemingly contradictory experiences of the clients, midwives may have been providing reassurance but simultaneously reinforcing their own position as being the power holders by virtue of their knowledge. Such an example was presented by Helen (refer p. 175)

who felt that midwives were "*quite reluctant with pain relief and things*" (i3 p12) even when the clients expressed a need for some analgesia.

However, while all of midwives in this study have conscientiously attempted to share their power with their clients, the idea of the socio-political power maintained by dominant groups such as obstetricians was also explored in this thesis. The concept of hegemonic masculinity as outlined in Chapter Four (refer p. 80) remains very strong in continuing to foster the beliefs of the dominant group ostensibly in the interest of midwives and clients although this was not in many instances acknowledged openly. The wider system of socio-political domination thus appeared inevitable to both midwives and clients to the extent that it was considered to be natural even by the participants in this study who could be considered to be disadvantaged by it through having to undergo certain invasive procedures throughout pregnancy.

The midwives in this study appeared to comply with some practices which although deemed necessary by the medical profession have been questioned by Rothman (1982). They were, however, unable to verbalise their own feelings as to their necessity. Clients, too did not question or object to these, and appeared to believe that they were a necessary part of bring pregnant. Individual midwives in this study spoke of the carrying out of certain procedures such as blood tests and scans which have been extensively developed by the medical profession for example in the pre-natal period (refer Chapter Seven, pp. 148-149) and which have come to be embedded in the notion of "common sense" although these were time consuming and in some instances carried an element of risk to clients.

Results of these tests, unlike the nature of the midwife/client relationship, were documented on clinical records. By such

documentation these assume an air of importance and neither midwives nor clients questioned the necessity for these procedures.

Indeed, midwives actions in relation to these traditions appeared to support the status quo, whereby the power of the written over the spoken remains dominant. Other examples have been documented elsewhere in this study and serve to emphasise the power that androcentric science still holds over the midwives and their clients in this study.

Midwives have suggested that sometimes this is necessary in the interests of protecting themselves against "omissions" which could incur the wrath of the power holders and sometimes in the interest of protecting their clients against unnecessary trouble. Although the New Zealand College of Midwives has been involved in the production of new guidelines from the Department of Health (1992) concerning pre-natal care, individual midwives in this study appeared unwilling to challenge the status quo, despite the fact that discussions were taking place at the time of collecting data for this study.

Despite the above argument it is not to say that midwives and clients were unaware of the socio-political constraints acting upon them. Within the bounds of individual partnerships, each had the capacity to effect positive change. Within the confines of individual midwife/client relationships, clients expressed clear wishes and, where necessary, midwives were prepared to act as client advocates in a number of compromising circumstances. In rare instances where there had been friction between midwife and client every effort was made to overcome this through constructive, ongoing dialogue.

By concentrating on individual partnerships, and the power inherent within, therefore, midwives effectively accept a masculinist, hierarchical

view of power in which one party has power over the other. Although each midwife was striving to balance this power equally with her clients examples were given throughout Chapter Eight where this was not occurring. By concentrating on the power inherent in their relationships with clients, midwives may have distanced themselves from other members of their profession and the opportunity to debate ongoing issues concerning the nature of midwifery practice. While some of these issues were extensively debated prior to the 1990 Nurses Amendment Act, midwives need to continue such discussions with the aim of defining midwifery practice in the new era of independence if we are to continue to claim to be "different."

Praxis

As outlined in Chapter Four (refer pp. 75-77), the concept of praxis provides an opportunity for turning critical thought into emancipatory action. Examples of praxis were found in interviews with all of the midwives and clients. It was particularly evident amongst the midwives where they reflected upon instances which had not gone according to plan but which on reflection they felt enriched their practice. Examples of this are found in Chapter Seven (refer pp. 148-149).

For individual clients the opportunity to engage in praxis occurred when they felt able to say that it was themselves who were "in charge" of their birth and then turn these words into action. How each client did this differed but all felt that when in labour they could call their midwives at times which were appropriate to each of them, though for the most part this had been agreed by discussion and negotiation.

While the strengths of the individual midwife/client partnerships were evident, once again these appeared to suppress the notion of a collective praxis. The adoption of the concept of partnership while facilitative of

individual midwives may be counter-productive for the future of midwifery as a whole if further political gains are to be made.

For a feminist praxis to occur in which midwifery develops further the advances leading up to the 1990 Nurses Amendment Act, midwives and their clients will have to engage in collective rather than individual partnerships. Midwives and their clients could, for example, reconstitute some of the action groups that were in evidence in the mid to late 1980s in order that this may happen.

However, it is not simply due to unwillingness of the individual participants that collective action did not always take place. Some of the study's limitations have occurred for other reasons which are discussed at the end of this chapter. Firstly the implications of the study for midwifery practice and education are discussed.

Implications for midwifery practice

As discussed above this study has uncovered some of the underlying structures within midwifery practice in relation to the key concepts of subjectivity, power and praxis. It is, however, the interpretation of these findings in relation to the arena of clinical midwifery practice which will determine the success of this study. This section considers the relevance of the findings for midwifery practice in New Zealand today and as it is envisaged in the future.

As described in Chapter Two (refer pp. 22-27), midwives are seeking innovative ways of practising which will provide the best possible service to their clients. In this study some of the ways in which the power of the medical profession was reflected in institutional, taken-for-granted practices have been identified. This power has worked

negatively to constrain rather than facilitate the development of midwifery as an independent, yet complementary profession.

Within the clinical area contradictions were clearly evident, between the midwives' personal and professional knowledge and the parameters which had been set for their practice. As has been discussed above, midwifery generally remains an oral culture in which midwives "come to know" through experience and intuition. The extent to which this is done is dependent on the historical and socio-political context in which that knowledge is produced. Yet this study has also shown how midwives sometimes view their knowledge as isolated from these social structures, so masking alternative meanings, understandings and actions (refer Chapter Seven, pp. 155-164).

It is not surprising, however, that these midwives and clients were able only to partially surface the social construction of the constraints and frustrations they experienced. Despite the legislative changes established knowledge structures are firmly embedded and communicated in everyday practices. Yet, by reinforcing such beliefs, midwives continue to perpetuate their own position of subordination in relation to the medical profession with its androcentric knowledge base and detailed documentation.

It remains the written documentation which is seen by the power holders as "legitimate" and so by not documenting the areas of midwifery practice such as intimacy and intuition which are perhaps unique to midwifery, midwifery knowledge is somehow conceived of as less legitimate than medical knowledge. Yet by its very nature midwifery knowledge does not lend itself to documentation. Documentation of midwifery practice for the purposes of client record keeping and audits of practice are therefore carried out in stereotypical form, differing little from records of medical practitioners.

However, through the transcription of tapes on which midwives describe the essence of their practice for the purposes of this and other research, midwives are beginning to articulate some of the concepts which are intrinsic to their practice. As experienced practising midwives are encouraged to share their ways of knowing amongst themselves and with less experienced midwives a body of knowledge distinct to the discipline may be developed and passed on orally through a number of structures to other midwives. The valuing of oral culture by midwives and others could then challenge the legitimacy of the written discourse of the medical profession and actively support the further development of skills which are generally the domain of women and in particular, midwives.

To be successful in achieving support for the oral culture of midwifery, mechanisms would need to be in place which support its development. Support groups whose aim is to critique existing structures in a constructive manner need to be in place and their value recognised. Midwifery already has such structures in the form of the peer review groups which were mentioned in Chapter Seven (refer pp. 136-137). While these currently operate in a manner which is primarily for the purposes of surveillance, often the discussion generated therein could form the basis for transformative action of a more political, woman centred kind. Such action is essential if midwives are to be able to systematically generate knowledge from practice and use that knowledge in turn to inform their practice.

However, the power of the written word has been demonstrated throughout this thesis, and it is through adopting this medium that midwives may primarily be able to legitimate their practice. The documentation by midwives in this study was conforming to standards required by institutions and was not shared by clients (refer Chapter Eight p. 160). In the future, however, midwives together with their

clients may be able to document the process of pregnancies through the use of language which is women centred and thus different. This may begin to create a written body of midwifery knowledge.

Implications for midwifery education

While the focus of this thesis has been midwifery practice, practice cannot occur in a vacuum which is removed from education. Midwives in education and practice settings need to be supportive of each other, providing opportunities for midwives from both settings to share experiences with a view to developing critical reflection of these experiences. In this way, midwives and midwifery students in clinical areas will come to question some of the taken-for-granted practices and explanations with a view to reshaping and reformulating those which no longer are meaningful for clients.

Given such a supportive climate, midwives in educational institutions would be able to work closely with their colleagues in practice to create curricula which are both woman centred and valuing of midwifery's oral culture as well as assisting to create a written body of midwifery knowledge. In this way, effective and satisfying midwifery practice based upon a reinterpretation of power structures may result.

Limitations of this study

One of the original intentions of this research was that by engaging in a dialogic process participants would come to understand that the 1990 Nurses Amendment Act was a beginning rather than an end and that ongoing work was needed to ensure midwifery's continuing success. Through further dialogue the nature of this work could then be revealed and later transformed into praxis. That this expectation was

not fully realised is in part due to the processes specific to this study, as well as the limitations of the theoretical framework outlined above.

A major limitation of this study was the time period in which data collection was carried out. The ramifications of the 1990 Nurses Amendment Act were still being worked through and independent midwives were still considered fairly radical by some colleagues and clients alike. To expect more changes to occur at this time may have been unrealistic although as discussed above there needs to be continuing dialogue amongst midwives and clients as to the ongoing scope and direction of midwifery practice.

As discussed in Chapter Five, the reflexive nature both of this research and independent midwifery practice itself is not totally in accord with notions of clear limits and end points. The process of the participants' self reflection has the potential to continue beyond the time of data collection. This is clearly visible by the participants' continued interest in and reactions to draft copies of the thesis. Written material such as this thesis, therefore, can only hope to capture and preserve in time a small part of the ongoing changes in midwifery both nationally and internationally. However, in initiating this process of self reflection this research is totally enmeshed in the practice world of midwives.

The inclusion of participants at all stages in the research was in itself slightly problematic. Both midwives and clients stated that they enjoyed participating in this research, finding it thought provoking and in one instance "part of the ongoing work to continually review practice" (Julie, personal communication). They were especially pleased to be consulted at many points throughout the study and to have the opportunity of retaining transcripts and draft reports.

A final session was held with the midwives to present an initial overview of the findings and debate some of the key issues with the group. This proved to be exciting and stimulating for us all. The issue of continuity of care, proved to be the focal point of the discussion as we discussed the findings relating to one-to-one continuity of care (refer Chapter Nine pp. 191-192). However this discussion was not carried through when I received copies of the draft reports which were returned to me from participants. Once again, the written word may have been seen as too powerful a medium for the participants in this study to contribute to although the oral discussion had been taped and subsequently transcribed.

Such a group meeting was not possible with the clients in the study as they had requested confidentiality. Had such a meeting been possible with all the participants the final analysis may have been more participatory. Instead, I relied on written comments from each participant. Most tended to accept my interpretations of their situations rather than debating these as we had done in the interviews.

Acceptance of the power of the written word is thus again overtly evident. Here some of the concerns expressed by Oakley (1981) and Webb (1993) discussed in Chapter Five (refer p. 91) concerning power of the researcher may be justified as the final thesis is essentially attributable to me. This forms a direct contrast to the semi-structured interview approach to data collection where a more equitable balance of power between me and the participants is clearly evident, with participants discussing and debating issues which were important to them.

However the analysis of the data took account of each piece of evidence being interpreted in the context of the total situation of each participant. The negotiation of meaning from various data sources, and the

enhanced understandings of participants of their individual situations ensured that the validity of this study as outlined in Chapter Five (refer pp. 93-95) was not compromised. However, as generalisability is not one of the characteristics of this form of research, ultimately it is left to readers to reflect upon the findings and arrive at their own conclusions as to the applicability of the data (Sandelowski, 1993).

Implications for future research

As shown in Chapter Two, midwifery in New Zealand is enjoying a renaissance and this research serves as a beginning in analysing some of the key issues embedded in the practice of midwifery. In this way this study offers midwifery in New Zealand the beginnings of a research basis in its own discipline. By the adoption of a feminist-critical approach, in which the domination of the masculinist science of obstetrics over midwifery was clearly articulated, issues which are essential to midwifery practice were able to be surfaced by participants in this study.

Studies such as this, therefore, have the potential to illuminate both the strengths as well as the social, political and historical barriers which may constrain midwifery practice. However, it is acknowledged that this study like other pioneering works, is the first in its field in New Zealand and there is a need for other studies, using similar theoretical frameworks, to further document the essence of midwifery practice. It is through such studies that midwives ultimately may come to generate theories which in turn form a distinct basis for midwifery practice.

Some of the concepts identified as important by the participants in this study therefore require further research. The notion of intimacy, for example, which was touched upon as intrinsic to the midwife/client relationship needs to be further explored. Likewise, how midwives

come to know, what they know and how such knowledge is utilised could be the topics for future studies. Theoretical frameworks for midwifery practice were also identified as requiring further research.

Further dimensions could also be added by providing the opportunity for studying midwifery practice in other settings such as hospitals and doctor's practices. Results of such studies could contribute to the provision of a broader picture of midwifery practice in New Zealand. Opportunity should also be provided for midwives, from all areas of practice to engage in shared self-reflective research with the aim of uncovering constraints which are common to all and which could then be used to advance midwifery practice based on these shared understandings.

There is also a place for evaluation research in relation to pregnancy outcomes for women who opt for midwifery care, those who opt for medical care and those who opt for some combination of both. With fiscal restraints being exercised in the whole area of health, such studies, given valid results, could provide midwives with a database on which to argue for continued or enhanced funding.

Other aspects of pregnancy have been surfaced by this study as requiring further research. While these are not exclusive to midwives, they would be relevant to midwifery practice. For example, research into the area of pain during labour needs to be ongoing and with midwives now adopting a number of different approaches to this, midwifery input into such studies is required. Further research is required into the expectations of labour and the contrasts which were surfaced by women expecting their first child and those in subsequent pregnancies. Social support in the post-natal setting has also been identified as requiring further exploration.

Finally, midwives might also consider jointly their relationship with other health professionals through research. While this study partially reflected midwives' views of their relationship with the medical and nursing professions, it was undertaken from a midwifery perspective and focused on the relationship of midwives and clients. Ethnographic studies which involved a researcher working with the entire population of one geographic or clinical area may be of use in determining the shared experiences of clients and other health professionals in that area.

There is thus considerable potential for research in the area of midwifery utilising a variety of methodologies. That such research is carried out in New Zealand as well as elsewhere is vital both for maintaining the credibility of midwifery but also for ensuring its continuance based upon sound research.

Concluding statement

Through the use of feminist-critical research this study has analysed some of the concepts on which midwifery in New Zealand has based its practice. The analysis of these concepts has shown how midwives and clients develop ways of co-creating the experience of childbirth "within but around" the medical structures which are still all pervasive. The methodological strength of the study has enabled the strengths and weaknesses of the midwife/client partnership to be analysed through the concepts of intersubjectivity, power/knowledge and praxis. The insights gained have enhanced my respect for independent midwives and their clients who are seen to have chosen "alternatives." It is hoped that by my bringing together the participants to discuss some of the present day constraints, this thesis will empower midwives to continue their quest for recognition in New Zealand and elsewhere.

APPENDIX ONE

Definition of a midwife

A person who, having been regularly admitted to a midwifery educational programme duly recognised in the jurisdiction in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

The sphere of practice: she must be able to give the necessary supervision, care and advice to women during pregnancy, labour and postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.

She has an important task in counselling and education - not only for patients, but also within the family and community. The work should involve ante-natal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care.

She may practise in hospitals, clinics, health units, domiciliary conditions or any other service (World Health Organisation, 1966).

APPENDIX TWO

Letter from a participant

Dear Val

...I have read and enjoyed your draft. Am quite happy with how you have used, interpreted my comments and the context you have used them.

Many thanks for sending me a copy. I would be very interested in seeing a final copy & seeing your final results & feelings on this area...

I have found my time here to be one of my most rewarding and challenging times I have put in! Am looking forward to the future also. Appreciated being part of your study. It is good to be constantly assessing, reflecting your practice/relationship with women, other midwives and yourself & the interviews & discussions we had highlighted this - so thank you very much.

All the best to you as you complete this & venture into other challenges & ways of practising too. It is so important to have women, midwives doing this research & information building especially relating to NZ

Thanks & all the best

APPENDIX THREE

Information for Prospective Participants

Client information

My name is Valerie Fleming and I am undertaking a Ph.D. degree at Massey University, Palmerston North. My particular area of interest is midwifery practice and my research is focused in this field. Specifically in my research I intend to look at how independent midwives and their clients work together to create distinctive experiences of pregnancy and birthing.

I am seeking your help in this project by asking you to agree to an initial meeting with a view to your participating in the study. In this meeting I would give you in depth information about the nature of the study and its possible implications. I anticipate at this stage that your involvement would be for approximately one hour per month over a nine month period.

In this time I would conduct interviews with you together with your midwife (midwives) and once in a group setting with other women who were at approximately the same stage of pregnancy as yourself. These interviews will be audio-taped, with the tape being started or stopped at your discretion. Each interview would begin with a renegotiation of your consent to participate. Participation or non-participation in this project will not affect your midwifery care in any way.

Should you have any questions at this point please do not hesitate to contact me at: 18, Oxford Street, Palmerston North or call (06) 358 1258 (collect). I look forward to meeting you again in the near future.

Midwife information

My name is Valerie Fleming and I am undertaking a Ph.D. degree at Massey University, Palmerston North. My particular area of interest is midwifery practice and my research is focused in this field. Specifically in my research I intend to look at how independent midwives and their clients work together to create distinctive experiences of pregnancy and birthing.

I am seeking your help in this project by asking you to agree to an initial meeting with a view to your participating in the study. In this meeting I would give you in depth information about the nature of the study and its possible implications. I anticipate at this stage that your involvement would be for approximately one to two hours per month over a nine month period.

In this time I would conduct interviews with you together with your individual clients. Occasionally interviews would take place in group settings with the other midwives and women who were at approximately the same stage of pregnancy. These interviews will be audio-taped, with the tape being started or stopped at your discretion. Each interview would begin with a renegotiation of your consent to participate.

Should you have any questions at this point please do not hesitate to contact me at: 18, Oxford Street, Palmerston North or call (06) 358 1258 (collect). I look forward to meeting you again in the near future.

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