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**INDEPENDENT MIDWIFERY
PRACTICE:
A CRITICAL SOCIAL APPROACH**

A thesis presented in partial fulfilment of the
requirements for the degree of Master of Philosophy in
Nursing at Massey University

Colleen A. De Vore

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ABSTRACT

This study commenced three years after the passing of the Nurses Amendment Act 1990 which gave midwives legal authority to practise without medical supervision.

It explored the social and political contexts of the work-lives of four independent midwives in New Zealand. A critical social approach was used to examine how midwives manage and negotiate their practice in an environment in which a dominant medical discourse prevail. In-depth individual case studies were used for data collection and reporting.

The research process provided an opportunity for participants to examine their taken-for-granted work environments and consider those personal actions and hegemonic structures which exist to constrain their practice. The participants surfaced those actions which could be described as counter-hegemonic and resistant to the dominant medical discourse. The study also illuminated those cognitive and physical actions which demonstrated compliance with medicalised childbirth and thus maintained the status quo. Midwives in this study used strategies of responsible subversion, the generation of midwifery language and the presentation of an alternative midwifery model of childbirth to contest medicalised childbirth. Within a context of assumed authority by doctors over the midwives the dominance of medical discourse prevailed. The participants were aware of the vulnerability of midwifery knowledge when it was made visible. It ran the risk of being dismissed as unscientific by medicine, or being incorporated into the dominant medical discourse on a superficial level. Conversely, midwifery knowledge that was not made visible was likely to remain marginalised and unrecognised.

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PREFACE

Background to the Study

Since the passing of the 1990 Nurses Amendment Act, New Zealand midwives have been able, on their own responsibility, to support childbearing families throughout their pregnancy, assist women giving birth at home or in hospital and maintain the postpartum care of those families for up to six weeks. The Act allows midwives the same rights, privileges and remuneration as doctors when conducting normal births. The work environment of midwives, as they experience and negotiate their practices is of interest to many health professionals as the economic and health reforms impact on New Zealand society. As a predominantly female profession attempting to carve a niche previously monopolised by the male dominated medical profession, the experience of midwives provides a unique opportunity to explore the socio-political context of such an endeavour.

The aims of the study are:

- To explore with independent midwives the socio-political context of their practice.
- To analyse the social construction of that practice in order to make it explicit and therefore open to critique and reconstruction.
- To consider actions which might be taken to maintain and further advance midwifery autonomy.

The Research Topic

The research has used case studies within the conceptual framework of critical social theory to explore the political and socially generated constraints on the personal and professional actions of independent midwives. In-depth interviews were used to explore the ways in which independent midwives perceived, negotiated and understood their practice lives. Social critical theory formed the analytical framework for the researcher and participants to explore and describe the social and political underpinnings of each midwife's practice in a way that is "*socially critical*" (Perry, 1986, p.13) rather than personally or "*self critical*".

The researcher anticipated that the study would explicate the social constraints and realities of independent practice so that the beginnings of an emancipatory, counter-hegemonic process could take place. However, much of the politico-historical thinking which lays the foundation to such an exercise had already been discussed, researched and reflected upon by many midwives.

Previous to the study, as women and midwives reviewed the social, historical, and political construction of childbirth, two models of care emerged; a medical model and a midwifery model. Historically and currently there is a tension between those two models. That tension is embedded in historically situated economic, professional and philosophical foundations of maternity care both in New Zealand and world-wide. It is within this tension that independent midwives practice in New Zealand.

The midwifery model, in presenting an alternative philosophy of childbirth, challenges the taken-for-granted authority of medicine to judge what is to be counted as optimal maternity care. Having established legal and economic recognition and autonomy, midwives are engaged in actions which resist the control of their profession by medicine. They experience considerable stress and difficulty in these resistant activities, often finding that embodied and embedded habits emerge which contradict their acclaimed ways of caring for childbearing families.

Structure of the Thesis

This thesis is presented in ten chapters.

Chapters One to Four provide the context and methodological issues relevant to the study. **Chapter One** introduces the social, political and historical contexts of the study. It gives a brief overview of how midwives, with women, came to recognise and contest the medical dominance of maternity care. **Chapter Two** explores the relevant literature both from New Zealand and internationally. It focuses in particular on the medicalisation of childbirth. **Chapter Three** presents the concepts and methodological issues relevant to research using a critical social approach. **Chapter Four** outlines the research process of this study.

Chapters Five to Eight present the individual case studies of four midwives as they reflect on and explore the constraints and realities of their work-lives as independent practitioners.

Chapter Nine integrates the four case studies and provides a critical social analysis of independent midwifery practice as perceived by the four participants.

Chapter Ten completes the study. It gives an overview of the study, and discusses its limitations and implications.

GLOSSARY

Cardiotocograph: (toco or C.T.G.). A form of electronic monitoring which measures the fetal heart rate and uterine contractions. These are usually recorded in graph form onto paper to give a visual display.

Ecbolics: Drugs used to stimulate uterine contractions. In some countries it is routine to administer these drugs after the birth of the baby to prevent post partum haemorrhage.

General Practitioner: (GP). A medical practitioner or doctor who has a general private medical practice within the community. Some who have obstetric qualifications also deliver infants under the same sort of arrangements as midwives i.e. they have contracts with the Crown Health Enterprise. Others, who do not attend births, may supervise the antenatal care along with a consultant who delivers the women in a hospital. General practitioners, whether they conduct deliveries or not, are usually the first health professionals a woman sees in order to confirm her pregnancy. These doctors then may refer these women for care during their pregnancy and birth to another GP who practises obstetrics, a consultant obstetrician or a midwife. It is in this power of referral that lies their power to control midwives. The term GP is used throughout the text for this is the common abbreviation used in oral language.

Risk list: The term risk is used to refer to the likelihood that a deviation from normal might occur during a pregnancy, delivery or postpartum. Risk is theoretically calculated according to the mathematical probability of a problematic situation occurring (Rothman, 1993). It is based on a woman's obstetric history and clinical assessment. The risk list is issued by various groups and committees who see themselves responsible for monitoring maternal and infant outcomes. Such guidelines are useful to practitioners in their decisions whether or not to refer women for specialist care. There is some critique of the list when it is used routinely, as routine use may result in a tool to reduce consumers choice of health practitioners.

Table of Contents

ABSTRACT.....	ii
ACKNOWLEDGEMENTS.....	iii
PREFACE.....	iv
Background to the Study.....	iv
The Research Topic.....	iv
Structure of the Thesis.....	v
GLOSSARY.....	vii
CHAPTER ONE: HISTORICAL OVERVIEW.....	1
Introduction.....	1
Midwives and Doctors.....	1
Midwives and Nurses.....	4
Midwifery Education.....	5
Midwives and Women in Childbirth.....	7
Midwives and Midwifery Practice.....	9
Models of Care: Medical or Midwifery?.....	10
Summary.....	12
CHAPTER TWO: LITERATURE REVIEW.....	14
Introduction.....	14
Major Themes.....	14
Medicalisation of Childbirth.....	14
Safe Maternity.....	16
Risks of Technology.....	17
Midwifery practice: Instituting an alternative model.....	19
Continuity of Care.....	21
Summary.....	26
CHAPTER THREE: METHODOLOGY.....	27
Introduction.....	27
Case Studies and Critical Social Science.....	27
Critical Social Approach.....	28
Enlightenment, Empowerment and Emancipation.....	30
Power.....	32
Power/knowledge.....	32
Knowledge of Worth.....	34
Language.....	34
Hegemony and False Consciousness.....	35
Embodied and Embedded Action.....	37
Resistance.....	37
Passive Resistance.....	38
Vocabularies of complaint.....	38
Resistance and Visibility.....	39
Incorporation by the Dominant Group.....	40
A Critical Social Approach to Research.....	41
CHAPTER FOUR: METHODS.....	43
Choosing the Participants.....	43
Initial Approach.....	44
Relationship Between Interviewer and Participants.....	44

Data Collection: Interviews.....	45
Interview Process	46
Participant Observation.....	46
Ethical Considerations	47
Confidentiality	50
Prevention of Risk	50
Reliability and Validity.....	50
Data Analysis.....	52
Summary	52
THE CASE STUDIES	53
INTRODUCTION AND OVERVIEW	54
Profile of Participants.....	54
Work-Life Organisation	54
Provider Options.....	55
Location Options	55
New Zealand Health System	56
Key to Referencing of Chapters Five to Nine	57
CHAPTER FIVE: CHRIS	58
Being a Midwife	58
Knowledge of Worth	59
Empowerment or Power?	61
Power and Control.....	66
Working Within a Midwifery Model: Nurture/Knowledge.....	68
Resistance.....	69
Resistance by Creating Alternatives.....	69
Raising Consciousness	70
The Dilemma Of Visible Midwifery Knowledge.....	72
Redefining the norm.....	74
Contestation	75
Because We Are Women	76
Summary	77
CHAPTER SIX: SUE.....	79
Being a midwife.....	79
Making Midwifery Visible.....	85
Professional Power and Obstetricians.....	86
Sharing Knowledge.....	90
Summary	91
CHAPTER SEVEN: MARY	92
Being a midwife.....	92
Burnout	94
Bridging the Gaps.....	95
Economic Interests	99
Power Relationships	102
The Safety Issue	104
Invisibility of Midwifery Practice.....	105
Medical Power and Control	107
Women and Doctors: An Issue of Power	110
Summary	111
Post Script.....	112

CHAPTER EIGHT: NINA.....	113
Being a Midwife.....	113
Working With Others.....	114
Power and Control.....	117
Medicalised Birth as the Norm.....	120
Legitimising Midwifery Practice.....	121
Exploring the Reasons Why.....	122
Summary.....	124
CHAPTER NINE: DATA INTEGRATION AND CRITIQUE.....	125
Introduction.....	125
Knowledge of Worth.....	125
Childbirth: Only Normal in Retrospect.....	130
Working in a Stressful Environment.....	132
Forms of Resistance: Working In Another Way.....	135
Negotiating Relationships.....	137
Strength in Unity.....	139
Visibility: Should We Tell?.....	141
Working in Partnership With Women.....	143
Gaining Recognition.....	144
Summary.....	145
CHAPTER TEN: CONCLUSIONS AND RECOMMENDATIONS.....	148
Introduction.....	148
Major findings.....	149
Embodied and Embedded Action.....	149
Medical dominance.....	149
Dilemma of Choice for Women.....	149
Resistance.....	150
Implications for Health Practitioners.....	151
Limitations of Study.....	152
Future Research.....	153
Concluding Statement.....	153
APPENDIX A.....	154
Example of Initial Contact Phone Call.....	154
Example of Information Given at Initial Interview.....	154
APPENDIX B.....	156
Independent Midwives: a Critical Social Approach to Their Practice.....	156
Consent to Participate in Research.....	156
APPENDIX C.....	157
Information Sheet for Prospective Participants (Clients) of Research Titled: Independent Midwives: a Critical Social Approach.....	157
APPENDIX D.....	159
Independent Midwives: A Critical Social Approach to Their Practice.....	159
Consent of Families Involved in the Research.....	159
REFERENCES.....	160

CHAPTER ONE

HISTORICAL OVERVIEW

Introduction

The history of childbirth in New Zealand presents a complex matrix of economic, social and political events which highlight the tensions among those health attendants who claim childbearing families as their practice domain. This chapter briefly outlines the historical context for this study. It explores the historical relationships between midwives and doctors, midwives and nurses, midwives and women, and discusses two models of childbirth which have emerged to influence New Zealand maternity services and professional practices therein.

The social, historical and political contexts of women's reproductive health have been documented both in New Zealand (Donley, 1986; Hill, 1982; McSherry, 1986; Mein-Smith, 1986; Moloney, 1992) and elsewhere (Arney, 1982; Dingwall, Rafferty & Webster, 1988; Donnison, 1988; Ehrenreich & English, 1979; Kitinger, 1984, 1988; Litoff, 1978, 1986, 1990; Melosh, 1982; Oakley, 1980, 1984; Rothman, 1991; Towler & Bramall, 1986). To some, childbirth is a normal natural process for which women's bodies are well suited. Those that view childbirth as a family process, deeply entwined with meanings of what it is to be female, place emphasis on the psychological and spiritual experiences for childbearing women. Others however, approach childbirth as a potentially pathological process and claim that birth is only normal in retrospect. From each of these perspectives, childbirth has been scrutinised, criticised and revolutionised. An exploration of the historical relationships between midwives and doctors and midwives and nurses, adds insight to the present day practice climate of independent midwives in New Zealand.

Midwives and Doctors

Joan Donley who is often referred to as the matriarch of New Zealand midwifery and the homebirth movement (McLoughlin, 1993), has been very influential in changes in New Zealand midwifery practices. According to Donley (1986) doctors have had as their interests the control of childbirth and therefore the control of midwifery. Concerned that both their power and their incomes would suffer, doctors resisted the

passing of the 1904 Midwives Act which had as its aim, "to provide for the Better Training [sic] of Midwives and to regulate the Practice of Midwifery" (The Midwives Act, 1904, p.1). The first St Helen's Hospital opened in 1905. Doctors opposed the setting up of these St Helen's Hospitals which were to have been established throughout the country for the exclusive training of midwives. Donley (1986) states that doctors were concerned about their access to "clinical material" (p.37) which they required as part of their obstetric training.

Dr Doris Gordon, a prominent New Zealand doctor specialising in obstetrics in the early 1900s, suggested in her autobiography, that the obstetric training of doctors was indeed inadequate:

We students [doctors] hunted in pairs, one delivered the baby and the other washed it but both counted the one as 'a delivery' (Gordon, 1955, p.63), (single quotations in original).

At first the admission of trainee doctors into the midwifery training schools was strongly resisted by the Health Department but by 1919 doctors were admitted to St Helen's in Dunedin so that they might have more cases with which to gain delivery experience (Hill, 1982). By 1931 it was decided by the Health Department that only four of the seven St Helen's Hospitals were to remain designated as midwifery training schools: Auckland, Wellington, Christchurch and Invercargill (Hill, 1982). They were soon opened to the patients of general practitioners and obstetricians, with student midwives now working under medical supervision. This encroachment of medical personnel into the midwifery education and practice domain meant that a *medical model* (refer page 9) of childbirth prevailed. The hegemonic structures of education and health institutions ensured that medicine, with its hierarchical relations of power/knowledge remained the dominant discourse (refer Chapter Three). Midwives were socialised into a role of subservience to medicine in terms of both knowledge and practice. This had the effect of making midwifery knowledge invisible and convinced midwives that by adapting to medicalised childbirth (refer Chapter Two) they were working in the interests of midwifery and women (Donley, 1986).

Doctors were concerned that their incomes would suffer because patients would choose St Helen's hospitals. To quell these concerns doctors were reassured that St Helen's maternity facilities would only to be available to the deserving poor; that is, those wives of working men who could not afford the doctor's fee. Thus doctors were relieved of the burden of non-paying patients but could attend their more lucrative private clients. However, doctors maintained their medical domination of these midwifery schools by playing a key role in midwifery education as lecturers and

examiners (Hill, 1982). It is not surprising therefore, that as early as 1918 concern was expressed by Miss Maclean, Assistant Inspector and Deputy Registrar of Nurses and Midwives. In her report to Parliament on the effects of the 1904 Midwives Act, she noted that midwives were deferring to doctors and not caring for childbearing women as their independent cases, as was intended. She stated:

...they have not acted as midwives, merely as maternity nurses working under doctors. One reason for this is reluctance on the part of many to take the responsibility of acting without a doctor, and fear that by so doing they would alienate the medical profession, which so far has strongly discouraged women from working independently (Appendices to the Journals of House of Representatives, New Zealand, Vol. II, 1918).

Anxious to maintain their influence and power over obstetrics, and thus New Zealand childbearing women and their midwife attendants, doctors formed the Obstetrical Society in 1927 (Gordon, 1955). This Society soon lobbied for what they claimed was better care for childbearing women: hospitalised childbirth, and increased use of medication and technology. Underlying this move was the belief of doctors that pregnancy and labour was not a normal process. Dr Doris Gordon is quoted as saying that labour was, "abnormal and pathological and the pregnancy from start to finish is a process fraught with danger" (Mein Smith, 1986, p.82). This attitude prevailed and consequently, by 1938, hospital birth under medical supervision became the norm (Hill, 1982). Midwives now consider that as a result of such attitudes, childbirth has been taken from the control of women, and their bodies have become objectified as a vessel from which the infant is extracted in circumstances which resemble a crisis situation (Donley, 1986).

Belgrave (1991) suggests that once doctors had control of birth through the technology of scientific medicine, midwives in New Zealand had no option but to emulate the medical profession as doctors became the accepted gatekeepers to entry into the health profession. The debate about increasing use of technology in obstetric practice and whether it is entirely beneficial for childbearing women is addressed in Chapter Two. The historical works of Arney (1982), Donnison (1988), Ehrenreich and English (1979), Litoff (1978, 1986, 1990), Towler and Bramall (1986) all add credence to the idea that internationally midwives have had their role as independent practitioners diminished due to the medicalisation of childbirth and its portrayal as a potentially unsafe process needing close medical supervision. Dingwall et al. (1988) suggest that in England, as a result of technology and hospitalised childbirth, British midwives have turned into "an extension of the doctor rather than an alternative practitioner" (p.171). While American studies (Litoff, 1978, 1986, 1990) demonstrate

similar patterns of medical control to that experienced by New Zealand and English midwives, Lutoff (1990) argues that midwives are more than "victims of an elite misogynist medical establishment" (p.443). She suggests that factors of midwifery invisibility, poor pay and the quest for safe maternity also contributed to the decline of midwifery autonomy. The safety issue is further addressed in Chapter Two and the problem of invisibility considered throughout the case study discussions.

In New Zealand, as the majority of women moved to hospital births, it was taken-for-granted that doctors would be the *natural* practitioners to deliver babies. By 1971, the Nurses Act was changed so that it became an offence for midwives to practise without a medical practitioner taking overall responsibility for the case. Now midwives were firmly controlled by medical authority and it was not until the Nurses Amendment Act 1990 that midwives could again practise autonomously.

The 1990 Act was not introduced without protest from doctors. In a sense, the issues are similar to those at the beginning of this century when midwifery registration was introduced. Issues of education, power and control, autonomy, safety and economics continue to be debated (McLoughlin, 1993; Strid, 1994; Guilliland, 1989). The historical attitude that doctors should supervise and control midwifery practice persists in the face of the current legal position that gives midwives the right to practise independently. It is the effects of this taken-for-granted medical dominance of childbirth that will be the focus of this thesis.

Midwives and Nurses

Dingwall et al. (1988) gives a useful outline of the historical relationship between the nursing and midwifery professions with their complex mixture of goals, motives, and sectional interests as they impacted on midwifery licensing and maternity services in England. Historically, midwives have not seen themselves as a branch of nursing. From as early as 1888, the Midwives' Institute, representing English midwives, refused to join forces with the British Nurses Association. They insisted that they were "independent practitioners" whereas nurses were "medical auxiliaries" (Dingwall et al., 1988, p.156).

In New Zealand, midwives became a *special interest section* of the Nurses Association in 1969 and thus midwifery was seen at this time as a branch of nursing politically, educationally and professionally. However, midwives claimed that nurses, particularly those affiliated to the New Zealand Registered Nurses Association (hereafter

NZRNA), allowed legislation in the form of the Nurses Act 1971, to be passed. This ensured that doctors supervised all deliveries, thus robbing the midwife of her ability to practise her particular skill autonomously. According to Donley (1986), the change did not appear to present difficulties for the majority of practising midwives as most were employed in hospitals and accepted medical dominance. It was not until the 1980s, when groups of homebirth midwives and their consumer supporters protested at the decreased choice for women, that midwives became conscious of their own professional subordination. The perceived lack of support from the NZRNA highlighted the fundamental differences in the interests of nurses and midwives. Midwives responded by forming their own representative group in 1988; the New Zealand College of Midwives (NZCOM hereafter).

The political and professional separation of nursing and midwifery in New Zealand is significant to this study as it contributed to the process whereby midwives have clearly defined their practice philosophy as separate from both nursing and medicine. In analysing the fact that nurses were closely aligned philosophically and professionally with the medical profession, midwives considered it in their interests to distance themselves from nurses and therefore the *medical model* of childbirth. The NZCOM is now seen by midwives as their legitimate professional, representative body, though the legal authority for registration still lies with the Nursing Council of New Zealand. Midwives also wanted to ensure their separation from what they saw as medically based nursing education. They envisaged a change to a more humanistic, health focused educational framework which would better reflect midwifery philosophy. A brief account of this is given below.

Midwifery Education

Educationally there is a clear historical link between midwifery and nursing. The 1925 Nurses and Midwives Registration Act legislated that application for education for midwifery certification became a choice of either entry as a Registered General Nurse, or following the completion of a maternity nurse certification followed by midwifery. Thus, at that time, there were several categories of training:

- Class 1: Registered nurse qualifying as maternity nurse
 - Class 2: Unregistered women qualifying as maternity nurse
 - Class 3: Registered nurse qualifying as a midwife
 - Class 4: Maternity nurse qualifying as midwife
- (Quoted from minutes Nurses and Midwives Registration Board 14th October 1927, Hill 1982, p.77)

It was possible for a woman wishing to train as a midwife to complete her Class 2 maternity training and then her Class 4 midwifery training without ever being a registered general nurse. Thus there was *direct entry* into the midwifery programme via maternity nursing for those women who did not wish to become general nurses. This separate maternity training was gradually phased out and finally abolished in 1973 (Hill, 1982) thus closing any direct access to midwifery via the maternity nurse route. Midwives now had to become registered as general nurses before pursuing a midwifery career. From 1956 the maternity programme for Registered General Nurses, though not midwifery, was incorporated into the general nursing programme and renamed obstetrics. Registered General Nurses were now RGONs (Registered General and Obstetric Nurses) and were able to complete midwifery certification by six months training at a St Helen's school of Midwifery. From 1979 this course was replaced by a one year post-basic maternal and child health course (Hill, 1982). The most significant component of this step was that it was no longer a total midwifery course but an Advanced Diploma of *Nursing* course with a midwifery option. All students, once again, had access into midwifery programmes only after registering as a comprehensive or general nurse.

This blending of midwifery and nursing education has caused some dispute between nurses and midwives as the latter considered such training to be insufficient to train autonomous practitioners (Hill, 1982). Midwives felt that nurses who had undergone training which incorporated medical, surgical and psychiatric illness were inculcated with medically oriented methods and theories and that this focus served to perpetuate the medicalised view of childbirth. Midwives claimed that until childbirth was seen from an underlying assumption of wellness and as a normal life event, those working in the area would fail to see increased routine technological interventions as deleterious to women's birth experiences. Hegemonic educational structures are therefore seen to reinforce medical power and control of childbirth.

A strong lobby group was established to highlight the need for direct entry midwifery courses; that is educational courses which did not require a nursing qualification as a prerequisite. The College of Midwives, The Homebirth Association, the Direct Entry Taskforce, Maternity Action, and Save the Midwife groups all contributed to this aim (Stodart, 1990). In a task force discussion on direct entry midwifery courses, recognition is given to concepts common to nursing and midwifery. These are: caring, respect for race and culture, and an emphasis on primary health care and wellness. However, the task force concludes: "Ultimately it is essential that midwifery is recognised and acknowledged as a profession in its own right." (Strid, 1990, p.9).

Midwives base this claim to difference by reference to the World Health Organisation definition of midwifery:

A midwife is a person who is qualified to practise midwifery. She is trained to give necessary care and advice to women during pregnancy, labour and the postnatal period and to conduct normal deliveries on her own responsibility and to care for the newly born infant.

At all times she must be able to recognise the warning signs of abnormal or potentially abnormal conditions which necessitate referral to a doctor and to carry out emergency measures in the absence of a doctor. (World Health Organisation, Quoted in Strid, 1990, p.10).

The crucial portion of this definition is the phrase "a midwife is a *person*". Advocates of direct entry education for midwives claimed that this indicates that nursing should not be a prerequisite to midwifery practice. Strong lobbying resulted in the Nurses Amendment Act 1990 incorporating a law change which allowed for two direct entry midwifery pilot programmes in Auckland and Otago.

While midwives claimed it was seen as a positive move to reduce the influence of nursing and establish midwifery as a distinct profession, the dispute as to whether midwifery is a specialised form of nursing or is a specific profession in its own right remains an area of debate among many health professionals (Stodart, 1990). Midwives, by making nursing knowledge problematic, were able to define their own educational needs as those which would endorse a *midwifery model* (refer page 9) of autonomous practice rather than the traditional one which they believed, confirmed medical dominance. This transformative action which resulted in the setting up of an alternative educational programme to those which socialised its members into the dominant *medical model*, can be called counter-hegemonic (refer Chapter Three). Its purpose was to prevent the inculcation and assimilation of the dominant medical discourse and replace it with one which followed the philosophy of the *midwifery model*. Moloney (1992) indicates that this has been an effective strategy. The midwife participants in her study, who were encouraged to critically reflect upon the social, political and historical context of midwifery practice in their education, were able to continue to do so after their graduation.

Midwives and Women in Childbirth

Midwives claim that birth is an experience that belongs to women and that the midwives' role is to facilitate and support that experience. The term *with women* is used to indicate a process of partnership and participation with childbearing women

and their families. This woman-centred approach is the basis of the midwives' claim to a particular practice called midwifery (Flint, 1986, 1993). Similar to midwives, women have been influenced by the claims that progressive scientific medicine is in the best interests of childbearing women.

In the 1920s women were exhorted to increase the population for the fledgling colony. Parkes (1991) noted that those women who protested the presence of unmarried male medical students at deliveries were soon silenced by the accusation that they lacked patriotism, because they were unwilling to act as medical material which would benefit other women. In the late 1930s it was women who claimed the right to have chloroform and then twilight sleep to relieve them of the pain of childbirth (Mein Smith, 1986). Twilight sleep produced analgesia and amnesia as a result of an injection of morphine and scopolomine. Mein Smith (1986) suggests that one of the unintended consequences of the wide use of these drugs was the opportunity it gave doctors to claim that they were essential attendants for childbirth and that delivery was best carried out in hospitals under their supervision.

However, it was also the nation's women who later sought to humanise childbirth practices and assisted in reclaiming midwifery practice from the dominant medical paradigm. The formation of the Homebirth Association in 1978, and the Save the Midwife groups in 1983 focused the activities of women as they sought to reclaim childbirth as a women-centred experience. The La Leche league pointed out that requiring infants to be placed in a near sterile environment from birth, in order to be protected even from their own mothers, was incongruent with the aim of establishing successful breast feeding. Established routines, such as four hourly feeding and the banning of women from having their infants by their bedsides, were seen as measures which inhibited breastfeeding. Other hospital practices were also criticised, such as the four hourly panning and swabbing of post partum women and their prolonged confinement to bed. Donley (1986) points out that, though these actions were originally instigated by the medical hierarchy in the name of safe maternity, it was the nursing and midwifery staff who were most criticised. It would appear that midwives, working in the medically dominated obstetric hospital system soon became entrenched in the disease focused model of medicine (refer medicalisation p. 14). Reflection and critique of institutionalised practices paved the way for midwives to establish the validity of their knowledge and experiences which were contrary to established hospital practices.

The active participation of women in their own births has been a major focus of midwifery practice. It has been this conscious partnership with women that enabled midwives to lobby so effectively for change and resulted in the return of their autonomy in the form of the 1990 Nurses Amendment Act (Guilliland & Pairman, 1994). This form of "situated pedagogy" is described by Freire and Shor (1987, p.104) who claim that an educational process which situates the taken-for-granted knowledge and beliefs in their socio-political and historical contexts enables people to participate in a process of reflection which enlightens the dominating forces which constrain their lives.

Midwives and Midwifery Practice

While midwifery practice may refer to that practice carried out by professionals educated and registered as midwives, it may also be used to define a particular philosophical underpinning. In the latter instance midwifery practice can be carried out by any person; lay, medical, nursing, or midwife who works with childbearing women and their families within a certain framework. For the purpose of this research the term *midwifery model* is used to refer to the practice of those midwives who assert that pregnancy is a natural life event, and therefore maintain that most women are able to give birth to healthy infants with minimal medical intervention if they are given sufficient knowledge, support and encouragement. In this model the birthing woman is in control and midwifery practice is woman focused. The *midwifery model* used in this way can therefore refer to practices of midwives, nurses, doctors or any attendant of childbirth who maintains this philosophical belief and conducts their practice accordingly.

The second model is that of the *medical model* or "technocratic paradigm" (Bassett-Smith, 1988, p.12). This model of practice has an underlying belief that childbirth is only normal in retrospect and therefore needs to be monitored, manipulated and controlled by using as many medical technologies they deem necessary to safely deliver a live infant. In this model the attendant is in control and the pregnancy or labour, rather than the woman, is the focus of practice. It is therefore less holistic in its approach. Some midwives endorse this *medical model* of practice.

The *midwifery model* does not condemn the use of technology and recognises it is required for "particular complications" (McSherry, 1986, p.7). The differences in the underlying philosophical beliefs of the two models gives a different practice focus to each, though both see the safety of the mother and infant as important.

Models of Care: Medical or Midwifery?

The focus on the midwife as the provider of maternity care is intertwined with the idea that there is a distinction between medical and midwifery approaches to childbirth. For Kirkham (1983, p.81) medicalised births are "managed" or "conducted" by the attendant while Short (1992, p.135) suggests the difference is between the "lived body experience" of the midwifery model and the "object body" perspective of the *medical model*. Rothman (1991, p.262) shows how the *medical model* has "doing something" as its cornerstone. This differs from the practices of midwives who develop techniques for avoiding interference. Rothman gives the example of how the midwives in her study redefined the onset of the second stage of labour to commence when the woman begins to push effectively. This means that if the woman rests for periods of time after full cervical dilatation this is not considered abnormal. Those practising within the *medical model* would consider such a rest period at this time as abnormal. Such practitioners would feel they were obliged to *do something* and consider that medical intervention would be required. This highlights the differences in the approach of the two models. Whereas midwifery would require the practitioner to watch, wait and observe the process of each individual birth and develop knowledge from practice, medical intervention and action is based on prescriptive routinised practice governed by so called objective data. Thus periods of rest as described above may be considered statistically abnormal and the need for interventions considered.

Macintyre (1977) summarises the *medical model* as follows:

Pregnancy and childbirth are regarded as states and processes akin to illness, relatively divorced from a social and psychological context. It is seen as appropriate for women to cede control over the process to medical experts, to adopt a relatively passive role of acquiescence in medical instruction and to remain relatively ignorant of the basis of professional decisions. Childbirth is regarded as highly hazardous, with medical assistance and intervention being uniformly necessary. The physical experiences of childbirth are perceived negatively and therefore to be alleviated or removed from consciousness whenever possible. (p.482)

Such an attitude to childbirth results in control of the delivery by the attendant rather than the woman, whereas in the *midwifery model* the woman gives birth and she is supported in this role by her attendants. The *midwifery model* is described by McSherry (1986):

Pregnancy and childbirth are regarded as natural processes embedded in a social and psychological context, undergone by healthy women largely under their own control, and as positive and fulfilling experiences. Medical assistance is seen as minimally necessary as an insurance against complications, and medical intervention as only necessary in the event of particular complications. Unless such complications occur, the woman is not regarded as being in the sick or patient role, and her relationship with the medical profession is a relatively egalitarian one of active participation in, and full knowledge of, the process of childbearing... The midwifery model draws on a form of childbirth management that was practised by the traditional midwife. Its main characteristics, then as now, were non-intervention and emotional support (p.6-7).

Kitzinger (1988) describes the difference between the two models thus: "She (the midwife) is literally 'mid' or 'with' her in an empathetic relationship while the obstetrician 'stands in front of the woman" (p.1) (emphasis in the original). This does not mean however that the *midwifery model* ignores the possibility of deviations from normal. Midwifery care includes both "careful observation and sensitive awareness" (p.18).

Some authors (Flint, 1993; Houd, 1993; Knox, 1993; Page, 1993), focus on the importance of choice and continuity of carer for women and consider that such care should be based on the midwife's ability to maintain the woman's self esteem and dignity throughout this exciting life event. A study on aspects of women's knowledge by Belenky, Clinchy, Goldberger and Tarule (1986) supports this view of birth as crucial to the developmental process of women. The authors quote one of their participants who had had a homebirth against the advice of her doctor as saying:

I learned a lot about having faith in myself...I always thought doctors were like Gods and knew the answers to everything, but now I am glad I know it for myself. I can figure things out for myself and I don't need them. I ended up learning it was me that knew it all and they didn't (p.84).

The *midwifery model* with its underlying philosophy of maintaining childbirth as a natural life experience results in the nurturance, empowerment and reaffirmation of women and their families. The re-emergence of an alternative model of practice challenges the assumptions of taken-for-granted dominant medical discourse. It serves not only to give choice for women but also as an alternative ideological base from which midwives can critique the *medical model* and expose the power relations which exist within it.

Because the underlying assumptions and values of each model differ there is a tension between those attendants who practise obstetrics and those who practise midwifery. That tension is embedded in historically situated economic, professional and philosophical foundations of childbirth practices both in New Zealand and world-wide. It is within this tension that independent midwives practise in New Zealand. This thesis addresses the effects that tension has on midwives as they seek to establish an alternative practice paradigm.

Summary

Midwives have not been passive recipients of the historical and socio-political events which have seen their opportunities to practise in different ways change, both in New Zealand and internationally. By reflecting on the socio-political and historical contexts of the role of midwifery, midwives have developed a critical consciousness of their profession's subordination which has resulted in reduced options for childbearing women. They have been able to distance themselves from their cultural traditions, in order that they might critically reflect upon them. In partnership with women, they have participated in their own empowerment, to bring about change and new directions in midwifery practices and childbirth options in New Zealand. These actions may be summarised as follows:

- The formation of the consumer based lobby groups to change the patterns of care to those that best meet the needs of the childbearing families.
- The recognition of nurses and midwives as different professions by the formation of the College of Midwives.
- The lobby for and piloting of two direct entry midwifery courses.
- The changing of the Nurses Act to allow midwives to take legal responsibility for their practice actions without medical supervision.
- The dissemination of the view that childbirth is primarily a normal natural process and not a pathological, medical one.
- The articulation of a distinctive *midwifery model* of childbirth care, which is different to that of the *medical model*.

According to critical social scientists, the purpose of such acts of empowerment is to change the social conditions of the participants so that they are free to act in a less oppressed manner. The goal is emancipation, and the purpose of this research, was to examine the emancipatory effect of the above actions for midwives and explore further possibilities for transformative action.

This chapter outlined the social, historical and political contexts from which two major models of maternity care emerged; that of the *medical model* and the *midwifery model*. However the boundaries are not as clear as they first appear since doctors can practise midwifery just as midwives can practise obstetrics. The question of whether or not midwives choose to practise within the *midwifery model* as outlined, is not a simple one. How midwives practise is tied historically, politically and economically to interpretations of what birthing outcomes are perceived to be the most desirable, and by whom. The following chapter addresses the research and dialogue which supports or refutes each model. It also explores how the socio-historical context described above impacts on the lives of independent midwives and the women with whom they work.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The previous chapter outlined the social, historical and political contexts from which two models of maternity care emerged; that of the medical model and the midwifery model. This chapter addresses the research and dialogue which supports or refutes each model.

Major Themes

Two of the major themes relevant to this research, which dominate the literature regarding childbirth throughout the western world, are the experience of childbirth and the question of who best provides professional care during that experience. The dissatisfaction with childbirth experiences has been researched and/or investigated by midwives and others from many different viewpoints. In New Zealand, Donley (1986) and McSherry (1986) have joined their counterparts overseas (Flint, 1988; Kitzinger, 1984; Oakley, 1989; Odent, 1984; Savage, 1987), to protest against what they call the medicalisation of childbirth. According to Bassett-Smith (1988), Donley (1986), Hedwig (1990) and Moloney (1992), this debate is firmly linked to ideas of what is normal and what is safe. The concept of the medicalisation of childbirth is the point from which many authors start.

Medicalisation of Childbirth

Those investigating the issue of birth attendants frequently begin with an historical analysis which links the demise of the midwife with greater medical involvement in childbirth. Donley (1986) traces the history of maternity services in New Zealand in order to outline the socio-political structures which explain how midwives have lost their position as "guardians of normal childbirth" (p.11). She claims:

Maternity care in New Zealand does not serve the real needs of mothers and their babies as they define them. Over the years the medical profession...have 'civilised' and upgraded childbirth from its primitive beginnings to make it a speciality worthy of their control. Their

technological skills and equipment have converted childbirth from a private personal experience to a controlled clinical one. This medical achievement has not necessarily been in the interests of mothers and babies. Nor has it been beneficial to midwives who are the traditional supporters and guardians of normal childbirth. The midwife has been upgraded and refurbished to become a nurse-midwife hybrid, a medically oriented handmaiden, while the real midwife is an endangered species (p.11).

Her book entitled Save the midwife, clearly identifies her political focus. This book, along with conference addresses, (Donley, 1988, 1990) has been instrumental in raising the consciousness of midwives and engaging them in ideology critique (refer Chapter Three). She suggested that the re-emergence of midwives with their non-interventionist philosophy of childbirth would benefit women by returning their control over birth choices. Her purpose was to recapture, for midwives, what she saw as their rightful role as autonomous practitioners, separate from nurses and very different from medically based doctors. In a powerful conference address in August 1988, Donley warned midwives they either had to take strong political action or face extinction. From this conference, a working party emerged to form the College of Midwives. It included representatives from the Homebirth Association, Maternity Action Alliance and Save the Midwives (Guilliland, 1989). In her book Donley traced the events which culminated in the social construction of childbirth as a medical crisis rather than a natural life event. While her book may be criticised for lack of academic rigour, the more academic work of the historian Mein Smith (1986) supports many of her claims.

Mein Smith (1986) takes a revisionist approach to historical data, questioning the assumption that progressive medicine and hospitalisation was the main factor in reducing maternal mortality rates in the interwar years. She attempts to disentangle the web of self interest of general practitioners, obstetricians, midwives, Health Department officials, New Zealand women and politicians in the purported goal of safe maternity. The debates and policy making took place within the social context of that time: State funding of maternity care, the need to increase the population of a growing colony, and a belief in eugenics by many of the policy makers (Fleming, 1981).

The earlier debates focused on the issue of safe maternity. When a tension arose with the emergence of the midwifery and medical models of care (refer Chapter One) the issue of safety re-emerged.

Safe Maternity

Griffith (1992) suggests that there is a tension between the two childbirth philosophies; one seeks the "perfect experience" and the other the "perfect outcome". The "perfect experience" is described as a birth which "articulates around collaborative decision making, no unnecessary interventions including no analgesia, as well as being a fulfilling and joyous experience" (Griffith, 1992, p.61). By contrast "perfect outcome" is a physically healthy mother and baby. She asserts that neither are attainable 100% of the time and cautions that technology used to achieve the "perfect outcome" may also contribute to complications.

Donley (1986) claims that the trend to ensure all births took place in hospitals, particularly large ones, was not done in the interest of safety but for the purpose of creating a specialisation of childbirth under medical control. As small maternity hospitals were closed down on the grounds that they were unsafe due to the absence of specialists and technological apparatus, the obstetric specialists were able to concentrate their power in large institutions and squeeze out those General Practitioners who were willing to practise in smaller units or support homebirths. Rosenblatt, Reinkin, and Shoemack's (1985) statistical study supports the claim that smaller hospitals did not present any increased risk of poor birth outcomes. The report showed that a system existed whereby women were being effectively screened to enable those at risk to be transferred to larger regional hospitals as required. The study concludes:

Our reports do not support this assumption (of lack of safety). The statistics indicate that low risk mothers fare better in low technology environments. It is possible that small hospitals in New Zealand achieve better outcomes partly because the level of medical intervention and the setting in which the births occurs are more appropriate to the medical and non-medical requirements of the mothers who go there (p.431).

The proposal that obstetrical emergencies are so unpredictable that *all* pregnancies and deliveries should be conducted as though there might be a medical crisis was not upheld by the above study. Arney (1982, p.54) claims that it was by emphasising the "pathological potential" of birth that doctors were able to maintain public faith in medicalised birth. The New Zealand Medical Association's submission to the Nurses' Amendment Bill demonstrated this stance of birth as pathological. They stated that while they appreciated the growing emphasis on the normality of birth they cautioned that "even in low risk obstetrics, major risks may arise" (New Zealand Medical Association, 1990, p.1). As a result of this stance, women have been socialised into believing that it is their responsibility to ensure they take all possible steps to protect

their unborn from the ever present danger that something might go wrong. Many believe that the only way to achieve this is to obtain institutionalised medical care with its accompanying routine use of technology.

The New Zealand National Council of Women demonstrated that this attitude is prevalent in New Zealand in their submission on the 1990 Nurses' Amendment Bill which included a statement from some of their members:

We do not support a change to the restrictions currently on the practice of midwifery. Our particular concern is at the actual birth where sudden emergencies can arise. We feel the present arrangements provide for the needs of the mother facing unexpected complications (National Council of Women of New Zealand, 1990, p.2).

The submission also supported doctors as gatekeepers of maternity care and suggested that all women first be assessed by a doctor and referred to a midwife at his/her discretion. Midwifery care would then be delegated by the doctor. Such a statement assumes that medical decisions will be made in the best interests of women without the influence of economic and professional interests.

Risks of Technology

Those researchers and others who express concern about medicalised childbirth, point out that technology has been shown to increase the possibility of less than ideal outcomes in terms of costs and what is now commonly termed as a cascade of further interventions (Banta & Thacker, 1979; Beech & Robinson, 1992; Brinsden & Clark, 1978; Haverkamp, Orleans, Langendoerfer, McFee, Murphy, & Thompson, 1979; Stirling, 1990). For example, Banta and Thacker (1979) report a greater than expected number of caesarean sections when electronic fetal monitoring is used. They indicated that such surgery, with its accompanying risks, was more likely to contribute to morbidity and mortality rates. Stirling (1990) reports an induced birth at 26 weeks gestation when two ultrasound scans failed to detect a viable baby. In spite of the mother's insistence that she could feel the baby moving, the technological report was given credence over that of the mother's experiences, and an intrauterine death diagnosed. The infant lived after the induction as a result of further technology but such cases of iatrogenesis are often poorly documented and researched.

In the *New England Journal of Medicine*, acknowledged by doctors as a clinically prestigious publication, a report of a controlled study of the effects of routine ultrasound screening demonstrated that it was costly, ineffective and did not improve birth outcomes (Ewigman, Crane, Frigoletto, LeFevre, Bain & McNellis, 1993). The

editorial (Berkowitz, 1993) cautioned further about the as yet undocumented subtle effects of such technology on the fetus suggesting that to continue routine use of ultrasound during pregnancy could not be scientifically supported. There has been very little in the way of medical response acknowledging the risks of technology or the contribution that alternative, less interventionist midwifery care can make to birth outcomes. This point is confirmed by Donnison (1988, p.202) who gives the example of a three year research project in which midwives reduced the perinatal mortality rate from 23.9 to 10.3%, yet it "was discontinued at the insistence of the Californian Medical Association". Litoff (1990) points out that in spite of a high technological approach to childbirth, the American statistics show that birth outcomes throughout the United States of America are lagging behind those of their European counterparts. She attributes some of the better maternal and perinatal outcomes of Holland to the high midwifery input. Further studies that support the claim that midwives contribute to positive maternal outcomes are those by Kitzinger (1988) and Jordan (1993). Kitzinger's study positively correlates the poor perinatal statistics of Italy with a low provision of care by midwives. Jordan suggests that comparative statistics of Holland, America, Sweden and Yucatan indicates that midwives contribute to positive birth outcomes. Griffith's (1988) Australian research concluded that midwives using alternative midwifery practices to alleviate pain and monitor progress reduced medical interventions without compromising the safety of women and their infants.

The effects of medicalised childbirth cannot simply be measured in terms of statistical outcomes of mortality and morbidity. Young (1984) argues that technological monitoring apparatus is not merely a neutral system which simply provides data to monitor the progress of pregnancy and birth. She maintains that technology disempowers women by devaluing their experiences and knowledge. The example quoted above from Griffith (1988) appears to confirm her findings. Young suggests that childbirth education has decreased medical power by demystifying what was once private medical knowledge. Now that obstetric knowledge is increasingly available in the public domain, women are empowered to critique and examine it and make choices on its utilisation. However, while women might have more knowledge of birth technologies, it does not follow that they will opt for a less interventionist pregnancy and birth due to the hegemonic structures (refer Chapter Three) which support medicalised childbirth.

While recognising that the movement towards natural childbirth has some merit, those who follow the medical model still argue that maternity safety can only be achieved in a technologically abundant hospitalised situation and that the issue of safety should be

the main deciding factor when considering birth options (Bonham, cited in Ray, 1980). Parry (1980), a tutor specialist in obstetrics and gynaecology at Otago University, gave an argument typical of the late seventies. He clearly focused on safety as the reason for being cautious about homebirths stating that they were "an added risk to pregnancy" (p.11). His suggestions regarding more humanised hospital services were cosmetic and consisted of changing the paint colour of the labour wards and supplying a television room and a cupboard full of toys. On the interpersonal relationship side he suggested that one must resist referring to "that caesar in the end bed" (p.11). According to Treichler (1990) the above comments are typical of those practitioners who wish to maintain power and superficially adapt their practices while preserving their ideological standpoint. This resistance to change by incorporating it into the dominant discourse is further explored in Chapter Three. Fundamental attitudes have changed little. They would not encompass the idea of working with women to give them choice and control, nor acknowledge the significance to women of the social, psychological and spiritual experiences of childbirth. Because of the resistance to change, midwives who attempt to practise in a different way may have difficulty in finding an environment which supports and validates their alternative practices.

Midwifery practice: Instituting an alternative model

As discussed above, some practitioners advocate that humanised hospital births within technology rich environments would result in ideal birth situations. However, just as the midwives in 1935 were seen to be practising "merely as maternity nurses" (refer p.3), current New Zealand studies indicate that the place of work affects the ability of midwives to practise in ways that endorse the midwifery model. Hedwig's (1990) interview/survey, which focused on the satisfaction and dissatisfaction of midwives with their practice, found that many hospital-based midwives described their work as satisfying and rewarding. However, a specific question about the less desirable aspects of their work revealed that "lack of recognition of skills", "birth too medicalised" and "not being an independent practitioner with autonomy and therefore being able to make one's own decisions" were negative factors (Hedwig, 1990, p.90). In-depth analysis of the socio-political basis of these factors was not explored thus limiting the relevance of Hedwig's study to this research. That study was conducted before the introduction of the Nurses' Amendment Act 1990. A replication of that study may now reveal changes resulting from the Act.

It is claimed by Bassett-Smith (1988), Donley (1986), and Moloney (1992) that the competition for recognition between the medical model and midwifery model causes tension for those following the practice principles of the latter because the hospital system endorses and maintains the legitimacy of the medical model. Moloney (1992) used critical analysis of case studies to identify the constraints to the practice of five midwives who worked in a hospital setting. She concluded that it was the socio-political context that prevented these practitioners using the midwifery model as the basis for their practice. They felt that their practice was undervalued and their knowledge assumed to be inferior to medical knowledge. The midwives in her study also found that there was a conflict of interests when they tried to balance the demands of the hospital hierarchy with the needs of the women in their care.

Prior to Moloney's (1992) study, Bassett-Smith (1988) found that midwives had to balance the needs of birthing women with the requirements of the institution. She concluded that, "considerable tension exists between knowledge and skill base that a midwife has and the way in which she practises in the hospital" (p.144). She also indicated that the hospital context may not be conducive to practising in the way they wished: "The constraints that are part of the setting negatively affect the care offered to birthing women" (p. 144). The inhibiting effects of the hospital system on the relationships formed between midwives and childbearing women are shown by Kitzinger (1988). She demonstrated that midwives who were locked into the task oriented hospital system restricted their time with patients and gave them limited information. Kirkham (1983) established that the communication styles maintained by midwives in the labour wards at one British hospital were designed to discourage questions and choice. She suggested that this was a direct result of the hierarchical environment which existed in the hospital, and consequently restricted the patient to the role of a passive observer rather than an active participant in her birth.

An Australian study by Street (1992) confirmed that nurses are affected in a similar way to midwives. This thesis draws heavily upon her theoretical base which used a critical ethnographic approach. Furthermore, it highlights how nursing knowledge and practice remains subordinate to medicine for similar reasons that midwifery knowledge had become marginalised in the past. The institutional hospital setting reinforced medical power to the detriment of nursing and constrained nurses to work in ways that subverted their expertise.

There appears to be an assumption that independent midwives who work in a less institutionalised context may be able to practise more freely, unfettered by the institutionalised hospital practices. Moloney (1992) goes further in suggesting that:

through regaining an independent status there is an opportunity for midwives to gain insight into how the health care system might be reorganised beyond medical domination and how social change may be brought about in institutional hierarchies that are dominated by technical forms of knowledge (p.8).

Such a statement fails to take into account the embeddedness of the dominant medical discourse which does not merely exist within a particular institution but permeates most social structures (refer Chapter Three). Moloney's optimism is not confirmed by English research where midwives have always been legally able to practise independently of doctor supervision for normal births. Studies by Flint (1986), Robinson & Wilson-Barnett (1989) and Walker (1976) consistently demonstrate that English midwifery skills are undervalued, under-utilised and unrecognised. Beech & Robinson (1992) claim that British midwives often intervene during deliveries by rupturing membranes or performing episiotomies even though they may not consider them necessary and are able to make such judgement in their own right. The authors claim that they do so "because they worked in institutions where obstetricians had the power" (p.395). The issue of power being embedded in routinised ways of acting is further explored in Chapter Three.

It is evident that institutionalised care constrains autonomous midwifery practice. This present study sought to surface those factors which inhibit midwives as they attempt to work within a different paradigm. Its purpose was to uncover the ways in which midwives perpetuate and/or resist those constraints and contradictions. Furthermore it sought to explore and generate transformative actions in order that those constraints might be reduced.

Continuity of Care

Childbearing women report that one of the major factors which contributes to an unsatisfactory childbearing experience is the number of caregivers involved (Flint 1993). Moloney (1992, p.131) found that her hospital midwife participants were able to clearly articulate that "intermittent care-delivery within the hospital system" was not in the women's or midwives' interests. It resulted in conflicting advice for women, prevented the establishment of a therapeutic relationship between the birthing woman

and her midwife and prevented midwifery practice from becoming visible to women. Moloney (1992) stated that two different proposals for schemes which would incorporate the philosophy of continuity of midwifery care were "rejected without dialogue" (p.134). She claimed that this demonstrated the inability of midwife managers "to move beyond the narrow function of socialising midwives to conform with the status quo" (p.131). Bassett-Smith's (1988) study supported the notion of the importance of an ongoing therapeutic relationship between a midwife and childbearing women. She argued that continuity of care is necessary to maintain a process of authentication. Authenticating was described as a mutual process whereby the birthing woman and the midwife engage in a relationship which results in the woman being able to "understand her experience of childbirth and ascribe positive meaning to it, and in this way, incorporate it into the self as a woman, sexual being and parent" (p.124). Bassett-Smith suggests that a successful authenticating process during birth can result in a more positive outcome for women so that they can more easily move into their mothering role. Successful authentication can be deferred and disrupted by changes in their midwife attendants since the flow of the interpersonal relationship is interrupted, and energy is diverted from labour work to the re-establishment of the relationship with each new attendant.

Institutional care is guided by routines, protocols and guidelines. These prescriptions for practice are directed by the philosophies of the medical model which focuses on potential risks. For those practitioners who focus on obstetric rather than midwifery care, an ideal childbirth is one in which the physical safety of the mother and baby is maintained. This medicalised view is difficult to change if positive outcomes are predominantly measured in terms of successful interventions. This is because *doing to* rather than *being with* women is the focus of the medical model. This results in a belief that rational and objective medical knowledge will give prescriptions for the correct solutions. In contrast midwifery knowledge, grounded in practical experience, enables midwives to understand and appreciate individual differences within a framework of suspended judgement. Moloney (1992) describes the resultant differences in the approaches to knowledge:

Whereas it appears that medical practice is shaped by the fundamental belief that an objective, systematic understanding of their work will lead naturally to the 'correct' solutions, midwives here assume that certain phenomena may have many potential meanings and the particular interpretation of meanings will depend upon the context in which the phenomena are perceived (p.104).

Moloney (1992) argues that prescriptive medical childbirth practices that define *safe* interventions result in a routinised and mechanistic care regardless of the specific

woman's situation and needs. She gives an example of how doctors place rigid boundaries on the *time* they will allow for natural physiological placental separation. With little regard for the existence of clinical signs which indicate the need for intervention with drugs, *time* dictates medical action. Moloney (1992) argues that:

this illustrates how safety as a dogma may be instrumentally used whereby the active participation of women in their birthing experiences is denied and empirical observations of women overridden (p.86).

Medicine's assumed authority to dictate what counts as knowledge of worth, what is safe and who should control childbirth is further explored in Chapter Three.

Treichler (1990) (refer page 19) indicates that medical definitions of childbirth as pathological are not easily relinquished. It is more likely that medicine will adopt the terminology of new ideologies to reinforce their existing discourse. Sandelowski (1988) uses the example of ultrasonography to illustrate this point. Doctors were quick to point out the positive aspects of ultrasonography which they claimed facilitated maternal/fetal attachment. She suggests that the negative aspects of this technology are ignored. Women's reporting of data is seen as subjective and therefore less reliable unless confirmed by so called objective information. This attitude towards women's presentation of data is illustrated in an article in a nursing journal which cautions that patients may "forge" their kick chart recordings in order to procure an induction of labour (Ellis, 1986, p.8). Oakley (1986) further argues that technologically produced data reduces the amount of interaction between women and their caregivers. Sandelowski (1988) cautions that those who adopted medical methods of collecting data reduced intimate and tactile contact with women.

The Royal New Zealand College of Obstetricians and Gynaecologists (1990) submission to the Nurses' Amendment Bill appears to indicate that while midwives may be able to meet the needs of women, doctors are the guardians of the unborn child; "There is also a need to bear in mind the vulnerability and needs of the unborn child who may need protection" (p.1). They do not make clear from whom the unborn child needs protection but Muller (1990) expresses concern about the increased tendency for doctors to claim the fetus should be protected from their own mothers. This idea that the fetus is a separate entity from the mother has arisen from the increased use of ultrasonic screening. In the United States of America this has resulted in mothers being ordered by the courts to acquiesce to compulsory interventions and technological investigations.

With increased research into the importance of birthing experiences to women (Jakobsen, 1991; Oakley, 1988; McSherry, 1986) more attention is being given to the value of women-centred care. Oakley's (1988) research produces convincing evidence that social support in pregnancy not only increases a woman's self concept but results in improved pregnancy outcomes. Giving birth cannot be described simply in physiological terms. Women are deeply connected to the birthing process both socially and psychologically.

The idea of connected knowing by women is the focus of the work of Belenky, Clinchy, Goldberger & Tarule (1986). This research concluded that women become knowledgeable through their own experiences. Caregivers will therefore best enhance women's self knowledge by relating new knowledge to the experiences of those women. The role of the educator or caregiver is to work in partnership with the woman to make sense and meaning of her own experiences. Midwives are described as "connected knowers" by Moloney (1992) who states that:

Authority of a connected knower rests on the commonality of experience and involves receptive rationality. This gives the knower an ability to take on the perspective of 'the other' (p.104).

There is a danger that any technological means of data collection is more likely to alienate women from their birthing experiences because technological data is given more credence than personal experiences.

The surfacing of a midwifery model, as described in Chapter One, has implications for midwifery practice in terms of utilisation of skills, practice priorities and interpersonal relationships with childbearing women. One of the practice priorities made explicit by the New Zealand College of Midwives' (1993) standards for midwifery practice is the commitment to work in partnership with women. Guilliland and Pairman (1994) emphasise that this requires a focus on women and their needs so that women are empowered through information, choices and enhanced confidence to regain control over their childbirth experiences. Flint (1993) suggests that this results in a form of mutual empowerment whereby the midwife and woman empower each other:

Many midwives involved in continuity of carer appreciate the support they have from the women they are becoming involved with. A close friendship is formed between the mother and the midwife and this enables the midwife to be braver and enables the mother to be more powerful (p.3).

Strid (1994), a strong advocate for women's choice and campaigner for direct entry midwifery, presented a paper at the 1994 National Midwives' Conference challenging

New Zealand midwives to maintain this women-centred focus. She expressed concern that the changing economic and political climate and the search for professional recognition interfered with collaborative women-centred practice. She was concerned that midwives did not always fully understand that a partnership should include women in policy making, practice options and choice of practitioner. She recognised that choice for women was often negated by the medical profession's gatekeeping role expressed in the form of *risk lists* (see glossary), and the refusal of doctors to work with independent midwives. Furthermore, she acknowledged that women, socialised into believing that the birth was a hazardous process requiring medical attendants, were ambivalent about trusting their bodies to birth without routine interventions and medical attendants.

Arney (1982) claims that the demand for changes in childbirth practices did not arise from a need for safer births but from women insisting that their needs and experiences be acknowledged and authenticated. With so much positive evidence to support the idea that the midwifery model of care is congruent with women's preferences the question remains why so many women still insist on medical care for births. Oakley (1993) analyses the power of medicine to dominate obstetrics from a feminist perspective. She suggests that patriarchal power over women is mirrored in the power relations of obstetricians with childbearing women. Barclay (1986) also uses feminist theory to conclude in her Australian research that midwifery remains invisible due to their gendered roles. Just as women's work often remains invisible so too does the work of midwives. This ensures medical dominance of childbirth even though it is the midwives who are experts in normal births. She warns that unless midwives make their expertise visible they will continue to be used as doctor's handmaidens. She suggests that midwives need their own language to do this because:

The knowledge which becomes public and is legitimated in a male dominated society is the knowledge of men: it is based on their own experience and reflects their own perspectives. (p.26).

The issue of power, language and visibility are further explored in Chapter Three.

Most proponents of the midwifery model suggest that midwives move philosophically, educationally and even physically away from medicalised care in order to reinstate the traditional midwifery practice of working to support women with normal births. However, research by three American doctors (Baldwin, Hutchinson, & Rosenblatt, 1992) suggests the opposite. They found that the professional relationships between licensed, homebirth midwives, and doctors were reported to be unsatisfactory. This was not the case with certified nurse midwives who practised within mainstream

institutional settings. The researchers therefore concluded that the solution to the problem was for the licensed midwives to have more opportunities to practise and train within the hospital. These authors failed to question whether the tensions in the relationships were due to the fact that the licensed midwives practised outside the mainstream of medicine. Philosophical differences may have been the disrupting factor in preventing collaboration. Working within the hospital system may in fact have highlighted and increased the level of tension between the two groups. The difficulties of establishing an alternative model of practice while working side by side with a powerful medical profession that consider their particular model of care superior is further examined in the Chapter Three.

Summary

The literature addresses the dual issues of safety and experience. It has been assumed that in order to obtain one the other must be forfeited to some degree. Those who argue for hospital births where technology is readily available suggest that humanising the hospital environment is the best compromise. The claim that technology rich environments show a positive correlation to better outcomes does not seem to be substantiated by the evidence. It would seem that technology may increase risks.

Proponents of alternative services, whether in smaller birth centres or home births, argue that safety should encompass psychological as well as physical aspects. Midwives claim to deliver care which is women-centred and gives continuity of care, and is as non-interventionist as possible. Evidence suggests that midwives offer care which decreases morbidity and mortality rates, while still ensuring high levels of positive experiences.

The next chapter focuses on the critical social approach used to interpret and analyse how the study participants interpreted and negotiated the socio-political context of the workplace.

CHAPTER THREE

METHODOLOGY

Introduction

This study explored the work-lives of four independent midwives who practised in a New Zealand urban/rural area. It focused on the social, political and economic constraints that impacted on the lives of these health professionals as they cared for childbearing families within the context of the New Zealand health care system. The case study method was used in conjunction with critical social theory which provided the theoretical base for analysis in a similar manner to that used by Perry (1985), Hickson (1988), and Moloney (1992).

Case Studies and Critical Social Science

Yin (1984, 1993) justifies the use of case studies in scientific research. Case studies may be explanatory, exploratory and/or descriptive. They are an ideal method when the researcher has "little control over events" and involve "complex social phenomena" (Yin, 1984, p.14). Yin quotes Schramm who states that case studies "try to illuminate a decision or set of decisions, why they were taken, how they were implemented and with what result" (p.23). Case studies were therefore an appropriate method to explore the work-lives of independent midwives because they enabled me as the researcher to conduct in-depth interviews to surface the underlying reasons for, and consequences of, decisions and events. This produced rich, descriptive data for analysis using a critical social approach.

Comstock (1982) states that:

A consistent critical method which treats society as a human construction and people as the active subjects of that construction would be based on a dialogue with its subjects rather than the observation or experimental manipulation of people (p.371).

Comparisons and critique of empirical analytical, interpretative and critical methodologies are documented by Allan, Benner and Diekelman (1986), Clare (1991) and Hickson (1988). Positivistic methods of data collection, which treat the participants as objects, would not be consistent with the empowering and emancipatory

goals of research using a critical social approach. However, the use of case studies using a critical framework does not prevent coercion and manipulation of the participants. Further reflection on this problem is discussed in the section on ethical considerations.

Critical Social Approach

The term critical social science, may be used interchangeably with critical social theory, and is associated with social movements such as feminism, Marxism and liberal pedagogy (Freire, 1972). Fay (1987) claims that critical social science is a composite of four theories: a theory of false consciousness that explains the causes of misunderstandings; a theory of crisis which examines the causes and nature of the crisis; a theory of transformative action which explains what needs to be altered and the action to be taken; and a theory of education. Giroux (1983) describes critical theory as a school of thought or philosophy, and a process of critique. Critical social science grew from a critique of positivists, for their scientism, or science's belief in itself, by the 'Frankfurt school' scholars Horkheimer, Adorno and later Habermas.

Habermas' (1971) work sought to situate knowledge in the context of human interests and disputed the contention that knowledge can be value-free. He identified knowledge constitutive interests integral to all human life that gave rise to three paradigms of science, each of which contributes to the development of knowledge. They are those of *technical interests* from which empirical analytical science (positivism) emerged; *practical interests* from which hermeneutical and/or historical knowledge emerged; and *emancipatory interests* from which evolved critical social science. An excellent example of these interests is given in the work of the liberal educationalist Paulo Freire (1988). In discussing the educational needs of rural workers of developing nations he asserts that technical knowledge is taught to those who are needed to do the work only insofar as it enables them to produce goods and services. Such knowledge has prediction and control as its purpose rather than that of human freedom and happiness. Knowledge that would enable workers to examine their own socio-political condition is not encouraged and thus their knowledge remains technical.

Moloney (1992) gives the example of traditional midwifery education with its focus on numbers of deliveries and rigid procedures as a form of technical knowledge. She states:

Education in midwifery and nursing is shaped by forms of technical control which arise from a dominant and frozen ideology of technical values which are reinforced in practice (p.118).

Likewise, medical knowledge and practice is essentially technical knowledge, based on an assumption of the ability to predict, manipulate and control disease and health deviations, with little reference to the human factors involved. It has been argued (refer Chapter Two) that this approach has resulted in the medicalisation of childbirth with a dominance of prescriptive practices unrelated to the experience and needs of childbearing women.

Hermeneutical or historical knowledge enables people to cope with change, or to work in better relationships with their fellow workers or employees. In Habermasian terms, this knowledge serves the needs of *practical interests* because it enables subjective understanding to occur. However, it is more likely to assist in acceptance of the status quo rather than encourage reflection upon the existing power relationships and question in whose interests those relationships exist (Fay, 1987). It thus fails to meet the criteria of emancipatory knowledge since it does not assist the participants to take transformative action and generate change that is in their own interests and which is the fundamental purpose of critical social science.

While a single definition of critical social science is not readily available, this research uses a critical social approach which maintains the underlying assumptions of critical social science. Stevens (1989) outlines six such assumptions :

1. All research and theory are political in that the social, economic and political processes of a society are reflected in the microcosm of scholarly investigation.
2. Oppressive structural relations pervade modern industrial society; they usually function automatically, are taken for granted, and remain unexamined.
3. Mythical, religious, scientific, practical and political interpretations of the world are open to systematic questioning and critique.
4. Social conditions are not interpreted as natural and constant but are rather viewed as created by specific historical situations.
5. Understanding of the changing conditions of human suffering can be gained through an historical study of the development of oppressive arrangements in society.
6. Liberation from oppressive structures is an indispensable condition of the quest for human potential, completion, and authenticity (p.59).

Stevens' first statement reinforces Habermas' contention that all science is knowledge constitutive as described above. This enables epistemological and ontological assumptions to be seen as problematic, as proposed in Stevens' third statement. All underlying values, beliefs and truth claims are open to scrutiny in a way that enables participants to examine their personal and public ideologies as socially constructed rather than fixed. Medical knowledge and the practice of medically based childbirth, derived from an empirico-analytical paradigm, is thereby open to scrutiny. This also enables the basis for medical authority and power claims to be challenged and questioned. Fay(1987) suggests that this be done by a process of *ideology critique*.

Ideology critique is not purely a negative activity for it not only seeks to point out the error in a people's self understandings and the way this error helps to maintain a social order which is thwarting to them; it also attempts to reveal the truth which these self understandings contain, by uncovering their hidden meanings and by making explicit the new self-conceptions they implicitly contain (p.100).

This educational process in which the researcher and the participants work reflexively to deconstruct everyday, taken-for-granted realities in ways that are congruent with their own experiences and needs, constitutes a process of *enlightenment*.

To some extent a process of ideology critique had already taken place in New Zealand, as shown in Chapters One and Two. Those authors who documented the historical development and effect of medicalised childbirth in New Zealand, exposed the social construction of medical practices for critique, as suggested by Stevens' (1989) fifth assertion above.

Enlightenment, Empowerment and Emancipation

The processes of enlightenment and empowerment exist as major components of the emancipatory goal inherent in a critical social approach. Enlightenment is an educative process that enables individuals, groups, and/or communities, to understand the personal, social and political structures which constrain their daily lives and with this knowledge make changes to their life patterns. Examples of this process may be found in the "women's liberation movement" where women, through a process of consciousness raising came to see patriarchal power structures inhibiting the interests and aspirations of women (Fay, 1986, p.111).

The use of the empirico-analytical findings of those authors who question the effectiveness and interests of medicalised childbirth (refer Chapter Two) are relevant to presenting a case of childbirth as a socially constructed phenomenon which serves the interests of medicine. By illuminating those processes and structures which maintained the dominant medical ideologies of childbirth, midwives and women were able to take actions necessary for change to take place. These economic, educational and political changes were outlined in Chapter One.

The empowering actions of midwives that have already taken place and are continuing as a result of this enlightenment were summarised on page 12. It is within the context of this action that the midwifery model emerged to represent an alternative ideology which further illuminated the historical contradictions of medically based maternity care. This alternative model demonstrated that the ideologically frozen understandings of medicalised childbirth were incongruent with the needs of childbearing women and the midwives who worked with them. An opportunity arose for conscious political action to alter the unequal power base of childbirth care.

Empowerment activities take place in close relationships with participants and enables them to take actions that change or challenge the social constructions which impinge upon their life choices and chances. Midwives claim to work *with* women in such a way that it empowers them to take control of their birthing experiences. This is in contrast to the medical model which emphasises the management and control of deliveries while birthing women remain passive recipients of health care. The social practices that existed to constrain midwives in this process of empowerment with women are the focus of this study.

While it has been argued that women and midwives have already undergone considerable education which constitutes the beginnings of a process of enlightenment, education itself is insufficient to bring about emancipation. Nielson (1992) warns that because of the unequal distribution of power the dominant group is likely to resist change and take measures to ensure it maintains the privileged power position. This may be done by an overt display of strength, or by a superficial incorporation of ideas for change while firmly maintaining their power base. Geuss (1981) summarises the difficulties in effecting change:

To abolish an established social institution which is deeply rooted in the interests of some social class will in general require more than a change in the form of consciousness of the oppressed: it will require a long course of political action. Until that course of action has been brought to a successful completion, the institution will continue to exist and to exert its baleful influence on even enlightened agents, restricting their freedom and frustrating their desires (p.75-76).

This study examines the influences which exert pressure on and frustrate midwives in their attempts to establish an alternative model of childbirth. It also considers action which might be taken to unshackle those constraints. Chapters One and Two outlined how the medical, obstetric model has emerged as the dominant practice focus. The assumption that doctors can officially designate what is to be defined as a healthy pregnancy illustrates the power of medicine. Childbirth encompasses much more than the simple aim of a physically safe mother and baby obtained by the work of an altruistic and competent medical profession. It involves the various values, beliefs and experiences of women, midwives and doctors, who all bring their own perspectives of what is important to childbirth. From a critical social science perspective the values of the dominant group are likely to prevail and therefore the issues of power must be considered.

Power

Power is defined by Bullock and Stallybrass (1977, p.490) as "the ability of its holder to exact compliance or obedience of other individuals to his will on whatsoever basis". However, power is not always as overt or dominant as this definition might suggest. Power becomes institutionalised within the social structures of the family, education, legislation, economy and religion so that it has the appearance of being the natural order of things. Thus the ability to maintain power, and therefore one's interests, is supported and defended even by those who are disadvantaged by it. This is the process of *hegemony* which is discussed later in this chapter (refer p. 35).

Power/knowledge

In Chapter One a particular ideological view of childbirth was shown to have emerged as doctors claimed that both science and technology legitimatised their authority to dominate childbirth practices. Turner (1987), cites Foucault (1977), in claiming that this is more accurately called power/knowledge and suggests that this creates a tension from which new knowledge might emerge. Street (1992) asserts that the concept of power/knowledge has a gender bias. Her critical ethnographic study of the work-lives

of Australian nurses surfaced the concept of nurturance/knowledge. She uses this alternative concept to describe the process whereby nurses use their knowledge to support and comfort patients without disempowering them. To be nurturant is to create a space or environment that facilitates the growth or meets the needs of another at a particular time. This concept is congruent with the practices of midwives as they seek to work *with* birthing families, rather than to *manage* their pregnancies and deliveries. Moloney (1992, p.91) demonstrated that while midwives have an opportunity to display "power over" the women with whom they worked as a result of authority derived from their knowledge, her research participants described what could more properly be called "power with". She suggested that "power with is interpreted as knowledge which is shared in a dialogical relationship" (p.91). This contrasted with "power over" in which an unequal relationship is maintained by withholding knowledge or presenting knowledge as authoritative and non-negotiable.

Turner (1987) suggests that one way which a group may maintain its power/knowledge is to claim a particular knowledge form that cannot be categorised or reduced to routine procedures but needs to be interpreted by the powerholders. For example, doctors claim they need to screen all childbearing women so that they can interpret their pregnancies as *normal* or requiring further medical surveillance (Royal New Zealand College of Obstetricians and Gynaecologists, 1990). Ironically, at the same time they suggest that because of the "pathological potential" of childbirth this can never be absolute and will always be open to interpretation (Arney, 1982, p.54). Thus they can claim that their specific medical expertise, as opposed to midwifery knowledge, must always be available. Paradoxically, they suggest that risks can be categorised in the form of *risk lists* which are then used to dictate to midwives which women may come under midwifery only care. Risk lists supposedly predict those women whose pregnancies demonstrate a higher than normal propensity for poor outcomes and therefore require medical supervision. Niehoff and Schneider (1993, p.123) caution that the risk-factor approach to disease prediction is problematic. Not only are such predictions "laden with values and interests" but risks and opportunities are not on opposite ends of a continuum and may exist at the same time. Furthermore many risks are often contingent upon social conditions which cannot be solved by medical interventions alone. Midwives resist the routine application of risk and claim that each woman must be assessed, and the interpretation of risk be made having regard to the particular living conditions and life patterns of the individual.

Knowledge of Worth

Power/knowledge not only legitimates a particular way of thinking and acting but also claims the authority to decide by what criteria those acts or thoughts might be judged. Thus maternity care is not simply the neutral scientific activity medicine purports it to be but it is a socio-political one, embodying the varying interests and purposes of those involved in it. Because the authority of medicine is based on an assumption of scientific, objective neutrality, all other competing knowledge claims are dismissed as unscientific unless they meet the criteria of such analytical rationalism. Medicine presumes the authority to judge alternative knowledge, such as midwifery knowledge and the subjective experiences of women as less than scientific. This further enhances the power of medicine to dominate and control alternative practices and even label them as unsafe. Street (1991, p.262) refers to this "acceptance of medical knowledge as normative knowledge" as being reflected in the way in which most judgements regarding health care are made using biomedical criteria. This, according to Street, includes the setting of standards and the provision of research and project funds.

Language

Turner (1987), drawing on the work of Foucault, discusses how language and power are intertwined:

We know or see what our language permits, because we can never naively apprehend or know 'reality' outside of language... Scientific knowledge of the world is a form of narrative (a story) and like all narratives science depends on various conventions of language (p.11-12). (Single quotations and parenthesis in original).

According to etymologist Spender (1985) vernacular language is a form of patriarchal domination and assists powerful groups to ensure their definitions and descriptions of situations and actions remain the accepted masculine genre. Treichler (1990, p.124) calls the ability of medicine to define child birth as a "monopoly of... linguistic capital". She states that the profession's ability to define childbirth as a medical event gives professional authority and material resources. She describes how the medical profession in the United States used language to discredit an alternative birthing centre: "child abuse", "a disgrace to modern obstetrics".

The subordinate group not only has to learn the official language of the dominant group but the words they use to describe their experiences may be dismissed as non-scientific. An example of the medical description of normal birth is given by Oakley (1993). She suggests that the medical definition of normal includes the use of episiotomy and artificial rupture of membranes whereas the birthing women in her

study considered that such a birth was anything but normal. The emergence of language which better describes the subordinate group's experiences and understandings can be a form of resistance. Thus a well articulated midwifery model which describes its practice, values and skills in a language congruent with the experiences of childbearing women becomes a political tool for enlightenment and empowerment.

Power is manifested in the medical profession's domination through its language and its ability to decide what is to be counted as acceptable scientific knowledge. It is further legitimated by social acceptance of their power/knowledge. This social acceptance and support of taken-for-granted authority of a dominant group by the subordinate one is called hegemony.

Hegemony and False Consciousness

Stevens' (1989) second statement (refer page 29) on the critical social approach outlines the assumption that unequal power relationships which pervade society are embedded in our taken-for-granted everyday world. So embedded are these oppressive relationships that they are not readily identified by individuals or groups therein. They not only fail to recognise that certain actions are not in their own interests, but perpetuate that oppression by their own actions. Thus a form of false consciousness (Fay, 1987) and hegemony persists constraining the free will and full potential of the subordinate groups. The problem of humans acting in ways that demonstrate they are unaware of and indeed perpetuate their own oppression has been addressed in Fay's self estrangement theory, Freud's concept of the unconscious in psychoanalytic theory and Marx's theory of false consciousness (Fay, 1987). Gramsci's concept of hegemony illuminates how this false consciousness serves to maintain and support domination (Simon, 1977; Williams, 1977). The concept of hegemony is defined by Simon (1977) as:

...a relation between classes in which one class or fraction of a class exercises leadership over the other classes and strata through gaining the active consent of the members of those classes and strata (p.78).

He considers that the "active consent" is gained by means of "intellectual and moral leadership" (p.78). Moloney (1992) claims that hegemony exists within the power relations of medicine and midwifery. Historically this has been achieved because the subordinate midwifery group has not questioned medical knowledge or the interests it serves but, instead, endorses and supports it by accommodating it within their

language, educational system and hierarchical structures. Midwifery knowledge and expertise has become invisible and unacknowledged because midwifery has colluded in its own subordination. The setting up of direct entry midwifery courses which focus on midwifery knowledge is therefore counter-hegemonic.

The active consent to subordination creates a challenge for those wishing to bring about change, because the oppressed group comes to accept its unequal social condition thus suppressing the motivating force of dialectically opposed understandings of groups. When new and alternative understandings fail to emerge through a process of enlightenment, it is difficult to instigate change. Such groups may resist liberating change, as shown by women who saw the suffragette movement as unfeminine. In Chapter Two an example was given from the work of Moloney (1992) of how those midwives in charge, who were best positioned to make changes that would support and endorse the midwifery model, refused to do so. They therefore supported the interests of medicine in maintaining an institutionalised pattern of care which was not women-centred.

Hegemony then is not the passive acceptance of the dominant group ideologies but the active consent to them, by oppressed groups that consciously support the ideas and beliefs of the dominant group in their everyday lives. Herein lies the beginnings of false consciousness whereby the ideas and beliefs of the dominant group become frozen or fixed as permanent social norms, rather than socially constructed realities which are able to be deconstructed and reconstructed.

The problem of what constitutes false consciousness arises in research using a critical social approach. If the process of enlightenment is to reveal how actors have become participants in their own oppression, how can one be sure that this is not simply an imposition of another's ideologies which may be equally oppressive? This problem has been addressed more fully by writers such as Fay (1987) Geuss (1981) and Nielson (1992). Geuss (1981) argues that false consciousness exists when people hold certain normative beliefs "because their social institutions prevent them from subjecting it (sic) to free discussion" (p.62).

Habermas (1982) claims, in his theory of communicative action, that free discussion takes place in an ideal speech situation for which there are four criteria. Hickson (1988) used these criteria as a validity claim for her research which used a critical social approach as a means of analysing the practices of her nurse participants. Fay (1987) however, argues that not only is an ideal speech situation very difficult to

obtain, given the pervasiveness of power relations in society, but the concept of false consciousness is based on a mistaken assumption of cognitivism. He claims that hegemonic structures influence not only the way we think but also our bodily movements in time and space. Oppression permeates our bodies as well as our minds. It follows therefore that enlightened thinking and dialogue is not enough for liberatory actions. Changes in our daily patterns of movement in space also need to be altered. The following section further explores Fay's claims.

Embodied and Embedded Action

Taken-for-granted meanings and actions appear not only in our thinking, but become embodied in the everyday lives of participants. Embodiment involves the participants' actions in ways which make change extremely difficult. Street (1992) in a critical ethnography of nursing practice found that:

Nurses who are able to respect themselves as equals with the medical staff still find it difficult to act in ways that are emancipatory because of their embodied habits which they respond to on an unconscious level... (p.200).

She found nurses' language and actions often placed them in a subservient role in relation to their medical colleagues even when they felt they had superior knowledge of a situation. Likewise, midwifery knowledge and actions are embedded in traditional medically based patterns of responding and practising. This may restrict midwives' ability to work autonomously and in ways which demonstrate underlying midwifery philosophies. In this present study midwives give examples of the difficulties of resisting their embodied responses to medical and institutional expectations.

Resistance

It is argued that the use of a critical social approach to analyse the case studies of midwives' work experiences enables the researcher to maintain participants' meanings in context so that their experiences are not reified or separated from the socio-political contexts in which they take place. The process of the research is reflexive in that the participants and the researcher both change as they become more knowledgeable regarding the contradictions of their existence. This change is focused on enlightenment in which participants are freed from the hegemonic structures and ideologies to reveal their own interests. Emancipatory change can take place as work-life potentials of midwives are reconstructed in ways that are oriented and focused

toward midwifery based ideology and realities. Such moves can be described as forms of resistance. The subjects of subordination would refuse to endorse the current definition of their situation imposed upon them by those in power. Instead they would seek to find different interpretations of their situation, and thereby transform their lives. Street (1992) states:

Resistance develops as a group of people engage in a process of enlightenment through ideology critique and act upon this enlightenment to empower and emancipate others (p.233).

Chapter One briefly traced the historical and political process of how midwives, together with the women with whom they worked, reclaimed a distinctly different way to practise using the midwifery model. The emergence of an alternative model can be called counter-hegemonic and is a form of resistance. Resistance may be overt or passive.

Passive Resistance

Passive demonstrations of resistance may be conscious or unconscious. An attempt is made to subvert dominance covertly because it is seen as the only or most effective way of effecting change within a particular context. For example, Street's (1992) study illustrated this form of passive resistance when discussing the actions of intensive care nurses. Street's participants felt that a confrontation with doctors would have resulted in less than optimal outcome for clients. They considered that the focus of decision making would have been on *whose* decision would have prevailed rather than *which* option would have been in the best interests of the client. The maintenance of power relations thus became the main focus. Other authors (Short, Sharman, & Speedy, 1993; Street, 1992), refer to the doctor/nurse game whereby the nurse ensures the doctor feels he is the dominant decision maker while the nurse manipulates the situation so that the doctor's responses are congruent with her interpretation of the situation. Hutchinson (1990) used the term responsible subversion in her grounded theory study in which nurses considered themselves acting responsibly in the best interests of their clients, by subversively bending or ignoring institutional rules and policies. Similar instances of passive resistance are also found in midwifery.

Vocabularies of complaint

Turner (1987, p.152) describes the formation of "vocabularies of complaint" as representing a form of resistance. He suggests that, in nursing, these formations serve to de-legitimise the assumed authority of medicine, critique their position of lack of

autonomy and control, and contribute to group solidarity. One of the functions of vocabularies of complaint was the denigration of the doctor's contribution to maintaining health. Turner's work indicated that nurses claimed; "that doctors... represent a threat to the health of the patients who need protection from male medical intervention" (p.153). In Chapter Two the example of ultrasound was discussed as a form of routine medical technology from which women need protection. Turner warns that the effects of vocabularies of complaint may be limited because they have a cathartic effect and act as a safety valve. The motivating and unitary effects of such complaints are therefore lost as an effective force for social action.

Resistance and Visibility

It has been argued that the emergence of an alternative discourse can be a powerful counter-hegemonic strategy for confronting and challenging the existing power relations. The use of the term power/knowledge suggests that possession of specific knowledge is one way of gaining recognition and power. By making midwifery knowledge visible the potential exists for both positive and negative outcomes since:

Discourse transmits and produces power; it reinforces it, but it also undermines it and exposes it, renders it fragile and makes it possible to thwart it (Foucault, 1978, p.101).

The thwarting of an emerging discourse may occur by a process of incorporation, as described below, or a far more overt and confrontational suppression may occur. Foucault (1978) indicates that whereas silence and secrecy can act to shelter emergent power/knowledge and prevent it from coming under control of the dominant power, visibility can also be an asset. He uses the example of homosexuality. Once homosexuality was in the public domain it "made possible the formation of a 'reverse' discourse". It was then possible "to demand that its legitimacy or 'naturalness' be acknowledged" (p.101), (single quotation marks in the original). The problem of whether to expose a fragile emerging alternative discourse to scrutiny is problematic and is discussed throughout the case studies.

Spender (1985) describes the process of making the private public, or making women's experience visible, as a way of confirming female culture and making it legitimate. This is accompanied by the generation of an alternative descriptive language which in itself is a powerful political act of resistance. She states "as women engage in this process, it changes the rules for making sense of the world, it transforms the rules by

which patriarchal knowledge has been produced" (p.64). Women are thus empowered to find a different language to describe women's ways of being and knowing. It provides a basis from which to critique the taken-for-granted masculine interpretation of women's lives. Women, by describing the experiences of medicalised childbirth as a process of alienation, control and objectification are able to surface the power exhibited by the medical profession during the birthing process. Midwives, by listening to the voices of women, can better offer a women-centred service. Thus the distinctive vocabulary of midwifery is important to their establishment of a valid and visible alternative to the dominant medical discourse. Continuity of care, women-centred care, guardians of normal birth, and being with women are some of the emerging culture's language.

Incorporation by the Dominant Group

Often the dominant group will respond to the challenge for change or the redistribution of power by making superficial changes. Such changes are simply accommodated or *incorporated* into the dominant discourse which leaves the relations of power unchanged. Williams (1977, p.125) suggests that often "much incorporation looks like recognition, acknowledgement and thus a form of acceptance" of the emergent cultural group but its effect is to dilute and limit it, thus maintaining its marginality. An example of this was given in Chapter Two when doctors responded to demands for a more humanistic approach to childbirth by suggesting that there be a basket of toys in the wards and patients were not to be referred to by their medical conditions.

Spender (1985) refers to this process as absorption. She describes how language developed by women to describe their experiences are absorbed into the dominant masculine discourse, thus their political impact is silenced because an alternative female discourse is once more rendered invisible.

Street (1992) refers to a process of *accommodation* by both dominant and subordinate groups as they make changes to renegotiate roles or professional boundaries in a way that ensures the power relations are unchanged. She gives the example of intensive care nurses who undertake technical laboratory testing which the doctors find laborious and time consuming. Medical power is not threatened by these nurses performing tasks that were previously their domain because of the acceleration in even more complex medical technology preserves their power/knowledge. In a similar manner doctors were willing to concede the long and non-profitable labour care to midwives but not the actual birth. Midwives had previously accommodated doctors in

this by ensuring the doctor was present for the birth. This form of accommodation has now been removed by those midwives who claim the total childbearing experience as their domain and thus a tension, and a possibility of change, has arisen. In this thesis, adjustments of the subordinate group which maintain the status quo are referred to as *accommodation* while *incorporation* refers to the adjustments of the dominant group.

A Critical Social Approach to Research

It is argued that a critical social approach enabled me as the researcher to address the work lives of midwives as, "a problem of ideology and control" (Carr & Kemmis, 1983, p.28), rather than individual personal experiences as they pertained to each midwife. Unlike other paradigms, a critical social approach, enables the researcher to begin with the assumption that the nature of midwives' work-lives is politically, socially and historically situated and thus reflects the broader context in which their work takes place. Because there is no assumption that medicalised childbirths are always in the best interests of women, the purposes of taken-for-granted medical routines and actions are open to critique. The different philosophical base of midwifery practice enables different questions to be asked. For example, once birth was assumed to be a normal life event the routine use of technology can be challenged.

By making problematic the evolution of social structures and their functions the researcher and the participants seek clarification of the genesis of these phenomena and thus surface their incongruities and unequal relationships in the context of present day realities. This is the process of enlightenment by which people become aware of their false consciousness and the hegemonic structures which maintain them. However, the emancipation and transformation of the lives of human beings does not take place simply by surfacing and deconstructing oppressive social structures. Lives are only transformed by the deliberate, uncoerced actions of humans as they seek to bring about social change. This liberatory process has as its goal truth and happiness (Stevens, 1989). Stevens suggests that critical social theory has much to offer in the analysis of health care delivery:

Critical social theory holds the key to understanding the constraining environmental factors affecting people's health and provides the potential for transforming the conditions that hinder human potential (p.62).

In participating "in a programme of education with the subjects that gives them new ways of seeing their situation" (Comstock, 1982, p.385) the researcher facilitates the process of enlightenment which contributes to the emancipatory intent of critical social science.

The use of case studies provided rich and detailed data which could be analysed using a social critical approach. The method of data collection and ethical issues are discussed in the following chapter.

CHAPTER FOUR

METHODS

As discussed in the previous chapters, midwives have already been through a process of considerable reflection as they engaged in an endeavour to establish changes within their profession. It culminated in the Nurses Amendment Act 1990 which facilitated increased work choices for midwives and alternative birth options for women. The participants in this study had all taken advantage of the law changes to engage in independent practice.

Choosing the Participants

The participants chosen were not representative of any given population. The midwives who were chosen were considered *independent*. This term is difficult to define as it is used variously by different groups and often midwives themselves disagree on the implications of such a term. I therefore had the dilemma of placing my definition upon the potential participants in a way which is incongruent with a critical social approach. As a compromise I eventually considered some criteria which would best fit midwives as described in the World Health definition of midwives and adopted by the New Zealand College of Midwives and asked the participating midwives what they saw as independent practice during the interviews. The criteria I took into account in selecting participants were as follows:

1. Most if not all of their practice had to be carried out independent of hospital employment.
2. The midwives had to be within two hours travelling distance from my home. This was for my own convenience to contain costs and ensure I had sufficient time to complete the interviews within my work schedule. This did not appear to present any problems for selection and would only have caused difficulties if a representative sample had been required.
3. The midwives looked after their clients antenatally, intranatally and postnatally and did not restrict their practices to postnatal attendance as often occurs with community domiciliary midwives employed by hospitals.

Keeping these guidelines in mind I initially approached two midwives who advertised themselves as *Domiciliary midwives*. Having discussed with these midwives the focus and purpose of my research, I then asked for further contacts whom they thought would meet the criteria. From their recommendations I selected a further two midwives.

The four participants were women who met all the criteria as described above. They conducted some births on their own responsibility or within a shared care arrangement with doctors (refer Case Studies). All participants had access to at least one or sometimes two major obstetric hospitals as well as smaller satellite maternity hospitals.

Initial Approach

The potential participants were approached individually and asked if they would be willing to take part in the research. Either at that time or later, by post, a copy of the research proposal, an information sheet (refer Appendix A) and a copy of the consent form (refer Appendix B) were sent to them for their perusal. This was followed up by a phone call to arrange an initial interview to further discuss and clarify the research proposal should the participants wish to continue. All of the potential participants were willing to participate and interviews were arranged according to their preferences. It was at these initial interviews that written consent was obtained. I emphasised that written consent only confirmed that they understood the nature of the research and its intent. They could withdraw at any time during the research process.

Relationship Between Interviewer and Participants

The interviewees are called participants advisedly as this reflects the underlying assumption that the participating midwives and the researcher are in active partnership during the research process. Participants are not *subjects* which presupposes passivity, nor are they *objects* to which something is done, or viewed from a position of distance and even superiority.

The present script purposefully uses the term 'I' to refer to this researcher. Because I claimed a partnership relationship with the participants, to now be referred to as 'the researcher' gives a false impression of neutrality. Furthermore, once the term researcher is used the participants are portrayed as objects of research.

A critical social approach requires participants and researcher to become co-researchers whereby they reflexively work together to explore the practice lives of midwives in a way that is transforming, empowering and emancipatory. However, while the interviews were conducted in a manner which facilitated active partnership, each midwife brought with her different perspectives and ideas. The midwives brought with them their practice experiences and knowledge while I used my theoretical knowledge and observational skills. Because I too have had some midwifery practice, though not as an independent midwife, I could also share the experiences from my practice. This however also brought some difficulties to be considered. It was important that the theoretical base illuminated rather than imposed upon the data. Praxis was maintained by the constant examination of the data, to ensure that analysis was embedded therein, and by sharing drafts and case studies with the participants for consideration, confirmation and/or alteration. By a process of reflexivity then the tension between theory and practice was kept in balance and acknowledged.

Data Collection: Interviews

Semi-structured in-depth interviews were the method of choice for this research as it was necessary to explore and uncover the nature of the midwives' work constraints and the underlying socio-political structures that supported those constraints. Interviews took place over a period of eighteen months and resulted in 163 pages of transcripts. I met with all the participants for at least three interviews but one had four as the midwife was called out to attend a birth during one interview. A final interview in which I discussed the written case studies with the participants was not audiotaped. The audiotaped interviews were conducted at the participants' houses, my own house or place of work, or at a mutually agreed upon venue according to the convenience of the participant. Transcripts were typed by either myself or a transcriber, then copied and given to the participants before the next interview. The purpose was to enable both the participants and myself to reflect on what was said and to clarify points that were transcribed. At this initial review I was able to conduct a preliminary analysis which could serve as a focus for the next interview.

Interview Process

Interviews were recorded on audiotape with an understanding that the recording could cease at any time during the interview at the participant's request. The midwives were able to state at the next interview if they wanted any of the taped interview to be deleted before being used in the research report. Occasionally this occurred when the participants used a manner of speech or referred to colleagues in a way that they felt was inappropriate. The final draft of the report was available to ensure that the participants were not compromised to this effect in any way.

The audiotapes were for the most part transcribed by myself. This ensured that the words remained in the context of the interviews with their emphases, pauses and laughter. At this time I made preliminary analytical notes which formed part of the next interview.

The interviews usually commenced with discussion of what may have occurred in the intervening period between the interviews and then a review of the previous transcript took place focusing on any point that either I or the participant wished to clarify or pursue in greater depth. The participant discussed any issues or incidents in their work-lives which they felt contributed to the exploration. I also contributed my own experiences as they seemed relevant. On occasions I would refocus the interview by asking questions of the participant. For example, when a midwife talked about working with obstetricians I would ask how decisions were made or what actions they were able to take as midwives. The purpose was not to get answers for prepared question but rather to more deeply explore issues, reflect upon experiences and go beyond the taken-for-granted social constructs of the every-day lives of the midwives. Together we were then able to consider actions and situations in their socio-political context and uncover incongruencies between actions and words and discover constraints of practice which may have been previously unacknowledged.

Participant Observation

The purpose of accompanying the midwife on a visit to her client was to observe the midwife in the practice setting in which she worked. There was no intention that I should judge or appraise the midwife's work skills in any way but the observation helped to maintain the research focus on the midwife's practice in context. It also gave an opportunity to consider with the midwife any actions that she may not have been

aware of from a socio-political perspective. For example, one of the midwife's clients stated that her doctor had refused to continue to be her medical practitioner if she insisted on seeing her chosen midwife.

Three of the visits involved pregnant women and one was with a woman who had recently given birth. Each interview was arranged by the midwife who chose a client whom she considered would feel comfortable to be approached regarding the observation and would feel free to decline if she wished. The midwife first asked the client if she would consider being approached by me with a view to being present at an antenatal or postnatal midwifery visit. Unlike visits to a doctor's surgery these visits are made in the woman's home. To some degree this is an advantage because control is with the client who is more likely to reject a stranger entering their home if they are uncomfortable. I followed the midwife's initial contact with a phone call and, after an outline of the participant's involvement was explained, permission was sought to send an information sheet (refer Appendix C) and a consent form (refer Appendix D) to the woman. This ensured that the woman had time to peruse them before my next phone call asking if there was any other information required before seeking permission to attend with her midwife. I then visited the woman with the midwife who introduced her to me and formal consent was obtained. I took notes and tape recorded the verbal interchange during the visit. At the conclusion of the visit, with the midwife still present, I discussed generally what I had observed. Although the purpose was not to interview the clients the women often volunteered information about their relationship with the midwife, why they had chosen her and their previous birth experiences.

The data from these visits were used as a focal point at the following interview. For example one client had considered having an amniocentesis and this served as a focus for the next interview on the issues of informed consent and the midwifery model of practice.

Ethical Considerations

This research was conducted in a manner that ensured ethical research standards were maintained according to the international ethics standards as outlined in the Massey University code of ethical conduct for research and teaching. The proposal was presented to and discussed with the Massey University Human Ethics Committee.

An ethical consideration arises from the assumptions and ideology of critical social theory itself. Because its purpose is to enlighten participants so they might be

emancipated from previously held false perceptions and ways of acting which may not be in their interests, the process is openly interventionist. Unlike other forms of data collection which seek to describe phenomena or discover the meaning of certain phenomena to participants, the critical social approach seeks to uncover those social and personal constraints that inhibit freedom and individual agency. Furthermore it also explores ways of changing the socio-political and/or power bases which maintain and perpetuate those constraints. Thus freedom and self determination is an underlying goal of the critical social approach and the researcher must ensure that the research process itself remains free from coercion, oppression or imposition of interests.

Street (1992) gives an example in her critical ethnographic research as she reflected on her need for the participants to engage in coauthorship of her doctoral thesis:

In attempting to develop collaboration based coauthorship, I was imposing a collaborative style that disempowered these nurses, who were highly articulate within their oral culture but felt disempowered when required to document their own understandings... I recognised that I was intending to use my power/knowledge to bring about a change in their mode of expression in order to fit in with my research design (p.19).

In engaging in critical social research I was vigilant that my agenda of academic achievement and need for completion did not inhibit the participant's choice to freely consent, withdraw from the study at any time or have portions of the study deleted. The onus was on me as the researcher to ensure that the research process itself was emancipatory, transformative and empowering. While the ultimate goal of the critical process is emancipatory action, this should in no way be imposed upon the participants.

Clare (1991) suggests that the process of transcription review and data sharing with the participants goes some way to ensuring that they are not misrepresented in any way. Each typed transcript was presented to the participant before the next interview. At the beginning of each interview we discussed the previous interview and each of us clarified any points that were unclear. As I began to analyse the data the first draft was given to the participants for confirmation and further discussion. When the final case study was written I again returned to the participants for their comments. Apart from some colloquialisms no major changes were made at this stage. Confirmation by one participant was given with the words, "**To see it written down, it made me feel very emotional. Yes, that's how it is.**" (N. final interview)

The research process itself called for an uncovering of and reflection upon those actions in which midwives unconsciously participated in their own oppression. As the research process progressed I became very conscious of the fact that these midwives had in fact undergone considerable reflection on their practice before the research commenced. Furthermore, it would do them a great injustice not to highlight those acts of resistance that they had already taken or were taking as a result of that awareness. In writing and analysing the case studies I have therefore given equal weight to those strategies that the participants use to bring about change and resist medical domination in order to acknowledge and validate that process.

It was an important part of this study to recognise the manner in which resistance to the dominant medical discourse has taken and continues to take place. It is common for those authors using a critical social approach to emphasise the active participation of actors in their own oppression. For example Comstock (1982) suggests as one of his seven steps in critical social science research that it should: "Elucidate the fundamental contradictions which are developing as a result of actions based on ideologically frozen understandings" (p.383). Here he is suggesting that the researcher seeks to surface beliefs based on false consciousness. Nowhere does he suggest that the researcher might make explicit those actions which could properly be called resistance. Conversely this thesis argues that the focus on oppression is to the detriment of the participants because, naming a group as oppressed may result in failure to recognise that from oppression also comes resistance. There is a danger then that the researcher may attempt to exercise power over the participants by claiming superiority of knowledge necessary for emancipation while failing to acknowledge fully the potential for self empowerment of the participants. This problem of manipulation is outlined by Fay (1986) who asks:

Is (there) a way in which our theoretical thinking about man and society may be employed to guide our actions without at the same time encouraging a manipulative role for those in possession of this theory (p.56).

To name and recognise the active participation of the actors in their own enlightenment and emancipation is in itself an empowering process. It validates their activities and enables others to recognise their own forms of resistance. The forms of resistance these midwives maintained were both visible and covert.

Confidentiality

Confidentiality was maintained in several ways. A pseudonym was chosen for each participant and this was used in submitting the transcripts to the supervisor, to label the tapes and in the written report. Though minimal use was made of outside tape transcribers, they were instructed to maintain confidentiality and tapes were identified only by pseudonyms. During the recorded interviews participants could choose to have any dialogue wiped or the tape turned off on request. The informed consent form included the assurance that the tapes: *will be erased upon publication of this study* (See Appendix B).

The anonymity of the participant was maintained during the report writing phase by changing or excluding any personal data that might identify the participant. The midwives all asked if they could know who the other participants were and each consented that her name be given to all the participants. They all knew each other and often reported that they had discussed the research among themselves. This ability to identify with each other and share their feelings and thoughts about the research, though not part of this research design, could be considered to be an empowering process and could form the basis of future research.

Prevention of Risk

It is recognised that because the purpose of this research was generation of emancipatory knowledge and change, there were implications for the participants not often found in other research projects. It was required of me as the researcher to be available to participants in order to work through any difficulties that may have arisen and to arrange debriefing sessions if necessary. This was not required.

Reliability and Validity

The error of claiming researcher objectivity has been documented by several authors (Clarke, 1988; Parse, Coyne & Smith, 1985; Street, 1992; Swanson & Chenitz, 1982). Likewise, the difficulty of acknowledging researcher subjectivity is explored by Clare, 1991; Lather, 1989; Perry, 1985; and Street, 1992. The purpose is to maintain the data in its socio-historical context so that it might be examined holistically rather than as a reified phenomenon, an object apart from its context.

Researcher involvement raises the question of reliability of results especially since the researcher works with the participants to reinterpret their data. Because I too am a midwife there is a danger that my perceptions, formed before the research was commenced, would be a barrier to free and unfettered reflection on the data so that the social construction of the participants' realities can be unveiled, deconstructed and reconstructed. I had to recognise my position as an agent of change yet maintain a 'critical detachment' so that ideas were explored together and reframing of ideas was a result of joint illuminatory reflection rather than my enforced ideas.

I ensured that the interviews were participant focused and, in working with the participants, sought to validate the interpretations with them. The advantage of my midwifery knowledge to this research was that the language, colloquialisms and scientific terminology were understood and could thus be used in the interviews.

The validity of critical social science is not predicated on the assumption of neutral, value free objective observation of the research. Rather, it claims that such neutrality is a myth and "the validity of its concepts, data and theory is related to the historical aims and purposes of that subject" (Comstock, 1982, p.374). This validity claim is obtained from the confirmation of the participants and readers that its interpretation and critique of actions is congruent with their reflection and understandings:

The criterion for the truth of critical theorems is the response of the theory's subjects. Because it begins from the meanings its subjects attribute to social processes and attempts to rectify ideologically distorted meanings and values, its methods of investigation and validation is based on dialogue with its subjects (Comstock, 1982, p.378).

→ Such research will not be able to be generalised to the population at large. Nielson (1992, p.278) argues that generalisation is not an aim of research using a critical social approach. Rather it is what he calls "contextualist-historicist". This, he explains, accepts that such research is often culturally bound and speaks to "a particular group determinately situated at a reasonably specific time". While this might mean that such research is open to criticism of relativism it must be remembered that its purpose is not prediction and control but empowerment and emancipation of people within a particular historical moment.

Midwives, independent nurse practitioners and other health professionals may well identify with the experiences and insights that result from the study. This in itself will be validating. In addition the draft and final copies of the research were submitted to the participants to obtain their validation of interpretation and analyses.

Data Analysis

The main concepts as outlined in the previous chapter formed the analytical framework for data analysis. The data obtained at the preceding interview served as the catalyst for deeper consideration of the socially constructed ideologies and empowerment possibilities of midwifery practice. Key concepts such as power, resistance and knowledge assisted in maintaining a critical social focus to our discussions. Before the third interview I sent with the transcripts, preliminary analysis of the data. Under various headings such as power and the medical profession, working with women, and problems of visibility I indicated various parts of the script which I considered illustrated various interpretations. I was then able to clarify this with the participants in the following interview. Once the accuracy of this analysis was confirmed and the final interview completed I further reviewed all the tapes pertaining to each case study to generate individual and common themes. In the final phase I wrote up each case study and submitted a draft for the participants' comments. At this stage the participants either confirmed my analysis or suggested alternative wording and interpretations. The final case studies were then written and any changes reviewed with each participant.

Summary

Research that claims to use a critical social approach as its philosophical base, has as its purpose the surfacing of personal and public socio-political constraints that inhibit the lives of the participants. Then in partnership, both the researcher and participants seek ways to transform their lives. The use of in-depth semi-structured interviews best met the aims of this research. A process of joint reflection and collaboration ensured that the research process itself was not coercive. The next four chapters include the case studies of the participants. Each is individually recorded and analysed. They therefore vary in length and themes. The common patterns of these case studies are integrated in Chapter Nine.

THE CASE STUDIES

CASE STUDY ONE: CHRIS

CASE STUDY TWO: SUE

CASE STUDY THREE: MARY

CASE STUDY FOUR: NINA

INTRODUCTION AND OVERVIEW

Profile of Participants

The participants Nina, Chris, Mary and Sue were chosen for this study as described in Chapter Four. In order to maintain confidentiality, personal family details have not been included. All of the midwives had become Registered General and Obstetric or Comprehensive Nurses, before completing further education leading to midwifery registration. The latter was either undertaken as a six month course at a Saint Helen's midwifery training school or as a one year Maternal and Child Health Diploma Course at a polytechnic. Interestingly, all these midwives had the type of nurse-midwife education that midwives criticise as being nursing focused with a medical bias rather than the direct entry midwifery education that is being trialed in two polytechnics at present (refer Chapter One). For these -participants however, direct entry midwifery was not available as an educational option when they were students. All the participants had attended recent educational workshops and conferences as well as read current literature. Some had other formal education such as a university degree or a post graduate Diploma in Administration. All participants are active members of the College of Midwives.

Work-Life Organisation

An important aspect of midwives' work is that they, unlike most medical practitioners, visit their clients in their homes antenatally and postnatally and sometimes also attend births there. This means that midwives are 'out and about' a great deal, with client visits taking from thirty minutes and up to three hours and much longer for care during labour and birth. One midwife worked from a midwifery centre where a volunteer took messages and made phone calls and appointments. All the midwives had telepagers and answer phones and were available on a twenty four hour basis. This meant that their families were also very much involved with their work.

Mary, Chris, Nina, and Sue all had formal access agreements with one or more large metropolitan hospitals and several smaller rural maternity hospitals. Their case loads included a mix of midwifery only and shared care. At the beginning of the study Mary did not attend homebirths and only offered a domino service as described below. Ten months later at the time of the final interview, she also offered homebirths.

Provider Options

Since the introduction of the Nurses Amendment Act 1990 there has been an expanded choice for women both in terms of practitioner and places to give birth. Consequently, midwives may find they are working in several workplaces with a variety of colleagues. The word 'independent' generally refers to those midwives who are independent of the hospital system though this is never precisely true, since all the participants had access to hospital facilities with birthing women. In this case study 'independent' referred to those midwives who were not dependent on the hospital for their salary. The words "*to conduct normal deliveries on her own responsibility*" which the World Health Organisation used to define a midwife (Strid, 1990, p.10) are crucial to the essence of midwifery. It is these words that have been used to argue that midwifery is a profession in its own right, distinct from nursing as well as obstetrics, and that midwifery can and should be practised without medical involvement for normal cases.

Shared Care: Midwives who work with doctors are said to be working in a shared care capacity. These midwives may attend births at home or in the hospital according to the wishes of the woman and her labour outcomes. The specific responsibilities of each practitioner, doctor and midwife, are negotiated for each case. This negotiation can cause controversy if the professional relationship remains ambiguous.

Midwifery Only Care: Midwives carry out all of the maternity care without medical involvement. They may work with another midwife as a back up.

Location Options

Homebirth: The term *homebirth midwife* refers to those midwives who care for childbearing families antenatally, intranatally and postnatally with the intention of achieving a homebirth. They may do this on either a +midwifery only basis or in a shared care arrangement. If the women are admitted to hospital, homebirth midwives may continue to care for them there if they have an access agreement. However, if medical intervention such as a caesarean section or a forceps delivery is required, the woman usually becomes a hospital patient but in some circumstances the midwife may continue to care for the woman.

Domino Care: This term is an acronym for domiciliary in and ot of hospital. Midwifery care is offered to women in the community during pregnancy and continues

through to labour and the birth of her baby in hospital. When the woman returns to the community and is out of hospital postnatally, the midwife still continues her care. Usually these women return home within the first twenty four hours after birth. Domino midwives can be responsible for the delivery of the infant (midwifery only care) but may hand this responsibility over to a doctor (either a general practitioner or obstetrician), as shared care.

New Zealand Health System

During the time of this research the New Zealand health care system was undergoing considerable change. Twelve Area Health Boards were to change to twenty four health providers called Crown Health Enterprises (CHEs). There are now four separate funding bodies called Regional Health Authorities (R.H.A.s). This provider/funder split will mean that midwives will experience more economic changes. They will no longer be paid by the Health Department but will be required to contract their services with a R.H.A. It is unclear whether all women will have greater or less access to midwifery services as a result of these changes.

At the time of this research an interim arrangement was in existence and the midwives participating in this study were funded from the R.H.A.'s Joint Venture Health Benefits Unit.

Key to Referencing of Chapters Five to Nine

Case studies are referenced thus:

- **Bold** lettering refers to participants' dialogue with me as researcher.
- R. refers to researcher's dialogue with participants.
- (M.p5:1) refers to Mary, page five of the original transcribed interview script, interview number one.
- underlining and *italics* denote emphasis.
- [Field Notes, N.p.4] refers to notes taken on participant observation with midwives as they visited they women. This example reads Field notes taken with Nina page 4.
- [] Words enclosed in square brackets have been added to the dialogue by me as researcher to make the meaning clearer or when names or places are changed to maintain confidentiality.
- Because the participants use the term GP rather than the full term General Practitioner, the term GP is used throughout the scripts and refers to General Practitioners.

In Chapter Nine, references to participants dialogue are as follows:

- **Bold** lettering refers to participants dialogue with me as researcher.
- R. refers to researcher's dialogue with participants.
- Mary, 1:99 refers to Case study of Mary. Interview number one, cross referenced to page number 99 in this thesis.
- underlining and *italics* denote emphasis.

CHAPTER FIVE

CHRIS

Being a Midwife

Chris provided care for women who gave birth either in hospital or at home. For the former she had negotiated access to two base hospitals and several satellite maternity hospitals.

Chris clearly differentiated between obstetric practice and midwifery practice.

Obstetrics, I find, is a very mechanical view of a woman having a baby. It looks at the physiology. It looks at the way things work, in the minds of the medical profession. I find that midwifery doesn't always do what you think will happen in obstetrics. It's very much a relationship between the woman and the midwife. Midwifery to me is a woman having a baby and being in control and doing it her way. Whereas obstetrics is a woman in a strange environment being told what to do, to fit the institution, to fit the doctor; the doctor's requirements and perhaps the midwife's requirements if she is very obstetrically minded or an obstetric nurse. Midwifery concentrates more on birth as a natural part of living. That doesn't say that things don't go wrong but it tries to pick up the things that do go wrong and deal with them before they get to disaster proportions. You're not always going to do that. Just when you think you know all about it, you come a cropper. Just when you think you've got it all sussed something happens that is different from anything you've ever had before and things don't go the way you think they're going to and you end up with egg on your face. It's very humiliating.
(C.p1:2)

Chris identifies midwifery practice as having a different philosophy from obstetrics and identifies the main differences in terms of "relationship" and "control." She suggests that her practice experiences cause her to question the ritualistic medical model which appears to offer a sense of predictability and control for the practitioner. Such certainty is incongruent with Chris's practice. **"I find that midwifery doesn't always do what you think will happen in obstetrics"**. She demonstrates that midwifery skill and knowledge involve interpretation of events because sometimes, **"something happens that is different from anything you've ever had before"**. This claim to knowledge, which cannot be reduced to a set of predictable tasks, is one

way in which professional groups claim the legitimacy of a specialised body of knowledge (refer Chapter Three).

The success of a process of enlightenment whereby midwives clearly came to see and define themselves as possessing different practices and knowledge from obstetricians and doctors is seen in Chris' statement. She describes herself as working "**in a relationship**" *with* women rather than *with* doctors. Thus she no longer describes herself in relation to the medical profession as a doctor's handmaiden or subordinate to doctors. This power/knowledge (refer Chapter Three) generated by midwifery knowledge has enabled Chris to practise with some authority though she is aware that doctors do not necessarily endorse that knowledge.

Knowledge of Worth

Chris recognises that midwifery knowledge, derived from practice, remains invisible and unrecognised. Her experience guides her practice but when she attempts to share it with medical personnel it is discounted on the grounds of being inadequately researched by the empirico-analytical methods of medicine. Such an example is given by Chris as she discusses the medical practice of routinely giving drugs in an attempt to hasten the separation of the placenta and reduce blood loss. After an experience with a woman who had a large bleed from the placental site several hours after the giving of ecbolics (see glossary), Chris questioned the use of this medication.

And I talked to the doctor about that and said it was something I had seen before and wondered if it was because of this. And he said, "Oh you can't make that judgement on one case". But I said, "No, it's not just one case that I'm making it on," but unless you have facts and figures it's no use talking to them because you actually have to prove it... Well I think I have had a couple of minor bleeds at homebirths... but she's the only one that really scared me because it was a really bad bleed at the time. And I really feel it was from the syntocinon.... With syntocinon you might not have a bleed at all [at the birth]. Everything might be hunky dory. You have birth with a bleed with about a 100 ml blood loss and then an hour later the lady gets up to go to the toilet and `whoosh' it's everywhere. And I've seen it often in hospital as well where they have just used synto [syntocinon]. So I sort of feel if.... I'm not going to stay there for a couple of hours then it is much safer not using anything.

R. So this is an example of medical knowledge versus midwifery knowledge?

Yes, definitely

R. And your own knowledge?

And my own gut feeling and that is based on [many] years of experience..... But you see unless you have a research project or something like that and can say look at this, this and this... (C.p9:3).

Midwifery knowledge, grounded in practice is thus seen as somehow inferior to abstract knowledge based on scientific theory. Furthermore, when Chris was working in a 'shared care' situation with doctors there was a tension between midwifery and medical knowledge. This required Chris to constantly restate and defend her midwifery knowledge.

R. So by the time you get to the delivery you always know what the doctor wants and it's never an issue at the time of the birth?

Oh no.... The doctors know what I want and I am responsible because I am actually doing the birth care. I had one lady who was having her fourth baby and we had said nothing about it [the giving of ecbolics]... And the doctors are aware that at homebirths we don't normally use ecbolics and she [the mother] was on the mattress and we delivered the baby and he was there, just sitting in the corner. And right at third stage when the baby was out and she was cuddling the baby he said, "I would feel much more comfortable if she had an injection to make the afterbirth come. You know, I really think she should have the injection." And she sort of looked up and she was really tired and it was one of my earlier homebirths I wasn't as assertive then and I wasn't hung up on the idea of giving ecbolics and she looked up to me and said, "Well what difference would it make?" and I said, "Well it would make the afterbirth come quicker but apart from that we don't normally give the injection in homebirth situations", which she already knew because we had already talked about it. So she said "Well if it will make the doctor happier" and I said, "Well obviously." (C.p8:3)

Chris had said nothing to the doctor about her not giving routine drugs to promote placental separation which is common medical practice, because she felt in a homebirth situation her midwifery way of practising should have prevailed and a drug free birth be maintained if possible. Chris felt very much in charge of her midwifery knowledge and practice, stating that: "**the doctors are aware ..**" and "**I am responsible...**" She recognised that her lack of assertiveness at that time meant that the authority embedded in medical knowledge prevailed. In giving the woman the final choice she was unable to follow through with her own practice beliefs of a natural, physiological third stage. Here the non-institutional environment of a homebirth appeared to make very little difference to power relations. Medical dominance and decision making still prevailed. In Chapter Two previous researchers (Bassett-Smith, 1988; Hedwig, 1990; Moloney, 1992) proposed that the hospital environment contributed to constraints on

midwifery practice. However, it is clear that by itself, changing the environment does not result in emancipatory conditions.

Another interesting point is my question: "So you always know what the doctor wants...?" indicative of my bias toward the dominant medical discourse. The question, "Does the doctor always know what you want?" may have reflected the precedence of midwifery knowledge.

In the above example the woman was not able to firmly state she preferred either the medical or midwifery way of practising but indicated that her desire was to please the doctor; **"Well if it will make the doctor happier"**. This further confirms the ability of medical practitioners to have their wishes complied with. Even though the *woman* was having the baby and *Chris* was taking the responsibility, it was the doctor who had to be kept happy. This covert power, in which doctors, not women, are in control during childbirth is difficult for midwives to confront and change. Both *Chris* and the woman reinforced this power: *Chris* pointed out a possibly positive outcome; **"would make the afterbirth come quicker"** and the woman asked if the doctor would be happier. In terms of a critical social approach, both display false consciousness in that they appear to be unaware of how they are supporting and confirming medical power/knowledge. They are therefore unwittingly complicitous in their own oppression (refer Chapter Three).

Empowerment or Power?

Chris stated that her underlying midwifery philosophy had:

.....choice for women and control for women of their birth experience, being extremely high on the agenda. So those are the two things really. It needs to be informed choice but that's partly to protect my back. But really the whole key is an informed choice, a relaxed mother, who feels as though she has a friend looking after her, who is on her side.... yes... That really is the key to it.
(C.p1:3)

Chris saw **"choice and control"** for women as important components of her midwifery practice. This idea of empowering birthing women is an example of the midwives use of the nurture/knowledge concept as described by Street (1992), (refer Chapter Three). Ideally this meant that both the doctor and the midwife would empower women to make choices which best suited their circumstances by sharing of information and knowledge. *Chris* was aware that both doctors and midwives may impose their particular ways of practising on women.

But it's a really hard thing to do especially when you [Chris] have fairly set ideas and of course it's very hard for the doctors. They wouldn't even try. They have a set idea on something, that's it. You [the woman], get told what you are going to do.
(C.p8:3)

Chris is aware that giving choice to women is difficult because her "set ideas" may mean that these impinge upon the amount of choice a woman may be given. That she reflects on this difficulty shows she has some understanding of the power relations which can exist between women and their caregivers. Chris doubts that doctors are aware of this problem of power but believes that they see it as their professional right to tell women what to do.

Most doctors who do maternity care do not tell women about the choice. If the woman comes to them and says, "I would like a midwife and I think what I would like to do is to have the midwife visit me at home and see you a couple of times during pregnancy" and asks, "Would you come to the birth?" Some of them [doctors] would say, "Oh yes, you will be all right with her and you can see me such and such", whereas others will just not want to know and, [say] "Well you either have me or you have her," or, "You have her for the birth only but I do total antenatal care."

R. Which isn't very satisfying?

Well it's not. What the woman wants is of course for midwives to call, because it saves them getting their toddlers all organised when they go to the doctor.

R. But the midwives don't work like that? They say you can have whatever doctor you like and I'll negotiate, I'll be the one that makes the compromises?

Well we say to them, "You have choice. It's your choice. If you want the doctor to look after your pregnancy, I'll fit in with whatever you decide."

R. Is that frustrating at all?

Not really because I believe that the woman has the right to choose and a lot of those are happy with just you or whatever, but at least you show them that you are not going to be offended if they decide they would feel more comfortable having a doctor. I really feel I don't want to pressure women into just having just me. That it has got to be their choice. And it's their pregnancy and it's their birth, and they need to be comfortable with what's happening and what I usually say is, "You are going to do this [give birth]. You are the only one that really knows your circumstances and these are your options." And I feel this is part of my job. I don't see it as a compromise. Sometimes I feel like saying, "Don't go to him" and I might sort of say, "Well how do you feel about him or how are you getting on with him?" And if they say, "Well he's really abrupt," or "I don't feel at all comfortable with him," then I might say, "Well if you don't feel comfortable with him why go? You need to

have a practitioner you feel comfortable with." But I try to limit myself [laughs], and not say anything more than that because if it gets back.... I mean it certainly gets back to me what doctors say about me, so I am sure that they hear what we say about them.
(C.p15:4)

Chris is aware that the client/doctor relationship may not be ideal but is careful not to upset that relationship unless the woman clearly indicates she is not satisfied with him/her. She states this is because she feels the clients are entitled to choose their practitioner yet this is incongruent with other statements (refer Page 65) that women often do not know enough to make informed choices. Her final statement "**because if it gets back.**" indicates she is aware that to openly suggest some doctors are undesirable would jeopardise her working relationship with them as she relies on them for referrals. Here the authority of the power/knowledge of the doctors is overt. Yet it goes beyond authority derived from scientific medical knowledge to an authority which assumes they have the right to dictate which caregiver the woman can have and under what circumstances. This authority extends to encompass the control of both the woman and the midwife. As a result, medical practices were accommodated by Chris even though she knew the woman would prefer "**midwives to call**". The doctor's reluctance to share the antenatal care with Chris is not congruent with midwifery care which relies on the antenatal visits to plan birth options with women. Because of such incongruencies, this may mean that Chris will visit the woman in her home without financial recompense in order to establish a midwifery relationship. Yet Chris feels unable to challenge this and "**fits in**". The hegemonic power structures from which doctors derive authority with the complicity of those they dominate continues to exist in a manner which is taken-for-granted and therefore hidden and covert.

Basically I'm trying to make it easier for them [The women]. You've got to be careful because, as you say, the women are all different. And for some women there are absolutely no problems with having ecbolics and they would rather not be part of a confrontation or an issue or be confused by it. Yes there are times when... it's almost like saying you are not going to give them the information but you are looking at a total thing. Am I looking at, "Well they must make this choice, this choice, this choice and this choice?" or am I looking at a total good experience for them and looking at it holistically?

R. And so a totally good experience for them would be not to give them so many choices?

...and make them totally confused. Sometimes they will say to me, "The doctor said that I should have the injection to make the afterbirth come." Or they'll come to me and say, "I thought I'd like a midwife but I don't want a homebirth." And I'll say, "That's fine, I'll do what you want, as much as I can."
(C.p6:3)

There is a constant dilemma between giving the client the best possible birthing experience and recognising the power and control of the medical hierarchy that can constrain and sanction midwifery practice. Chris feels that the tension between medical and midwifery knowledge must not get in the way of ensuring the best experience for her clients. In this way nurturance/knowledge (refer Chapter Three) rather than power/knowledge is maintained. Chris is aware that the client can get caught in the middle of a power battle in deciding whose knowledge prevails. Furthermore, Chris is aware that the woman may well choose options that are contrary to her midwifery model of practice. While choice remained a goal for Chris she realised that women needed to be empowered to help them make these choices.

R. How do you empower someone and help them with choices when they have no idea about the choice?

I think just being a friend so that she can talk to you and get information from you is really important. You know when the doctor says, "Well it's your first baby and you have to go to hospital," there is someone [a midwife] who says, "Well that's not actually correct. It is actually your choice whether you go to hospital or not." If it is a high risk person then you might be saying, "Yes, well you do have to go to [large base hospital]," but you might also be saying, "But you don't necessarily have to go under the team [hospital doctors]. You can go under a midwife who will look after you there and look after you afterwards".
(C.p2:3)

Chris was aware that knowledge of options was one way of empowering women. Informing women that they had choices meant the work of midwives was able to be discussed and disseminated. However, some women may not know what questions to ask and therefore empowerment could also become another form of coercion if only selected knowledge was given by midwives. A tension would then arise between whether to use information in a power/knowledge or a nurture/knowledge way. This choice for midwives is made even more difficult when they realise that the better known dominant medical model of practice is likely to be chosen by women because of its taken-for-granted acceptability and visibility. The question of which knowledge should be conveyed, midwifery or medical, was a constant problem for Chris.

As we reflected on the problems of unequal power in relationships, Chris and I discussed the power of knowledge and the effect that has on assisting women to make free choices.

R. But philosophically if you think about this partnership which is between you and the woman or you, the woman and the doctor, it's not an equal partnership for those women who really haven't got the knowledge, haven't read around ...

No, no it's not

R. So then are you more like an advocate?

Yes I think you are. Well when you say partnership,it's more like a friendship than a partnership. A friend who has a lot of information and can help then to make things as easy as possible for them. A partnership, as you say, implies an equal partnership and if you have a woman like this woman we had today who was very knowledgeable, well then you are looking at some thing like a partnership. But when you have someone like a young woman I had and was completely poverty stricken and didn't know how to ring directory to get a phone number she needed, then how are you going to be a partner with her? You are more being a friend to her than a partner.

R. So what happens then as far as power goes. It must be really difficult to suss out what those women really want.

Yes, because they think of the doctors as the authority too and it takes quite a lot of work on your part to have them thinking of you as a resource rather than an authority figure. And I'm sure there are a lot of people who don't end up seeing the midwife as a resource. I mean there are a lot of midwives who are authority figures and it takes effort on your part to try and prevent that from happening. It takes a lot of effort actually, it's quite difficult.
(C.p3:3)

The empowering of women is not as simple as it first appears, in fact, according to Chris, it is "**quite difficult**". As she reflects on this dilemma of maintaining an equal partnership in a situation of unequal power/knowledge, Chris is aware of the power that exists in the hands of health professionals. She understands that the authority women confer on doctors may be easily transferred to midwives so that they too, become "**an authority figure**". The passive acceptance of women, whereby they concede authority to health professionals, is further evidence of the hegemonic structures which exist to maintain power relationships in maternity care. They are constantly reminded by the media and popular press that birth without medical supervision is dangerous. Women are not conscious of their own knowledge and contribution to childbirth and will require a process of enlightenment to illuminate their active consent to their subordination.

Chris is constantly aware that some of the decisions she makes are for her professional protection rather than the woman's essential wellbeing: **"It needs to be informed choice but that's partly to protect my own back"** (C.p1:3). Furthermore, Chris recognised that information could also be disempowering. She felt doctors often used information to increase their power and control rather than the woman's ability to make choices.

I have a woman at the moment who's having a planned homebirth after a caesarean section and she has an element of risk about that.... And we have a consultant who has spelled out in vast and vivid detail all the things that can go wrong and it's really scared her.

(C.p5.1)

Chris stated that this woman did not give in to the pressure and continued to plan for a homebirth with the option of hospitalisation if the need arose. Many women are not yet assertive enough to defy their doctors and often concede to their wishes. In continuing to accept the doctor's ultimatum, women thus participate in their own oppression. This is not a criticism of women however but a reflection of gendered power which pervades medicine as a result of a long process of socialisation of women to accept the authority of medicine and things masculine (Oakley, 1993). The frustration for midwives, in attempting to empower women in their birth experiences is that many women themselves are not acquainted with a process of enlightenment, empowerment and emancipation (refer Chapter Three).

Power and Control

Chris and I discussed how women-centred practice based on the midwifery model was not always easy.

R. You said in the last interview, "I really felt the pressure on me to do it the way they [doctors] wanted".

Oh definitely.

R. Now tell me about that pressure.

It's very strong. Unless you get a woman who is strong and who has read... Now let's say I have a woman who wants her eighth baby at home and I say to her, "That's fine. You go for it. You've never had a problem. You are a woman who's well nourished, with family support, go for it." But if I don't spell out to her that she is of higher risk of bleeding, therefore putting doubt in her

mind, then she's not informed. And if I don't inform her I'm liable if something goes wrong. I could lose my contract, then I'd lose what I love doing. I'd have to go back to work at the hospital which I'd hate. And so I feel I'm sowing seeds of doubt in that woman's mind and I feel I'm almost causing the problem just because I feel that pressure, "I must inform her". And yet in some ways she should know the risks but where are the stats for the risks? Where did they come from? Were they from Glasgow in the 1950s where people who had eight babies were probably undernourished and anaemic and having babies year after year? So it's very difficult. I can't say to the woman, "Look these are up to date stats. They checked them last year." And how did they gather the data? I've got no scientific basis for what I'm saying. It's just what I've been taught and what the obstetricians have been telling me. And that really annoys me.

R. And that's the pressure.

And that's the pressure and there is this high risk list that we were all brought up with very devoutly. And I'm not convinced about the high risk list but by the same token, I have to acknowledge that it's there, not so much to conform..... I have to be able to say to her, "Well this is what the medical view is." And she has to be strong in her own mind about what she wants to empower me. Yet I am supposed to be empowering her. So it is a real catch 22 situation. How can I empower her to do something which I'm going to get knocked on the head about if I don't tell her the bad things. It's very difficult. And so if you find a woman who has read widely and has come to the conclusion that this is really what she wants to do, it really gives you the power to get on with it and then you look at your stats. My stats [statistics] are really good, particularly for natural births.
(C.p.4:3)

Chris acknowledges that a well informed assertive woman empowers her to practice midwifery, rather than conforming to obstetrics, as it, "**gives you the power to get on with it**". Here Chris examines the power relationships and interests involved in decision making and information giving. Chris acknowledges that she has evidence to show her birthing methods have good outcomes but knows that they count for nothing with those who oversee her work. She considers it counter-productive and against her philosophy to emphasise all the things that can go wrong. Chris recognises the power of knowledge but is unsure about what degree of knowledge is empowering to women and when knowledge usurps their confidence. She has observed it is used as a power tactic to force women to concede to medical intervention, technology and hospitalisation from fear rather than informed choice. Chris is aware that midwifery practice is constrained in a similar manner.

**You know they have a thing where they [doctors] say, "Well this is dangerous," therefore they are the only ones that can do it. "Well this is tricky, this has side effects." Well what doesn't have side effects?
(C.p3:2)**

Because midwives have declared that they are 'the guardians of normal birth' (refer Chapter Two) the labelling of much of childbirth as abnormal or "**dangerous**" limits and controls midwifery practice and expands the medical domain. Here the underlying assumptions of the pathology of childbirth are used to emphasise the necessity for medical supervision and dominance and thus midwives dependence on medical authority. This is why Chris refers to "**this high risk list we were all brought up with very devoutly**" (C.p.4:3). Here the underlying assumptions of the pathology of childbirth are used to emphasise the necessity for medical supervision and dominance and dependence on medical authority. The *risk list* (refer glossary) in the past has had an untouchable sanctity about it. It is only by critiquing it as yet another form of power and control that it loses its mystical qualities.

Working Within a Midwifery Model: Nurture/Knowledge

Not all the births in Chris' practice involved constant negotiation and compromise. Midwives often talk of *working with* women and facilitating their births in order that they have a good experience as well as a safe birth. Chris talks about a labour which she attended as a 'midwifery only' case in which the woman was confident about her ability to give birth at home and was clear about what she wanted.

**I just sat and read a book and just popped my head in every now and again and listened to the baby's heartbeat now and again. But I did as little as I could not to disturb her, turned the light off, made sure the room was warm and just left them to it really because they were doing it very nicely and there wasn't the need for me to be involved. And sometimes I think it is very easy to take over, and what you are trying to do is to let them do it. So I was allowing her to do it and they knew I was there if they wanted me for anything.
(C.p6:2)**

Chris used her midwifery knowledge to monitor the progress of the labour but left the woman in control and leading the birthing process. In this way, the focus remains with the mother giving birth not the birth attendant. Belenky, Clinchy, Goldberger & Tarule (1986) talk of this empowering method of working with women and point out that, "taking care need not mean taking over" (p.213). Here is an example of nurturance/knowledge. The family knew Chris was there with her expertise and skill

but she nurtured their independence and control and was conscious of not exercising her power in a manner which was invasive. This is in direct contrast to the managed labours of the medical model which have *normal* parameters within which each labour should progress with prescribed interventions for any deviations such as artificially rupturing the membranes, augmenting the labour with medication or cutting the perineum to hasten delivery.

Resistance

Resistance by Creating Alternatives

The power/knowledge concept has been described in Chapter Three. From an assumption that doctors' medical-obstetrical knowledge is the only legitimate knowledge by which to practice safely comes their power to scrutinise and criticise midwifery practice. Because midwives recognised that evaluation of their practice would be carried out by doctors using the parameters of the medical model, midwives set up their own monitoring group. This emancipatory action enabled midwives to include consumers and focus on the process of their midwifery practice rather than medical outcomes. That is, rather than focusing on the number and type of births, the need for interventions and deviations from the norm, the experience of women was a legitimate part of the evaluation process.

One of the reasons they [domiciliary midwives] started this was because there were a lot of noises from the hospital saying, "We must have a way of assessing [independent] midwives' practice." That they [doctors] practiced for years without anyone assessing their practice didn't matter, midwives are another story you know - dangerous beasts.

(C.p1:2)

However midwives still had to submit to a review from each institution to ensure their access to the hospital in cases where the birthing woman required admission. Chris was aware that midwives were looked upon as "**dangerous beasts**" and therefore were likely to be investigated thoroughly:

You have to give them your statistics of how many births you've done, how many caesarean sections, how many this, how many that and then they look at that and two people interview you if required. And of course all the midwives got interviewed last year.

(C.p8:1)

The setting up of their own monitoring group can be seen as a strategy of resistance by midwives whereby consumer knowledge and experiences are viewed and used as valid monitoring tools. In rejecting the medical model as too narrowly focused to reflect midwifery practice, and instituting an alternative structure based on midwifery practice, midwives are consciously reinforcing their own philosophy, by making it visible, valid and acceptable.

Raising Consciousness

The problems of working with women who are unaware of their right to choose a caregiver and the best way of empowering them has been discussed. In contrast, Chris and I discussed one of her clients who was able to resist the doctor's demand that she have her baby in a large base hospital. I asked how this woman was able to be so firm in her decision.

R. What gave her the confidence to say, "I know I'm a first mother, but for me it's different, I'm having a homebirth"?

She didn't go to a doctor. She went to a doctor to find out if she was pregnant. I don't think she said she wanted a homebirth. I just got a phone call very early in her pregnancy saying would I come to see her and I did. And right from there she knew I'd done homebirths and I think I'd delivered one or two people who she knew, but they weren't first babies. And it was just a matter of, "This is what I would like to do." And I just encouraged her to do it and didn't say to her, "Well look you can't do that". You know I didn't put any doubt in her mind and also she has some friends who are used to delivering locally.... So I think she felt it was quite natural to deliver locally rather than go to [base hospital]. She talked to other people who had done it. She came to a couple of homebirth meetings and talked to women who had had homebirths. And everybody said, "Yes, go for it." And she has a sister who had a homebirth for her third baby a few months ago who had said, "I wish I'd done it for my first one. The doctor frightened me silly and I went to [base hospital] and had a terrible time." And it wasn't a terrible physical time it was a terrible time up here [points to head] because they wouldn't believe she was in labour.... She was really scared and nobody would believe her. And that is what stayed in her mind not the physical side of it.

R. So it's word of mouth isn't it?

Definitely. Yes. And lack of contact with medical practitioners. (laughs) And that's true because they [the doctors] do make them doubt themselves [the women] and [that results in their] lack of confidence.
(C.p5:2)

It was evident that the woman's assertiveness also assisted Chris to care for women in a way that followed midwifery model principles. This idea of women and midwives empowering each other was discussed in Chapter Two.

Chris also suggests that some doctors do not really serve the interests of women because they, "**do make them doubt themselves**" and in fact women are better off without doctors. This is similar to "the vocabularies of complaint" (Turner, 1987, p.152) discussed in Chapter Three and represents a form of resistance to the dominant discourse.

Chris found that women often share experiences which helps support their decisions to make alternative choices.

Also the other thing that is helpful is getting women to talk to other women who have `been there' `done that'. Sometimes I have a woman who is being pressured by a doctor to do it a certain way and I can say to her well these are the pros and these are the cons and then actually get her to talk to someone who has been through that or has done it. And sometimes that will help them considerably to help them make a decision.

(C.p4:2)

Chris found that simply declaring her intention to give women choices was insufficient. A counterbalance to the powerful knowledge-authority displayed by doctors had to be found. The shared experiential knowledge of women appeared to be a useful method of consciousness raising whereby women's knowledge was instrumental in creating new knowledge and new choices and confidence in their ability to deliver their infants in the way they desired. Spender (1985) outlines this process of empowerment of women as they articulate their life experiences.

The presentation of an alternative model of caring for childbearing families, such as Chris was offering, is a powerful counter-hegemonic action in challenging the existing taken-for-granted medical model. Chris recognised that in the past midwifery had become invisible, subsumed under nursing with midwives seen as 'just another nurse' and all that implied (refer Chapter One) that their specific expertise remained hidden. Part of the resistance for Chris was to make childbearing women, and others, conscious of midwives and what they do. Reclaiming the name of her profession and working from a visible midwifery centre were two strategies that assisted in this.

....the other thing is that the general population who believe that you go and see the doctor [for confirmation of pregnancy]. And as I said before I think that is improving because now I get the situation now when I ring up maybe to change an appointment

and the child answers the phone and without me saying who I am; I just say, "It's Chris, is your mum home?" "Mum it's the midwife," and the kids are learning the word midwife... The notices in the paper say, "Thanks to the doctor and midwife" or "Thanks to the midwife" whereas before it used to be thanks to doctors and nursing staff. You still get the odd ones like that but I think there is far more consciousness of that.

R. And is this place helping? [Refers to birthing centre].

Yes I think so. We have been putting ads [advertisements] in the paper and we have been getting a lot of people in for free pregnancy tests. Course most of them are negative but never mind. They have seen it in the paper and they didn't know we were here before.

(C.p13:4)

Visibility both verbally and structurally can be seen as forms of resistance. Here Chris is ensuring midwives are visible both in terms of where they are and who they are. Miller & Dzurec (1993) point out that all words have a political, emotional, historical and theoretical basis. For Chris the words '**nursing staff**' refers to someone who works under the medical profession's authority. In reclaiming their name, midwives are establishing their claim as a specific professional group based within their own social and historical past as outlined in Chapter One. This will increase their visibility and has had the effect of assisting midwives to reflect on and confirm their own practice parameters.

The Dilemma Of Visible Midwifery Knowledge

Chris recognised that sharing midwifery knowledge was an important way of legitimising it but she was reluctant to be exposed to the lack of respect with which midwifery knowledge was often received.

R. Do you share it with GPs much do you think, or do you just share it with midwives?

No. I do share it with GPs but I select the GP that I share it with.

R. So why is that?

Well because some GPs would just not listen and put you down.

(C.p8.4)

Aware of the negative responses she might get from some medical personnel Chris recognised that some medical practitioners were more open minded. Chris did mention one of her naturopathic methods, which was used to start women in labour, to a trusted medical colleague.

And I mentioned it to [an obstetrician] and she actually had had a GP working with her who induced his patients regularly using acupuncture with really good success rates.

R. So she was someone you felt comfortable with?

She was very open to the idea.

R. So an exchange of ideas you would be happy with?

Oh definitely.

R. But you wouldn't be happy when?

I wouldn't be happy if I thought they might use it against me basically.

R. In what way could they use it against you?

Well, I hear them putting people down you know. Hahaha she uses this. Hahaha she does this or these midwives they think blah blah..

(C.p8:4)

There was another reason for Chris to be careful about the knowledge she shared. Midwives had become aware that in declaring their own knowledge, parts of it were likely to be incorporated (refer Chapter Three) into the dominant medical discourse in a way that was not congruent with the midwifery model of practice. Furthermore, mindful of the power the medical profession had to determine the boundaries of midwifery practice, Chris saw it as beneficial to blur those boundaries so they could not be confined by further rules and regulations.

Yes, but also I don't really want them [doctors]... they have their own level of expertise... in some ways I suppose if it helps the woman then, yes, go for it, but on the other hand, I don't want to turn them into midwives. I sort of see their place as dealing with the abnormal and my place as dealing with the normal, up to a point and trying to negate the abnormal. Trying to make the abnormal, normal.

R. So this is special to midwifery practice and in a way you want to keep it as midwifery.

Yes and have it acknowledged as midwifery knowledge. If they take over certain aspects of midwifery practice then they could end up controlling that too and that would be another thing we wouldn't be allowed to do. See what I mean? It's keeping us independent.

R. So what you are saying is, "Okay, I won't use prostins. I will use other things that you haven't found out about yet.

That's right. Yeah.

R. Right. Around the gatepost.

Around the gatepost. If you can't go through it, go around it.

R. So they can be the gatekeeper with their prostins but you will find another way.

Yes or do my level best to. Yes.

R. And in a way you don't want them to know about that other way because then that would become yet another gate that you can't go through and have to go around?

Yes.

(C.p9:4)

Keeping knowledge invisible is a way of preventing it from being "exposed" which "renders it fragile" (Foucault, 1978, p.101.). However, there is a difficulty in knowledge that is not made visible because it does not present an overt alternative to the dominant discourse (refer Chapter Three). Chris also was aware that knowledge was closely related to power and therefore wished to maintain that power/knowledge for midwives. There is the possibility that midwifery knowledge may, like medical knowledge, make claims to authority, expertise and power in ways that are oppressive rather than empowering. While midwives claim to work with women such claims may result in new power relations between women and midwives. She gives an example of how doctors are incorporating the language of midwifery into medical discourse.

They don't like it when the woman decides to come to me completely..... it's a power thing. They say they give continuity throughout the whole of life... They don't realise how important it is for that woman to have that continuity of care for pregnancy labour and afterwards.

(C.p3.1)

Redefining the norm

I discussed with Chris a book I had read (Rothman 1991) which described American homebirth midwives' practice of rejecting the medical definition of various labour 'norms' and deriving new norms from their own parameters of practice. Chris identified similar redefinitions in her practice.

Well, parity, age [are examples]. I'm so sick of women being told they are elderly primips over the age of thirty and they have to go to [a large base hospital] to have their babies, when I've had some very successful homebirths and local births with women of that age group. And I mean you're looking at women over thirty who are healthy women, you are not looking at somebody who is horribly overweight, and is horribly unfit, and.... smokes cigarettes all day.

R. So your experience tells you this is okay and I'm monitoring her really well, but there is still that pressure of 'the norm' from a medical point of view, that gets enforced upon you?

Oh definitely, yes, and again what is the norm anyway? Yes, it is very hard sometimes. It's very stressful.
(C.p5:4)

Chris recognised that by describing a thirty year old woman having her first baby as potentially abnormal or *at risk*, her pregnancy is medicalised. This has the effect of reducing 'midwifery only' cases because the midwife would be obliged to consult with an obstetrician, and reduces the woman's choice of places where she can give birth. By making the definition of abnormal problematic, each instance is able to be examined by a process of ideology critique (refer Chapter Three), for its underlying assumptions, ideologies and rituals. Thus by challenging the definition of these women as *at risk* Chris is able to resist the designation of all thirty year old women having their first babies as 'sick' and in need of medical supervision. Recent medical statistics have confirmed that the midwives challenge was well placed. It has been shown that thirty year old women presenting with their first pregnancy are not at risk.

Contestation

Sometimes the midwives choose to contest the medical interpretation of their work. At the meetings where less than desirable birth outcomes were addressed, the midwives in the study often found themselves under scrutiny in a way that they perceived was considerably different from that of the medical practitioners. Chris related an incident where the doctor outlined a case involving a newborn who was later found to have a congenital heart condition. The newborn required resuscitation at birth and the doctor appeared to blame this on Chris' management of the birth rather than the heart condition. She felt her management had been wrongly criticised.

R. So you were able to get up and say that?

Oh yes. I mean I let him do his spiel and then I got up and said, "Well I'm sorry but I totally dispute your idea that the baby was on the perineum too long. Thirty five minutes in second stage, with no signs of fetal distress is not too long for a primip. And as soon as the baby stopped making progress I did an episiotomy and delivered it. I don't call that delayed second stage." And he said, "Well point taken," and didn't say anything more. So he certainly didn't say, "Well I'm sorry Chris I didn't realise." You know he just sort of grunted and said, "Point taken".... I feel the baby was flat, not because of the delivery, but, because of the heart problem.
(C.p8:2)

Chris was secure enough in her own knowledge to challenge the assumption that it was her practice that was at fault. She was sure that it was her midwifery practice that was under question. For midwives to challenge a doctor's interpretation of midwifery actions is difficult, because midwives often feel medical practitioners want to prove them incapable of safe practice. The challenging does have the effect of making alternative views visible and is thus a form of overt resistance. Chris did not always feel able to challenge or make suggestions at what was supposed to be an educational forum. When asked if she spoke out about another case that midwives disputed and where she felt the conclusions were based on false medical assumptions, she said, "**No I don't think you would have dared actually**" (C.p8:2). In an environment where medical personnel are in authority, midwives feel they have to judge when it is worth their while to resist that authority by overt challenges.

Because We Are Women

One of the most frequently discussed problems between hospital midwives and independent midwives was the issue of who did the cleaning up work after hospital deliveries. Generally this was circumvented by much of it being described as non-nursing with an aide being employed to scrub, polish and empty after deliveries. However, sometimes such as on night shift, no aide was available and the work to prepare for the next delivery was seen as the responsibility of the midwife conducting the delivery. Chris pointed out that doctors who deliver patients in hospitals were not expected to do any cleaning up work. It is accepted that they will complete the delivery and depart leaving the assisting midwife to do most of the documentation, observation and cleaning, with or without the help of the aide. She stated that often independent midwives have been working for many hours by the time their patient requires transfer to hospital and so the cleaning up may come at the end of twenty four hours of labour care. If the client is to remain in hospital, then the independent midwife is also responsible for transferring the mother and baby to the post-natal ward and ensuring her aftercare is planned and maintained. The arguments are interesting in that the positions taken by each of the factions involve the arguments of safety and responsibility. Chris describes this as follows:

I agree we should ensure that the premises are safe for the next person but I felt that it wasn't part of our job to do this. It's one of the things that will come up at our meeting. (Refers to a meeting between hospital and others who use their facilities) But if the staff are busy then certainly I think we should help. I mean it's only good co-operation really. But if there was an aide available, then I think it was up to management to make sure there was an aide

available. And that includes weekends and night duty, which hasn't got aides on at the moment and I felt it was management's responsibility to provide that support service.... By the time you've looked after someone for 18 hours, which can happen and then you're taking them to the shower and doing the baby and doing all the paper work which takes absolutely ages the last thing you need to do is all the cleaning.
(C.p17:1)

Chris refused to see cleaning up as a midwifery problem. She was taking the issue from a personal conflict between midwives to one concerning administrative structures. Chris' expressed philosophy, allowed her to view her responsibility to lie primarily with her clients rather than the cleaning task. While acknowledging that it was in the interests of incoming clients to maintain a clean, "safe" environment, she was not drawn into the argument on personal grounds. Chris was willing to fight this battle with the hospital management. Here the midwifery philosophy of the primacy of women-centred care, has been an empowering one. They can assert their right to have an aide's assistance with cleaning by being clear about their practice priorities and argue that lack of such assistance is detrimental to the care of birthing women. The use of the safety argument, which is so often used by the medical hierarchy (refer Chapter Two), is now seen as important in relation to the needs of childbearing women.

Summary

Chris is strong in her belief that the midwifery model of practice is beneficial to childbearing families. Her expert skill and knowledge, grounded in practice, enables her to be a strong advocate for her profession. Chris recognises that this is a difficult task when the dominant medical discourse is so pervasive. While she is able to reflect on which actions are empowering for women, she has some questions about the best way this might be achieved though this is not because she is unclear about her practice priorities. Her hesitancy does not stem from her uncertainty about her practice priorities but rather, it is due to her consciousness of the hegemonic structures which maintain the ascendancy of the medical model and the complex relationships between doctors, midwives and childbearing families.

Chris has found several means by which she can resist the dominant medical paradigm and work from an alternative midwifery model. Thus she goes beyond enlightenment to engage in action which is emancipatory for both midwives and women. The counter-hegemonic strategies are both passive and active. Some involve directly

challenging the medical model of practice for which she engages in a process of ideology critique. She is conscious that acts of midwifery are political acts because they make midwives and midwifery visible.

CHAPTER SIX

SUE

Being a midwife

Sue had practised midwifery in rural and urban areas both in hospital institutions and as a homebirth midwife. Her midwifery philosophy was based on choice for women within an underlying focus on birth as a normal life process. She saw childbirth as a time for women to find inner strength within themselves which enhanced their self concept.

...for me it means being with women in a way that strengthens them and makes them more whole, not just for that birthing time but for later on as well.

R. It's reaffirming women as women?

Mmmmm. Yeah, that's right.
(S.p4:2)

For Sue, midwifery practice was a way of empowering women which was holistic in nature. Her ideas expressed here are similar to those of Belenky, Clinchy, Goldberger & Tarule (1986) whose research showed that women could be strengthened by their ability to give birth in a way that enabled them to know themselves as knowers and achievers. Such knowledge is gained by their teacher/supporter assisting them to make sense and meaning of their experiences rather than asking women to rote learn according to the teachers perspective. Jakobsen's (1991, p.9) study also confirms this notion of birth as an "empowering experience". Of her own birthing experience she said, "I felt very much it was me, and my body, that was in control of the birth" (p.9). This way of working with women appears to be similar to Street's (1992) concept of nurturance/knowledge (refer Chapter Three). Here there is no notion of power over women but a sharing of knowledge that empowers them. The idea of care which "**makes them more whole**" is what Bassett-Smith (1988) called the authenticating process of the midwife (refer Chapter Two).

Because of her philosophy, Sue sees midwifery practice and childbirth as being so incompatible with the practice of medicine that she cannot imagine how obstetricians can combine the practice of both gynaecology and childbirth.

Something that I have never been able to understand as a midwife is how an obstetrician can also be a gynaecologist. To me they are not intermarrying disciplines at all. They come from different perspectives. One comes from procreation and life, for however long that might be. It might be just a couple of weeks after conception but it's still that wonder of new life. And gynaecology is more about physical stuff often. Something that has gone wrong with that life giving mechanism.

(S.p1:2).

Sue's perception of attendance at births as being completely different to medical treatment of gynaecological conditions is similar to the arguments that general surgeons presented when they resisted the move of obstetricians to expand into their field; that is surgery of the reproductive tract (Donley, 1986). The surgeons believed that they should be the surgical experts and doctors involved in childbirth should only practise obstetrics. However, by the process of objectification of women as 'reproductive systems' the practice of placing surgery of the reproductive system and childbirth in the same professional speciality was presented as logical and *natural*. Accordingly the Obstetric Society formed in 1927 by Dr Doris Gordon became the Obstetric and Gynaecological Society in 1936. Thus the present day system exists whereby medical practitioners in this speciality are obstetricians and gynaecologists. While Sue did not analyse her discomfit in terms of objectification of women, she had reflected sufficiently about the tension between the two specialities to acknowledge that it was incongruent to her practice philosophy. She was aware that the linking of obstetrics and gynaecology limited the perception of birth as "**that wonder of life**" and thus medical meaning and knowledge limited the practice of midwifery in ways that was not in the interests of the women giving birth or the midwives attending them. According to Sue, the midwifery focus on birth as an important event in life's process affects the approach midwives have towards their clients.

....for midwives, birthing is a normal healthy process and has nothing to do with being sick. And I think that that is the other difference with midwives and obstetricians and doctors. That doctors usually go in to ...they've got a pregnant woman and try and find out what's wrong whereas a midwife looks at a pregnant woman and says what's right. And then sees the things that are wrong only because they're not right..... Doctors look at a pregnant woman and try to find something wrong and midwives look at a pregnant woman and see what's right and when they see it's not quite right then they'll pick that up.

R. So they [midwives] see it as essentially healthy really.

Sure. Normal, and the whole of the woman's anatomy is geared up for it.

(S.p2:2)

Sue was clear that when health professionals work from a medical base they inevitably focus on detection of illness. Her focus on pregnancy as a normal healthy process meant that she worked from an underlying belief that generally pregnancy will have positive outcomes with minimal medical intervention and therefore was able to reinforce each woman in her ability to deliver her infant without routine medical intervention.

This fundamental difference between midwives and medical personnel also explains for Sue the differences between nurses and midwives. It is the nurses' adoption of the medical, sickness approach that Sue believes separates nurses from midwives.

I think that part is to do with wellness and illness. Traditionally, nursing is caring for the ill and it's really only recently that it has become preventative rather than hands on care of the ill.
(S.p1:1)

It is this illness approach that Sue believes has caused midwives to identify themselves as different from nurses. Sue clearly did not see herself as a 'nurse' even though her basic training was as a general nurse.

Sue also believes that technology which has become predominant in the medical approach to childbirth, can cause practitioners, nurses, midwives or doctors, to lose their focus of women-centred practice. She describes midwifery as being different from obstetrics.

.....some parts of what we call midwifery is actually obstetric nursing to me.

R. So tell me a bit more about that. Tell me what nurses do, compared with midwives to start off with.

Tell you what nurses do compared to midwives? Well, my midwifery practice has been so lacking in technological advance and that is how I see midwifery. And yet midwifery is being 'with women' but when you are with women and you're trying to do midwifery in a [hospital] situation when there is all this technology. It's very difficult to be 'with the woman', to keep her as your main focus and not all the other stuff [technology] as well. And I think I see nursing as, you have all the other stuff here and the client is over there [points to the far side of the room]. Whereas, with midwifery, the woman's here and the other stuff should be over there.
(S.p8:2)

Sue refers to "nurses", even though these practitioners may be nurse/midwives. In this way she distinguishes those midwives who work within a medical model within the

hospital using a technological approach from those who use a women-centred midwifery approach. "**This technology**" refers to the monitoring devices that record and display fetal heart sounds and maternal contractions. Sue feels that the technology distracts attention away from the mother as the central figure in the birthing process because it is so visible. Again Sue alludes to the objectification of women, as their bodies are seen as mechanisms which supply technological data for monitoring and analysing what is wrong, when in a hospital environment. Cooper (1993) describes a similar situation with the use of technology in intensive care units. Her research concluded that technology inhibits the nurse-patient caring relationship when the nurse takes on the values of the technology, that of "objectivity, rationality and detachment" (p.23) rather than focus on the meaning of the life event for the patient.

Although Sue is aware of how the focus on the labouring woman can be lost with the use of technology, when she is in a hospital situation, she still feels the pressure to use more technological aids when they are so visible and dominant in the labouring wards,

Personally I know I put the toco [cardiotocograph, see Glossary] on because I know that that is what is expected. Whether I think personally that it has to go on or not I'll put it on. It might only be on for five or ten minutes rather than for the whole labour or something like that but I still do. Like it's sort of like covering yourself.

(S.p8:1)

In practice areas like delivery suites the technological apparatus is very visible both in size and sound and thus supports the idea that birth is a medical event. To use the technology then becomes *normal* and *routine* and '**expected**'. Sue's statement of "**it's sort of like covering yourself**" shows that not to carry out electronic monitoring, even when she considers it not to be indicated, would be seen to be deviant or neglectful. She therefore feels compelled to use it in order that she is seen to be safe. Here Sue recognises the contradictions between her professional values as a midwife and the medical values which see technology as necessary and contributing to the wellbeing of the client, even to the extent that it becomes simply an extension of the patient (Cooper, 1993). Cooper sees this imposition of technology resulting in:

both nurse and patient are reduced to the status of objects - the nurse as an objective competent technologist and the patient as an object to be examined and evaluated.

(p.30).

The power of the environment to influence one's actions, can be seen to be part of the hegemonic structures which support institutionalised power. The unspoken protocols ensure that the technology is seen as routine and normal. For Sue, this generalises even to her body language. She gives an insightful account of how she changes when working in such a hospital environment.

I've never worked in a base hospital except as a casual and I transferred a woman once in ...[hospital] and she ended up having a normal birth. I took her along to the shower and she was having a shower before she went home and I went off to get a pad or something or another and I came back and said something like, "How are you doing?" And she said, "Is that you Sue?" and I said, "Yes". And she said, "Oh you sound like a real nurse!" [laughs] And I think that's what puts me off working in that environment because so quickly, for me personally, though some people do not have that problem because they work there more often, but you get that nurse walk and you get that nurse tone in your voice. Even if you don't put in the power points you're different to the midwife you are when you're not there.

R. And you think your environment does that?

Yeah The environment and the expectation of others ... who work there and who are part of the environment.
(S.p7:1).

This awareness of how hospital space influenced her work indicated that Sue had reflected deeply on those factors which impinged upon her practice. Having surfaced this previously unconscious behaviour, Sue recognised that her body language reflected a display of "**power points**" which were characteristic of an attitude of power and control. Such embodied actions make change very difficult and demonstrate that raising consciousness is not merely an act of cognition (refer Chapter Three). Such routine actions form a habitual repertoire of practices which perpetuate the hierarchical system of the hospital. Indeed Sue's previous comments in which she describes the need to carry out screening of a labouring woman, a routine hospital practice, suggests that this is so.

While Sue recognised the environment as influencing her in ways she would like to change she saw it as a personal responsibility stating that, "**Some people do not have that problem because they work there more often**". However, it may be that those working in the environment on a regular basis might well have not been conscious of their body language and taken on the various characteristics which represent power and control as being normal and even 'professional'. In other words such actions had become embodied within their practice.

Jakobsen (1991), refers to the unequal midwife/doctor relationship as being demonstrated in a similar way. Jakobsen's participant, a mother who had delivered an infant with both a doctor and a midwife present recognised a change in the environment when the doctor appeared.

though she is a sort of person that is quite a strong person I still feel her step into sort of second....It's a sort of slight switch in the air. Ann (the midwife) sort of has to put on good behaviour....(P.71)

Sue is aware that medical intervention during birth is frequently portrayed as something to be expected. Sue feels that most women need to be assured that they are capable of giving birth. She discussed how she teaches women how their pelvises are particularly shaped for this function: "**that's what their bodies were built for**" (S.p2:2). It appears to Sue that all women should be aware of their capabilities and have faith in their bodies. Sue feels that the ability of women to give birth is constantly undermined by the medical approach to childbirth.

She discusses her response to attending meetings in which less than desirable outcomes are analysed. The stated aims of these meetings were for the purposes of educating practitioners. Sue discusses the effects of the meeting on midwives:

As midwives we come away from the perinatal mortality meeting thinking we must be crazy...nothing normal ever happens! As a profession they [doctors] keep reinforcing... I know they use it as learning experiences but they're all really negative learning experiences all the time. It would be really neat if at the perinatal mortality meeting they had really positive reaffirming things as well. I think that if they just got a bath up there [at the hospital labour ward] and had a water birth....Would it come up under the perinatal mortality meeting that this could be done and how great it was for the baby and the woman? They wouldn't..[laughs],
(S.p8:1)

Sue demonstrates an awareness that the medical meeting, ostensibly set up as a learning experience, also has the covert role of reinforcing medical management of childbirth by constantly reminding them that birth is fraught with danger. Her example of how an alternative birthing facility would never be discussed at the meeting demonstrates a degree of cynicism about the educational purpose of the meeting, knowing "**they wouldn't**" because it would detract from the medical focus.

Sue's strategy for confirming her midwifery knowledge and philosophy in the face of such constant presentations which confirm the medical model, is to reflect on her own practice experiences.

I keep looking back. When I'm really feeling concerned about something I keep thinking, "Do I need to consult? Do I need to do this? What might the consequences be?" I go back to my practice and the normality of birth is reaffirmed. Do you know what I mean? Rather than the other way around. I mean I don't go back and think, "Oh [expletive]". I go back to my practice and think, "Yes this woman can do this. Yes it's okay. Yes!"

(S.p8:1)

Sue's counter-hegemonic strategy to the notion of birth as abnormal is to reflect on her practice experience. From her knowledge, grounded in practice, she is able to affirm for herself what she knows: that birth is for the most part a normal life event. Street (1992) refers to Polyani's concept of tacit knowledge to describe this practice based knowledge, which is context specific and experiential.

Polyani describes this as "connoisseurship" which recognises the qualitative judgements involved in clinical knowledge, a perceptual, intuitive grasp of the whole situation which can never be reduced to sets of rules to be technically applied in the situation. (p.196).

Sue is able to resist the definition of birth as a potentially abnormal event and question routinised medical interventions. Though, as described above, this becomes difficult in the hospital environment due to the multitude of explicit and covert hegemonic structures which serve to maintain the status quo. Such structures perpetuate what Freire (1970, p.215) calls "a culture of silence" which maintains the domination and authority of the powerful group by suppressing alternative ways of knowing and acting.

Making Midwifery Visible

Sue believes that midwifery expertise is unrecognised and thus invisible to other health professionals. She gives an example of rural maternity practice in which country doctors are often seen as courageous experts yet Sue suggests that it is the midwives who have the knowledge and practical skills.

The GPs in town would talk about how the GPs in the country were so much more capable and able to manage. But it wasn't the GPs that were able to manage it was the midwives who worked in those units who were able to detect when things weren't quite right.

(S.p2:1)

Yet Sue was to find that it was not only doctors who did not recognise the value of midwives. When talking to a group of post-graduate nurses at an education seminar Sue had asked them about their births:

The first question I asked was, "A number of you would have had children. Who were the people who were at the birth? Who took the responsibility for the birth of your baby and looked after you and that sort of thing?" And they all said, "The doctor," straight away. And so I asked, "Who else was there? Who was there when the baby was being born?"... "Oh the nurse," you know. These were health practitioners and they cannot actually identify the midwife as being the person who actually gives them the care during birth and before and afterwards. You know I find that really depressing. Because I feel if health practitioners don't identify midwives as being the people who have got the most to offer at that time, then how is anybody else supposed to identify them in that way.

(S.p3:2)

By reiterating the taken-for-granted myth that doctors deliver babies, rather than women and midwives, Sue's audience reinforced the invisibility of professional midwives and nurses. At the same time, they unwittingly enhanced the claim of the medical profession that birth is a medical event. Midwives as legitimate carers of childbearing women were thus reduced to doctors' handmaidens and were, according to Sue, almost made extinct by the invisibility of their work.

Professional Power and Obstetricians

Sue was aware of the influence of Joan Donley's speech entitled Midwives or moas (1988) in which she rallied midwives and consumers to resist the medical model of childbirth. From this meeting midwives and consumers resolved to work to increase choice for women by increasing the acceptability and influence of midwives as "guardians of normal childbirth" (Donley, 1986, p.1).

Women and midwives came together with a common interest of regaining the power to ensure childbirth returned to the control of women and their midwife attendants. This process of enlightenment is described in Chapters One and Two. Sue knew that this was not an automatic process. She was aware that obstetricians had a great deal of power through their authority of knowledge and that they, the obstetricians, wanted to maintain that monopoly by what she saw as controlling the practice of midwives.

And Joan Donley always said, "We've got to stay out of the power of the obstetricians," and that has certainly been our battle. And

that to me is the independence part I guess. Not only independent of the Area Health Board but independent of the obstetricians, who control the Area Health Board. Because certainly they would like to manipulate and control our practice.

(S.p7:1)

While Sue saw the necessity of being an autonomous practitioner she also knew that there were times when she would be obliged to work with obstetricians and doctors.

Secure in the expertise of her midwifery practice Sue prefers to work with obstetricians as a professional partnership when in a shared care situation. She was therefore particularly angry with one consultant who refused to discuss case management with her and the client but instead took the woman aside without acknowledging Sue's presence. Sue decided to challenge this behaviour:

Well I felt sufficiently angry that I made three appointments to see him at his rooms. And each time it was cancelled. I just really wanted to say to him that if we were caring for a woman together then I expected us to care for her in a professional way and if there was some discussion that needed to take place then we would do it together. And if he felt that the woman should be there then that's fine but he wasn't to do it without me being there. I just had no confidence in him.

R. But you didn't get that appointment?

No.

R. Who cancelled them?

I don't know, his nurse would ring and cancel. So in the end I thought awwwww [laughs]. If it comes to that I'll just say it to his face at the time. But I felt really betrayed by that.

(S.p6:1).

In spite of her persistence her attempts to get an appointment were unsuccessful. She said it made her **anxious** (S.p6:1), in case she had to work with the obstetrician in the future. The fact that she felt "**betrayed**" demonstrates Sue's belief in equal professional roles whereas the obstetrician had continued to thwart her attempts to confront him/her. This ability of obstetricians to dictate the terms by which they work with midwives and avoid challenges to that power is further evidence of their inability to see midwives as professional, independent practitioners with whom they should communicate on equal terms. In this case the obstetrician appeared to ignore Sue's attempts to set up a meeting with him in a way which demonstrated his power and control of the situation and maintained the status quo. He did not, for instance, attempt to give Sue alternative meeting times leaving her to make further

appointments. As a result of such power plays distorted communication patterns arose (refer Chapter Three) which resulted in Sue being "angry" and "betrayed".

Sue suggests that doctors find it difficult to communicate as professional equals with midwives as they have been socialised into believing in their own superiority.

Because they have never considered anyone other than other medical people to be on the same level as them. Like the obstetricians we have here are all of a similar age group, which is a bit older than me or the same age and I know by talking with people who went to medical school when I was doing my nursingat medical school they are told that they are god and they are up there, and they have the ability of life and death.

R. It's part of their socialisation?

Yeah, just put up on that pedestal and nurtured up on that pedestal all the time they are at medical school and then they come out and act like that, so everyone treats them like that. [laughs]

R. So you think that is quite a big constraint. It's their arrogance that's a constraint to you working together?

For sure. It's a huge constraint to honest constructive communication. It's very hard to talk on the same level to someone when they are up there [holds her hand up high] When they think they are up there..... Yes, they perceive themselves to be up there and I suppose until recently so did a lot of other people. Like the community, other professionals have put them up there as well. It's only, I think, particularly as midwives have realised our own worth, that we have realised that we are just as meaningful and have got just as much to offer as they have. But that's only in the last ten years as well.

(S.p4:3)

However, Sue acknowledges that individual doctors sometimes not only supported midwifery practice, but also consulted midwives in a more collegial way

And they've consulted, I mean really consulted. Asked opinion, taken advice and things like that. It's been a two way communication thing rather than the other way round...them dictating what care should be.

(S.p7:1)

Here, while recognising that individual obstetricians might see midwives as colleagues, Sue is able to distinguish between personal attributes and those collective groups and structures which work to maintain power and prestige at the expense of other health professionals. Street (1992) found that many of her nurse participants were at what she called the "the naive reforming stage" (p.225) whereby they considered that when certain personalities were removed then the oppressive situation would change. However, she points out that this prevents the in depth analysis of the underlying

structures and assumptions which perpetuate inequalities and conflict. Sue however was able to move beyond this stage to critique the basis of inequalities of the midwife doctor relationship, that of the assumption of the superiority of medical knowledge and the taken-for-granted acceptance of medical domination. As a result of this critique she was able to reflect on those structures which supported those assumptions.

Sue was aware that the training of doctors served to establish their superiority and thus perpetuate a system of dominance. Here education becomes another hegemonic structure whereby the perceived superiority of the medical profession has maintained a hierarchical structure which is not conducive to "**honest constructive communication**" (S.p4:3). Fay (1986) agrees that true communication can only take place in an environment of trust. Sue states that midwives have "**realised their own worth**". As a result of a process of enlightenment midwives have been able to recognise and define their practice as different but equal. It is not surprising then that midwives and doctors fail to communicate, given their mistrust of each others' practice philosophies.

Sue distinguishes the consultative sort of communication from other types of dialogue which appear to request information from midwives for the purposes of discrediting their practice. She related an incident in which she was closely questioned by a member of the medical profession about the midwives use of homeopathic remedies. During the discussion she began to feel uneasy about the purpose of the questions. She decided that doctors who make no effort to learn for themselves about alternative midwifery practices should be challenged "**to see where they are coming from**" (S.p11:3). This demonstrates Sue's awareness of how midwives' knowledge may not be used as a means of professional sharing but to gain power/knowledge over them (See Chapter Three). However, Sue realised how important it was to confirm midwifery practice with her colleagues. To this end some midwives had considered setting up a midwives' collective and which met fortnightly to discuss professional issues. She acknowledged the importance of a safe environment which would enable midwives to freely reflect on and share their practice

...I don't think you can talk about practice in a constructive way until people feel safe about talking about their practice.
(S.p6:3)

Sharing Knowledge

Sue thought that midwifery knowledge has remained hidden partly because it was seen as women's knowledge and therefore denigrated and devalued. Sue pointed out that even when midwifery knowledge led the way in childbirth practices its contribution was not acknowledged.

Like it wasn't seen as a positive thing that they [midwives in the past] were doing. They were seen to be doing all these secret, sort of spiritual things that men couldn't quite fathom. Like it was all very secretive as far as men went.

R. Do you mean the women kept it secret from the men or the men just saw it like that.

No, the men saw it like that. I mean the women probably kept it secret as well, because they couldn't trust the men obviously. They couldn't trust the men with the knowledge.

R. I wonder then if midwives have gotten back into that secretive stuff.

I don't think midwives have ever got out of it. That's a personal feeling of mine that as midwives we are very secretive about the little things that we learn on a personal level that have been helpful to us. And the person I learnt from, was Joan Donley the domiciliary midwife. She started to bring midwifery out of the closet: not just in a professional way but also in practice and she has encouraged us in the last fifteen years or so to share our knowledge with each other. And until she came along we weren't doing that.

(S.p9:3)

Sue believes that knowledge contributes to power and therefore considers that it has been necessary for women to be "secretive" about their childbearing practice in order to keep it safe. However, she also sees that knowledge needs to be shared so that it becomes visible, "out of the closet" and valued. Sue recognises that midwives do not often communicate with each other in constructive ways.

R. So do you think that would help? Talking about the practice more?

Yeah I think it would but I think locally that there are personalities that need to be dealt with as well. Like I don't think you can talk about practice in a constructive way until people feel safe about talking about their practice.

(S.p6:3)

Dialogue between midwives was difficult according to Sue due to "**personalities**". Here she defines differences as personal and focuses on individuals rather than recognising the actions, or lack of cohesiveness as being due to the hegemonic structures in which groups participate in their own oppression.

Summary

Sue demonstrated a great deal of awareness of the interests served by the various hegemonic structures within the childbirth domain. Her reflections on her practice environment enabled her to surface those factors which constrained it or prevented her from practising in ways that she wished. This included distorted ways of communicating between the professional groups, embodied ways of practising, and the invisibility of midwives work. Sue had several strategies by which she resisted attempts to maintain the medical model of practice. She attempted to confront medical personnel who refused to recognise her as a professional equal, and reaffirmed her practice philosophy by sharing with others and reminding herself of the normalcy of childbirth. Such strategies can be termed counter-hegemonic and are the continuation of the transformative process which began as midwives worked towards legislative autonomy.

CHAPTER SEVEN

MARY

Being a midwife

Mary did not offer a homebirth service at the time of the research. All Mary's childbearing families chose to deliver in hospital. Mary described the broad scope of midwifery practice.

Yes, it covers a lot of things. You become a social worker, a counsellor, a midwife and you do some of the screening things a doctor does as well. If you are doing total midwife care you are doing much more than what the doctors do, and you become a taxi driver because often you take them places, and an educator, and all sorts of things, and a friend. A friend is really important.

(M.p5:1)

Mary discussed the frustration of being a "friend" while having to fit the constraints of her work-life in with perceived client needs. Some clients did not fit in with the allowable paid period for postnatal visits, yet she saw that as a friend, she could not ignore them in their time of greatest need.

You can't just pick a person up and then just drop them. Once you get involved with them you've made a commitment to that person and you just can't just dump them and if they still need you, you have to be there and that's all there is to it. You just carry on with them. You are their friend and you do become their friend when you get to know them, especially if you've seen them a lot of times antenatally and you get to know the other children in the family and the husbands..... They rely on you, and they trust you....

(M.p6:1)

While Mary sees the importance of establishing a trusting relationship with childbearing women and their families she is aware also of the need to rationalise her workload. Unlike doctors, who for the most part operate their obstetric practice from an office surgery, Mary works from home and visits women in their homes to establish a friendship in which professional and personal boundaries meld. In this way a partnership is established with the childbearing families and Mary is able to maintain continuity of care (refer Chapter Two).

Even though Mary did all her deliveries in hospital she saw her work as different from that of hospital midwives.

You are always going to need hospital midwives to a certain extent, because they are the ones that know about all the high tech equipment andall the serious things when you need them. They are like specialists in a way. I mean they know about all the specialised equipment and stuff and they are familiar with it because they use it a lot more. And so you are still going to need them.

(M.p11:1)

Mary recognises the hospital midwives expertise in "**high tech equipment**", as a necessity for abnormal, "**serious**" maternity cases but did not see it as part of her work in the care of normal birthing women. Mary considered that the eight hour shift that midwives worked was incompatible with the philosophy of continuity of care which the midwifery model embraced.

I think you have to have a change in the attitudes in some of the hospital midwives, and some of the hospital staff, and some of the hierarchy in the system, because it doesn't work like a normal shift system.... And if the hospital hierarchy were prepared to change that system and allow a lot more flexibility for the individual midwives .. I think it could work. But the whole system needs to change.

(M.p11:1)

Mary appears to see that the solution to fragmented care is to change the sort of time structures midwives work so that they can be with birthing women throughout their labour, rather than in eight hour shifts. While this statement suggests reflection about practice priorities, Mary did not further her analysis about how the division of the childbearing process into antenatal, delivery and postnatal segments was a way of objectifying women's bodies according to the Cartesian, medical systems approach. The idea that "**some of the hierarchy in the system**" are the main constraints to changes oversimplifies the position whereby childbirth, situated within a medical hospital system, carries with it the ritualised components of shift work, and hierarchical decision making which are embodied and embedded in the unconscious actions of those who work within it. Moloney (1992) suggested that there was a reluctance for alternative roster systems to be instituted by those in decision making positions even though the initiatives were proposed by hospital midwives. She stated that this was due to the system of shift work which met the needs of hospital management rather than the needs of birthing women.

Burnout

Mary realised that with a philosophy of continuity of care, which may result in very long hours, she had to keep herself healthy in order to give quality care to her clients. To prevent burnout Mary has established several strategies.

At the time of the original interview she had made a decision to reassess her workload.

I haven't really had a holiday for the past two years. You know only a couple of weekends off here and there when I haven't been on call and that's usually been for courses and things like that. And when I'm on holiday and I'm anywhere near town, you sort of feel obliged to take [attend their deliveries] people that haven't delivered.

(M.p6:1)

Mary felt "**obliged**" to maintain her practice caseload even when she was on holiday. This highlights the difficulty of independent midwives who consider themselves the "**friends**" (M.pp6:1) of the families they work with as well as their health professional. To overcome the problem of long hours and a high workload Mary had considered working in partnership with another midwife.

I think if you had a team practice it could help in some ways but it partly defeats the purpose of having continuity of care, the same midwife all the way through.

(M.p6:1)

The underlying concept of "**continuity of care**" which independent midwives claim as one of their important practice foci is difficult to maintain due to the unpredictability of birthing needs in terms of time. Mary recognised that the problems of twenty four hour call needed to be addressed. However, the potential for burnout was not because of the long irregular hours. What Mary calls "**political stress**" also contributes to burnout.

I think a lot of it comes from the political stress. There's a lot of political stress and underlying currents that cause a lot of stress. Just having to be on the alert the whole time... In a way you're sort of on the defensive all the time.... you try not to be on the defensive but you've got to have your wits about you all the time, if you are working with anybody like any doctors or any hospital staff, and you also have to perform very, very well, because the slightest mistake you make, everybody comes down upon you like a ton of bricks. And somebody else in the hospital makes a heaps worse mistake but nobody says boo to them, but just because we are new and because of what we are doing at the moment, and because some people are feeling threatened by that. Yeah, it's quite a lot of pressure I think, to make sure you perform well, and you almost have to perform exceptionally well and just make sure you

don't say the wrong things and things like that. All midwives may not feel like that ...

(M.p7:1)

Mary is not just talking here about the stress health professionals feel when they need to perform at a high level due to the particular focus of their work. Here she recognises that midwives are under constant scrutiny as they try to create a niche for themselves as autonomous health practitioners. She feels compelled to **"perform exceptionally well"** as she tries to change the boundaries of accepted midwifery practice. While she did not describe it in terms of power Mary is aware of the sanctions likely to result from any mistakes she might make. The statement that **"everybody comes down on you like a ton of bricks"** illustrates that she feels she is in a hostile environment when working within the hospital. That this makes her feel **"defensive"** is not surprising though she considers it may be a personal problem: **"All midwives may not feel like that"**, rather than an institutionalised system of power which seeks to maintain the status quo.

Bridging the Gaps

Mary chose not to work as a homebirth midwife so all the women with whom she worked delivered within the hospital. Mary felt she had to work hard to be accepted as an independent midwife working within the hospital system.

Midwifery wouldn't get too far with people like me because I'm a lot quieter and because I've been very conscious of building bridges with doctors and things like that and I've gone their way a lot.

(M.p13:1)

In **"building bridges"** Mary had to compromise her practice ideals to be acceptable and to be considered safe by the medical practitioners and others with whom she worked and, to some extent, relied on for referrals.

I really wanted to create a good impression and I've always wanted to make it good for the midwives coming up and so I've done things that I would like not to have done, but I've done them because I've felt that it's bridged gaps. Like I've really tried to bridge gaps with doctors and tried to get good working relationships with the doctors and the staff at the hospital and that takes quite a bit of effort sometimes..... Well I think the main thing is to really make sure the lines of communication are open and you really have to go on overtime to do that because they [the doctors] don't do that with you. Well one or two of them might but most of them don't....

(M.p7.1b)

Mary appeared to accept that it was her responsibility to forge a professional relationship with others who were already established in the hospital system. Mary states that generally doctors did not see this as their role. This may be because doctors consider that midwives are mainly there to assist them rather than to work with the woman in labour. Street (1992) outlines a feminist analysis of nurses' hospital relationships and suggests that the profession works in ways that mimic the female role in a family. Similar to the manner in which the mother takes responsibility for nurturing relationships in the family, women health professionals working in hospitals are seen to take on this function.

Mary considers that good communication will assist in a three way partnership with the midwife, the doctor and the woman.

I think a lot of it has got to do with good communication and this is where a partnership with the doctor and the midwife and the woman can work really well because if you are discussing it, and the doctor trusts the midwife, then he listens to what she has to say and she is more in tune with what the woman is doing than the doctor is...I think with good communication you can work these things out between you. And then you know if it is really important that the doctor is there for delivery, then you can work it out but then the doctor doesn't mind being called earlier rather than later. Whereas some doctors get very cross at being called too early for a delivery and they are the ones who miss out on the deliveries because you can't call them too early....
(M.p12:2)

Mary did not seem surprised that "**some doctors get very cross**". She recognised that they have false expectations that precise delivery times are manageable and predictable and they will not be called too soon and have to wait around for the delivery. She did not analyse these expectations in terms of hierarchies of power or examine in whose interest is the delivery conducted and who should be the focus at this time, the woman or the doctor. She does recognise that as a midwife she is "**more in tune with the woman**" and is therefore in a better position to make decisions with both the woman and the doctor.

However, in order to build bridges in the relationship Mary is willing to concede the role of team leader to the doctor and allows him/her to dictate the terms of their partnership to a greater extent.

As far as my philosophy goes I don't personally have too many problems with the GPs because I don't push my philosophy. I really try to work in with them and so if they want to do all the antenatal care, and they want to do the delivery, then I let them and my visits then become extra visits but I think that is important

until they get used to what I'm doing. I mean it's already proved it's worth because now as things have got better, the GPs are doing more and more proper shared care. So they will do alternate visits with me now, whereas before they wouldn't...

(M.p8:1)

I just assume that if the doctor's there and she [the birthing woman] was his client initially then he would be the primary caregiver. Okay, I'm the primary caregiver when she is in labour but for the hospital record and for the political view, he is the one. So that's okay and if it's total midwife care, well then, I am [the primary caregiver].

(M.p9:1)

I usually try to put it so that they're making the decisions. Like, "Do you think it would be a good idea for them to have some antibiotics?"

(M.p5.2)

Here Mary's strategy to maintain a harmonious relationship with the doctors is to concede to the doctor the role of "**primary caregiver**". This would mean that the doctor would be the team leader and take ultimate responsibility for decision making. She is aware that this is a "**political view**" on her part in that she enables the doctor to appear to be in charge. This strategy has been described in Chapter Three as the doctor/nurse game.

Mary and I discussed the difficulties of ensuring that women were able to give birth the way they chose while ensuring that the doctor still felt he/she was the team leader.

That can be a little bit difficult with some doctors. Sometimes the doctors come in at the end and the lady is in whatever position she was going to be in anyway and they can't really do anything about it because she is not going to shift. I do try to be a bit considerate if I know that certain doctors want certain positions, then, if I think it's not hindering the lady or her progress, I'll try to accommodate that for the doctor. Like if there are doctors I know want them on the bed, well then we try to find a position on the bed that is suitable for the lady and is acceptable to the doctor. I haven't had many problems with that.

(M.p5.2)

This form of action in which the subordinate group adjusts to the needs of the dominant one so that overt confrontation is avoided is described by Street (1992:79) as "*accommodation*".

R. So you tend to do what the woman wants but keep in mind what the doctor wants as well?

Yes, but I haven't had too many women who have been really adamant that they want certain things. We've usually talked about most of this during the antenatal period and if they are

really adamant about certain things then we talk about it and discuss it, because I don't believe you can be too adamant about a lot of things when you are having a baby, because you [the birthing woman] just don't know what is going to happen at the time and how you are going to feel at the time and it doesn't matter how adamant a woman is in their antenatal period quite often they will change their mind when they are in labour. So, yes, usually we discuss it and I suppose I try to get the ladies to be reasonably open minded, because I know it is very difficult if you [the birthing woman] have set thoughts and ideas and it doesn't happen then you get very disappointed afterwards.
(M.p5.2)

While Mary appears to collude with the doctors in maintaining their power by suggesting that women keep "**reasonably open minded**" about their delivery outcomes, in a later interview Mary said this was not her intention. Rather, she wanted to ensure that women were aware of all the possibilities that may occur during birth so that they might adapt their approach as the labour and delivery progressed. While this approach may dilute the active resistance by women to routine interventions, Mary believes that women who are adamant about birth options are likely to "**get very disappointed**". Mary did not appear to consider that the reason she hasn't had "**too many women who have been really adamant that they want certain things**" may be a result of their socialisation and a belief that medical personnel are the best people to make decisions and choices about their birth choices.

In discussion about whether Mary felt there were times when she should deliver the baby instead of the doctor, she replied:

When a woman specifically requested that her doctor was called late, so he wouldn't be at the delivery... I have done that at the woman's specific request.
(M.p11:2)

Here Mary had taken action as a result of a "**woman's specific request.**" This is a form of mutual empowerment of midwives and women as they work together in partnership as outlined by Flint (1993). The delay in calling the doctor is described as responsible subversion by Hutchinson (1990). This passive resistance takes place when caregivers bend rules in order to better meet the needs of their clients (refer Chapter Three). However, it still means that decision making remains hidden for both the woman and the midwife. The structures remain that support the taken-for-granted authority and power of the doctors to act autonomously rather than in partnership with the woman. This would occur only when the doctor asked the woman who she would prefer to assist her delivery.

Mary stated that now she has more confidence she is able to assert her requirements of shared care:

....I'm changing. And as I've got more confidence and more experience and everything is changing a lot. And I've got the doctors' confidence now, I can step out and be a lot more assertive and do a lot more things and say to the women, "I won't take you on unless your doctor will do alternate visits with me," and stuff like that. Which is probably what I am going to do next year because now I've got their [the doctors'] confidence. But they could turn around and say, "No." Well, then the woman would have to choose. But I also think they would be more appeased to the idea because they already know me, and they have already worked with me to a certain extent.

(M.p13:1)

Mary is aware that by choosing to "**build bridges**" she has had to compromise on some of her practices. She states that one of her priorities is the ability to negotiate shared care with doctors. However, her statement indicates that it may be left for the woman to take a stand with her doctor rather than Mary stating to the doctors her terms of partnership. She is aware that the doctors may refuse to work this way but feels that now that they know her, she has the doctors' "**confidence**". This illustrates that Mary's thinking rests at the level of personal rather than structural analysis.

Economic Interests

I discussed with Mary how the delivery of the baby had become the focal point of medical concern. Whereas midwives saw the pregnancy, labour, delivery and aftercare as a continuous process, doctors placed each segment into separate episodes with birth as a crisis situation. Mary reflects on this delivery focus:

Yeah. It's funny isn't it. Like you [the birthing woman] need a doctor at the end to help you out. You've done everything else yourself but you [the birthing woman] aren't able to finish off the job. [laughs] And in actual fact that isn't true at all. Sometimes it is but most times you [the birthing woman] can do it very well by yourself and you don't need them [the doctors] at all. The women do it all themselves with a little bit of coaxing and encouragement and support.

R. So why do you think doctors and midwives get paid more for the delivery? I wonder if 'doing the delivery' is well paid because it is important or is it important because it gets the most pay?

Probably it has become important because it gets the most pay, I would say. From the doctors' point of view, I mean, they don't do anything else. They don't get paid for anything else. I mean they get paid for their antenatal and postnatal visits but they don't really get paid for anything else because they don't do anything else.

(M.p9:2)

Mary did not analyse the emphasis on birth as an issue of power and control but reflected on the economics of the situation. Her reflections demonstrated the beginnings of consciousness where the taken-for-granted structures and patterns of practice might be examined. She recognised that women gave birth and that birth attendants were there for "**coaxing and encouragement and support**" rather than the delivery.

Mary discussed the problems of setting the fee payments for doctors and midwives. She suggests that doctors were "**hassled**" (see quote M.pp9:1b below) since midwives not only got the same delivery fee as doctors but also got a *prolonged attendance* fee which recognised their attendance throughout labour. This labour care fee was not generally paid to doctors, being essentially midwifery work. Doctors usually left the labour care to midwives and only attended when notified by the midwife that the woman was about to deliver so the doctor may be with the woman only a short period for the actual delivery. This meant that the total antenatal, delivery and postnatal fee may be less for doctors than midwives. Mary suggests that this was only fair since in terms of quality time, midwifery care contributed many more hours than medical care. She gave antenatal visits as an example.

...and I spend two hours with that lady and get \$20, and so I think the labour [prolonged attendance fee] and delivery fee, while it was a lot if you looked at it in isolation, if you actually look at it for the whole care during the pregnancy, I think it worked out quite even and it covered all the extra things that you'd done and all the extra time that you'd put in, and that doctors don't put in, and therefore they don't need that extra. So I don't really have a hassle with the money. We earn it. I know that that is what the doctors get hassled about, but they'll get used to it.

(M.p9:1b)

Mary did not analyse the payment of 'prolonged attendance' fees as being a threat to doctors because it now made the contribution of midwives work visible. Previously, when hospital midwives cared for birthing women as part of their normal shift it was taken-for-granted that a midwife would do this work. The cost and contribution of this work to childbirth remained invisible until independent midwives were paid on a different scale to their hospital colleagues. Once independent midwives had their services costed in a similar way to doctors' fees, the length of time midwives spent

with birthing women became visible and could be counted as 'real work'. For doctors this not only meant that midwives had access to payments that they did not usually claim, but it also meant that midwifery work was defined and recognised as being different to that which they offered. Doctors were already arguing that they were the health practitioner that gave continuity of care to their clients by stating that they continued to look after the client and her family before and after the birthing process was completed (Royal New Zealand College of Obstetricians and Gynaecologists, 1989). However, once the work of the midwife was made visible, this weakened their case by demonstrating that it was midwives who in fact attended birthing women and had the greater input throughout her whole pregnancy, birth and aftercare.

Mary's suggestion that doctors will "get used to it" may be somewhat naive. The doctors' "hassle" may be much more than simply an economic consideration. Recognising midwifery knowledge through monetary reward threatens doctors' power/knowledge. It strengthens the midwives' case for claiming a particular knowledge and skill base.

The competition for fees is, according to Mary, the reason doctors are concerned about midwives who practise independently even though doctors were able to get an equivalent fee for delivering infants along with the attendant midwife.

I think it is the money that they get upset about. It's not really the work we do because I think underneath they really appreciate it.
(M.p8:1)

This statement also shows the concern for economic interests by the doctors. Mary considers that the doctors appreciate the midwives "underneath" suggesting that their acknowledgement of midwifery expertise remains unarticulated, unstated, and therefore invisible. While midwifery practice and expertise remain invisible the professional relationship between the midwife and doctor remains hierarchical. The doctor claims power through the authority of medical knowledge while showing reluctance to legitimise midwifery knowledge.

Power Relationships

I explored with Mary how major decisions were made during childbirth:

R. So who do you think should be making a decision?

Well I think you have to assess each case as an individual but I don't get any say in it because I am the midwife. And the midwife seems to be on the bottom of the line really. If a specialist is involved then the specialist automatically has all the decision. If a GP is involved then the GP has all the decisions, and if you've got a good GP then they will work in with the midwife, and discuss things, but usually they just do things. Say things and do things.

R. So the ideal situation would be what?

Would be for you to have a meeting and discuss with the woman and all the practitioners involved and discuss what was going to happen and what everybody felt would be best.

(M.p8:3)

Mary acknowledges that "**midwives are at the bottom of the line**" and are not seen as having a legitimate input into decision making during childbirth. This refusal by medical personnel to recognise midwifery expertise ensures midwifery knowledge remains subordinate to medicine and thus the dominant medical discourse prevails. Whereas for Mary the partnership should include women as well as the midwife and the doctor, she acknowledges that this rarely occurs. That the medical specialist "**automatically**" makes the decisions illuminates the taken-for-granted power/knowledge of medicine. This is not to deny medical expertise and knowledge necessarily. More it is the assumption that that knowledge gives medicine the right to make *all* the decisions without consultation.

Mary also believes that doctors have an elevated view of their status. According to Mary, status is perceived to be god-like:

...they've always been held up here, you know. They're god. In general practice that has gradually been reduced and they have had to become more people oriented and communicative and giving people an option for what they want for their bodies and things like that. They've had to become a lot more human. But there's a lot of hospital doctors who haven't got that because you [the woman] are admitted to hospital and you are on their turf and their territory, and they can say what they like to you, and do what they like to you and then you are very very powerless...And I think it's just those general attitudes and specialists have got it real bad.

(M.p8:3)

Mary understands that the hospital environment, in which doctors are dominant, ("**you are on their turf**"), contributes to the power of doctors. While a woman is on "**their territory**" she is "**very very powerless**". Mary is conscious that the hospital appears to be there for the doctors. There is no questioning of this taken-for-granted medical authority in an institution which is supposedly for childbearing families. Neither did Mary suggest that a change of environment, such as birthing at home or in a birthing centre, would contribute to increased power for women. However, she did acknowledge that doctors maintained their power with the collusion of those who now protest about their superior stance.

Yes, I think it's just a general attitude. And it's not all the doctors' fault either. Part of it is because people have put that on the doctor. We have put them in that higher position and now we are trying to tear them down, but there are still people who still put them in that high, elevated position and it's almost like they are giving them the power because maybe they don't know any better.
(M.p2:3)

In suggesting the "**it's not all the doctors' fault**" Mary recognises that medical dominance is supported and sanctioned by the community. This is an example of hegemony as described in Chapter Three. Mary is aware that the dominance of the medical model influences the manner in which health professionals deliver care.

I mean to be a midwife you know what labour care is and that sort of thing, but if you are in a situation where that's what is done in your hospital, and that is what is expected of you, then it is very easy to slot in to doing that... even if you know that that is not the thing to do. But if you are in a hospital where labour care is really done very efficiently, and where the midwife really does support the woman, theneverybody starts to do that, and they just get on and do it because that is what is expected, and that's what you do, and that's what being a midwife is. But if you are in a hospital where you give your patient lots of pain relief, and you don't sit with her, and you don't stay in the room with her, even if you are a hands on midwife, you slot into that pattern because that's what is expected.
(M.p12:1)

It's just that she (hospital midwife) is working in a different environment under a different system.
(M.p10:3)

The constraints that hospital midwives experience because "**that is what is expected of you**" within the system were recognised by Mary. These expectations are those of the dominant medical discourse ("**working...under a different system**"), with little acknowledgement of the expertise and supportive role of the midwife. Medicalised childbirth is perpetuated by midwives who feel constrained by the taken-for-granted efficiency of high technological and pharmaceutical care. When such care is

"expected" it becomes embodied and embedded in the practices of midwives, (**"it is very easy to slot in to doing that"**), who are constrained from caring in alternative ways. Mary recognises that change is instigated by the acceptance of a different way of practising; **"on the whole everybody starts to do that"**. Mary considers that it is her particular philosophy that enables her to work differently even though she too works in the hospital environment. She is unsure however if independent midwives do have real power to practise the way they wish to:

I suppose you do have a little bit more power, even if it is power that you can't use...It's to do with the relationship that you have with the woman and the hospital midwife doesn't have that relationship with the woman, and she [the woman] looks to the doctor all the time because he is the one making all the decisions and saying everything, and so therefore the midwife's role gets overlooked.

(M.p10:3b)

Mary is not sure about the true extent of her power to practise because, **"it is power that you can't use."** However, she does acknowledge that the relationship with the childbearing women gives credence to the role of the midwife. This again is a confirmation of how women empower midwives (refer Chapter Two). Mary recognises that the work of hospital midwives remains invisible even to the woman with whom she is working because the woman **"looks to the doctor all the time."** Here it is the woman who colludes with the doctor, maintaining his/her power. The opportunity of empowering the woman by giving her confidence in her own ability to take control of her birthing process, in partnership with the midwife, is thus lost.

The Safety Issue

Asked if she thought doctors had concerns about independent midwives safety to practise Mary said:

I think that probably specialists do, but I don't think it's the GPs so much. It's the specialists more than the GPs I think. And that's because the specialists regard the GPs sometimes as unsafe as well. That's an attitude problem that specialists [obstetricians] have. And I think if they just concentrated on dealing with the abnormal, which is what they're skilfully trained in and we need them for that, and cut out doing the normal deliveries and just left them to people like midwives and GPs, then it would be okay.

(M.p10:1)

Mary suggests that specialists have the most difficulty with midwifery practice because they have an **"attitude problem."** This attitude was not attributed to their philosophy but their belief that they were the experts in childbirth and therefore did not trust either

general practitioners or midwives and regarded them as unsafe. She does not accept this power/knowledge of the specialists but asserts that "**midwives and GPs**" should be left to do the normal deliveries, indicating that she believes they possess the expertise of normal birth.

Invisibility of Midwifery Practice

Mary recognises that the work of midwives remains invisible. She suggests that this is because childbearing women are not aware of the choices made available to them by midwives and therefore are not able to take advantage of what Mary sees as the benefits of midwifery care.

But they [childbearing women] aren't given the choice. Even in the community they are not given the choice, and it's only if they find out by hearsay or by accident that they really find out.....A lot of people don't know what a midwife is until they actually have the baby. A lot of women are saying, "We didn't need the doctor, he only came in at the end"..Once they have been through a labour and seen what the midwife does and see what the doctor does [in comparison].
(M.p12:1)

Mary is beginning to realise that by working collaboratively with women during birth, women realise that it is the midwife who supports them during labour. Thus, working with women has an empowering effect for midwives as it makes their practice visible and valued. This shift of emphasis from the importance of the delivery to the total birthing process reduces the dominance of medicine in childbirth because the perception of the doctor as the only expert is diminished once birth is perceived as a life process. As suggested by Flint (1993), the midwifery philosophy of working *with* women may prove to be one that most empowers midwives to have their particular skills recognised.

Mary reflected on how midwives who work in hospitals remain relatively invisible. Here she refers to herself as a hospital midwife:

I think that as hospital midwives we probably haven't had as big a profile as we should have and our work hasn't been as recognised as it should have been.
(M.p1:3)

It probably is changing a little bit because hospital midwives are raising their profile a little bit and people are becoming a lot more aware of what midwives are and what they actually do. Which is good, but it almost as though they have been taken-for-granted... Like, we are not just nurses. We are a different type of nurse but we have a very specific role. But it hasn't quite got through to everyone yet.

(M.p2:3)

As Mary reflects on the reasons why hospital midwives are not acknowledged she begins to surface the influences on midwifery of a nursing profession which is subsumed under the medical paradigm. She is unclear whether midwives are a "different type of nurse" with a "very specific role" or a different profession. This midwifery versus nursing debate was outlined in Chapter One.

Mary recognises the importance of the historical roots of midwifery and how it shifted from its community base to a medical institution.

The main thing is that it [midwifery practice] has been transferred to the hospital system and it has come under the nurses' role. In the old days everybody knew the midwife because the midwife visited her at home. And again people knew what the midwife was for and what she did... but then it became more and more that you went into hospital and you never saw the midwife except in hospital and her role was sort of devalued and it became that we did sort of come under the nurses' umbrella really.

(M.p2:3)

As Mary explores the reasons for the devaluing of midwifery knowledge she makes tentative connections between medicalised nursing and the demise of midwifery. She does not make explicit the connection between medical dominance and the subordination of nursing nor does she consider ways in which hospital structures maintain medical dominance and power. Below she considers how doctors, through their power/knowledge, have maintained their authority over childbirth practices.

And the doctors have worked it in more and more that they are the ones that deliver and that they are the only ones that have got all the knowledge. And in some ways that's where it has fallen down for women and women have suffered because of what's done by a lot of doctors. Well they are the authority on everything and the woman doesn't have any say in anything. And she has to do what the doctor says and that quite frequently involves intervention if it's specialists, and intervention becomes the result because the things doctors have made you [the birthing woman] do, like lying on your bed instead of walking around and things like that. And so women have sort of been given a hard time really but now they are beginning to assert themselves again. They've realised what has happened and they are beginning to stand up against it. But there are quite a lot of doctors who don't like that.

(M.p2:3)

Here Mary refers to the medicalisation of childbirth (refer Chapter Two) and the ascendancy of the medical model as birth was seen as a medical crisis. She believes that it has resulted in increased birth interventions and women being obliged to adopt a passive role. Mary thought that things had now changed as doctors were losing their power because of the assertiveness of women. She does not explore the reasons why women have "**realised what has happened**" and does not seem to recognise that midwives and women together, in presenting an alternative model of care, have assisted in an emancipatory process for childbearing women.

Medical Power and Control

Women's choices were often restricted by obstetricians.

I've had several women who have gone to the doctor,.... and they have been told by the specialist that they don't like working with independent midwives, but if the lady chooses to have an independent midwife they'll tolerate it; And if they are going to follow on with it, "Here is a list of people [independent midwives]," they want them to choose.

(M.p2:2)

Moloney's (1992) participants discussed how the autonomy of independent midwives, when compared to hospital midwives, could be a cause for conflict and inhibit collaboration. Moloney suggested that the similarities of their practice "*may be masked by the dominant power relations and ideologies*" (p.114) which highlights differences rather than the points of agreement. These differences are reinforced by doctors who refuse to work with some independent midwives and thus reward midwives willing to support medicalised childbirth. This further divides the midwifery collective and covertly punishes and denigrates, by lack of referral, midwives who work within the midwifery model.

Sometimes however, women chose to ignore the advice of the doctor.

Some women have had it recommended [by the doctor] that they [the women] don't need a midwife but they've kept on with me, so it hasn't become an issue for me because the lady still wanted me involved.

(M.p2:2)

Here Mary is discussing the perceived ability of obstetricians to be the gatekeeper for women's birth options. While they have no legislative ability to assume this role they are able to control which midwives the women chose by directing them to their list of

midwives with whom they prefer to work because they will comply with their philosophy. In this way obstetricians maintain their power by failing to give a complete range of choices of birth attendant to women. Underlying this action is their belief that the midwife is there to work for them. They make no effort to assist the woman to find a midwife who best suits her needs. Some obstetricians appear to fail to see childbirth as a partnership involving the family, the midwife and the consultant. They appear to assume their right to make decisions regarding the sorts of health professionals the woman should have. Mary states that they are not willing to negotiate the usual shared care practices whereby the medical and midwifery caregivers alternate visits during the antenatal period.

They don't do proper shared care. Like I can't do alternate visits with an obstetrician, so my visits to the lady are in essence, extra visits and I don't get any of their notes or anything. In actual fact I have very little to do with the obstetrician until it actually comes to the delivery and it happens that I am the midwife that looks after the lady during her labour.

R. So it is labour care really. It's not a reciprocal thing?

But it's not just labour care from my point of view because I will have seen the lady about five times antenatally and I follow her up postnatally as well, so from my point of view it's everything, but the obstetrician makes all the decisions as far as if he was going to induce her, or anything like that, he would just go ahead and do it.

R. So he is the primary caregiver in that case?

Yeah without any consultation.

R. And he doesn't share notes or anything?

No.

(M.p3:2)

Mary was aware that women's choices were restricted by the doctors' attitudes, and by implication, so too were the practices of midwives. If doctors persuaded women to use only their selected list of midwives they could covertly restrict midwives' access to clients unless the midwives worked in ways that pleased them. Doctors do not pay midwives, the government does, but this ability of referral and sanction does give them some power over the incomes of midwives. Furthermore, by refusing to "**do proper shared care**" obstetricians deny the specific expertise of the midwives and the importance of continuity of care for women. Their refusal to share information and decision making maintains their socially constructed authority and power and further marginalises midwifery practice.

Mary believed that doctors are threatened because some midwives are willing to challenge their practices.

Maybe they [the doctors] feel a little threatened because it's almost as though midwives are on a par with them. They [the midwives] aren't, but I do think they feel a little threatened and also because midwives question obstetrician's practice and that's quite threatening.

(M.p14:3)

In reflecting on why doctors appear threatened, Mary realises that the independent thinking of midwives allows them to question the previously taken-for-granted superiority of obstetric knowledge. This is a form of ideology critique (refer Chapter Three) which not only questions the technical knowledge of medicalised childbirth but also the narrowness of the Cartesian body systems approach premised on rational analytic science. Aware that obstetricians may not always approve of alternative non-medical practices of midwives Mary employs the following strategy to ensure she can continue those practices she finds beneficial to women.

I would never ask a specialist about the bath because I wouldn't like him to say no.

(M.p15:3)

This form of resistance which avoids personal confrontation means that Mary can continue to use a warm bath for pain relief instead of medication. It is suggested by Street (1992) that effective emancipatory change comes about by critiquing the underlying structures of power and how they are perpetuated rather than arguing about the efficacy of particular technical knowledge. Mary would gain little by arguing about what she can and cannot do. Ideology critique would be most effective if questions were posed about obstetricians' rights to have their preferences being met rather than those of birthing women. By questioning the authority of medical personnel to define what counts as normal childbirth, Mary is able to uncover the taken-for-granted authority of medical power/knowledge. Mary discusses the *risk list* (refer glossary) which is issued by doctors. Because this list outlines those pregnancies which obstetricians consider are likely to lead to abnormal outcomes it is effective in restricting midwifery only care of pregnant women.

I think certain parts are for safety and I think they are really important. But it's very easily turned into a control situation. Now the list we have got at the moment, I reasonably agree with, but we have just had this pamphlet which has been put out by the New Zealand College of Obstetricians and Gynaecologists stating their recommendations. And they have put out these recommendations of when a specialist should be involved and it's about fourteen pages.

R. It covers everything in pregnancy including pregnancy itself?

Yep, you could hardly be a pregnant lady without having been referred to a consultant. Something in this list will cover you. And one of the consultants here has bought it up and wants to make it [states name of hospital], policy...We [the midwives] have just been through it and put down our objections to it and which parts we think are unreasonable and things like that.

(M.p18:3)

Mary is aware that the risk list, ostensibly written for safety reasons, can "**very easily be turned into a control situation**". By critiquing the risk list together, midwives have overtly resisted medical assumptions that they are the accepted experts who have the authority to define the scope of midwifery practice. This awareness of structures that can constrain practice is the result of a process of enlightenment, described in Chapter One, whereby midwives are able to view medical decisions historically bound and open to critique.

Women and Doctors: An Issue of Power

Mary is clear that the focus of midwifery practice is different from that of doctors, because doctors do not work *with* women to empower them or to ensure they are assisted to have their needs met.

R. You were saying the obstetricians say, "You are my patient, you can trust me," but they don't actually get the woman to trust herself, her own body. They tend to say, "I'm the expert and I'll do what's best for you?"

Yeah, that's right and the lady doesn't really get a lot of say in it. And if the lady chooses to disagree with what the specialist says then the specialist will usually just dump her. That's their thing, like, "If you don't want to go with what I'm saying then you do it yourself. I'm not going to look after you anymore"..... But more often than not [obstetricians say], "It's just the policy" [that interventions to birth occur],...."It's standard"... [the doctors say], "You've had one previous caesarean section so I think it would be a good idea for you to have another caesarean section" or, "If you would like to have another caesarean section we will give you that opportunity. We can book it in on such and such a date and you don't need to have a trial of labour. If you have a trial of labour you know it's not that likely that you are going to succeed and you go through all that pain and everything and then still end up with another caesarean section," and, "We only let you go a very few hours, we don't let you go for a long time." It's all very sort of negative instruction.

(M.p11:3)

Mary identifies the power of doctors to influence childbearing women in two ways. One is an overt display of power and control in which they insist that women follow their advice or risk his/her refusal to continue his/her care of her. The other is a more subtle approach whereby real choice for women is reduced by implying that it would be inconceivable not to follow accepted medical practice. The example of caesarean section Mary used is timely because of consumer attempts to change the previously accepted medical dogma of, once a caesarean always a caesarean (Clements, 1991; Cohen & Estner, 1983). Led by the influential International Childbirth Educators Association women both in New Zealand and elsewhere have formed groups to change this way of thinking. The term VBAC (vaginal birth after caesarean) is used to express women's concerns that the decisions to repeat caesarean sections have become routinised by doctors. Women have successfully campaigned that each case should be considered on its own merits although, as illustrated above, some doctors use subtle means to persuade women that vaginal births following caesarean section are not a valid option and their chances of success are minimal. This is an example of risk being both an opportunity and a risk as described in Chapter Three. There is a risk that a repeat caesarean section will be required but there is also an opportunity for women to attempt to experience a vaginal birth following a previous caesarean section.

Summary

Mary was aware that there was considerable resistance by the medical profession to independent midwifery practitioners and chose to instigate change by building bridges. She was conscious of the constraints this placed on her practice and often felt the onus was on her to ensure working partnerships with doctors went smoothly. Mary demonstrated the beginnings of a process of enlightenment whereby she recognised how doctors maintained their power relationships by means of risk lists, reducing the choices of women to have the midwife of their choice, and assuming their right to make decisions about pregnancy and/or birth interventions without midwifery input.

Post Script

Due to conflicting schedules, it was almost a year after the first interview that Mary and I reflected on the final script and I found that she was practising differently. She was now doing homebirths and was more assertive about doing either total midwifery care, or doing shared care with doctors based on a collegial relationship. She was more assertive about taking time out for herself so that she was less likely to burn out. She had explored ways in which she could further empower women by "**giving them faith in themselves**". She felt midwives were now seen by doctors as having legitimate input into decision making but agreed with the analysis on page 101 that it was naive to think that doctors would get used to midwives getting paid on a similar scale to them.

She felt that women were becoming very much more assertive in the way they participated in their birthing experiences and less likely to consider that doctors are the best people to make decisions for them. As a result doctors were forced to become more flexible.

This revisiting of the script eleven months later demonstrates that each research project only captures a specific historical moment. This was referred to as *contextualist-historicist* by Nielson (1992), (refer Chapter Four). The constraint of time for the completion of research, while necessary, is also a limitation to the research. This postscript points the way for a future project in which the patterns of resistance and action are revisited and re-evaluated.

CHAPTER 8

NINA

Being a Midwife

Nina worked within a variety of practice options which provided valuable contrasts and insights into social relationships and structures which impinged on her practice. Nina was quite clear about her midwifery practice philosophy:

Well, the whole philosophy behind midwifery which is the basis for practice is that you work in a partnership with the woman and have a relationship with her. That is the whole base of the practice. I perceive birth as a normal life event, a social event, not a medical crisis, which is the whole basis of obstetrics, which is that birth is potentially very abnormal and their job is to identify the abnormal. I think the basis of their practice seems to be, live mother and live baby and that is as far as it goes. Whereas for me, as a midwife, it is very much more than that. It's the mother, the whole family, the birth experience, the welcoming of that child into their family and it's the height of emotions involved in it and midwifery is *being with* the woman as she goes through that experience. So there is all that whole *being withness* and partnership and facilitating of a positive birth for her and obviously their safety is a factor in that, but I don't think it is the basis of the practice, the way it is for obstetrics.

(N.p2:1)

There was a consciousness about Nina's practice which assisted her to clearly see the differences between obstetrics and midwifery. This enabled Nina to reject the socially constructed definition of childbirth as a "**medical crisis**". Bassett-Smith (1988) claims that the technocratic medical model, in the proclaimed interests of *safety*, has lost sight of the birth process and those that it most involves; childbearing women and their families.

When she first commenced practising as an independent midwife Nina was clear about the *woman-centredness* of her approach.

I wasn't going to give a damn about doctors, hospitals. I was there for the women and that was the main part of my philosophy and I remember repeating that time and time again to women, "I'm here to support you in the choices you make."

(N.p1:1)

However after more than a year's experience she became more and more aware that this philosophy was not always easy to put into practise. She was able to point to several constraining factors that prevented her from working in the way she believed best for childbearing women. Having come under the scrutiny of the medical profession, Nina felt compelled to work in a way that ensured her practice was beyond reproach. This often meant using technological interventions simply so she could document that she had done everything according to accepted routine medical practices.

I mean, I know that I'm not giving them a truly informed choice. It means I'm not practising midwifery the way I'd like to.... And the reason I'm doing it isn't for the woman's good or the baby's good. It's for me. To protect myself.
(N.p6:1)

This was not an unrealistic summation of the power of the medical profession to influence her practice. Doctors not only had the power not to recommend childbearing women to her but they also could refuse to work in a shared care partnership with her even if women expressed this as their wish. One of the women I visited with Nina [Field notes, N.p.4] volunteered the information that her usual general practitioner had advised her that she had to choose between a midwife (in this instance Nina) and himself. This woman chose to no longer visit that doctor. For some women this choice is not an easy one if an alternative doctor is not readily available, such as in rural areas. Furthermore doctors were also well represented on the review committees whereby approval was given for midwives to have access to hospital facilities with birthing women. While midwives such as Nina can legally practise autonomously according to the legislation, the institutional power structures that give doctors the apparent authority to oversee and constrain midwifery practice, persist.

Working With Others

While Nina acknowledged that her preference was to work with women 'on her own responsibility' various other health professionals were often involved depending on the woman's choices, medical necessity or the requirement to consult with others. Those other midwives who worked within the same midwifery philosophy were seen as the most rewarding people with whom to work.

There was no doctor involved so we haven't got that added stress. We can just go along and continue to use the midwifery philosophy.
(N.p2:1)

Well if there is a doctor involved then you definitely feel constrained by where they're at as far as birth goes. Some of them are still very anxious in homebirth situations and so there's always another person to consider [i.e. the doctor].

(N.p7:2)

It was something we had talked about as midwives. If you do a birth with just a midwife you just [gives a relaxing sigh], "Wasn't that nice." You know. You didn't have to entertain the doctor as well.

(N.p6:3)

The presence of a doctor for Nina meant a less relaxed atmosphere. In the second example she considered this to be due to the doctor's personal discomfort when attending a homebirth and away from their usual hospital environment. However it was also due to the philosophies of the obstetric and midwifery models which meant that practice priorities and ways of working with the families were different.

Nina saw it as important that when decisions were being made regarding interventions about pregnancy and/or birth then women would be supported with that decision making. She facilitated this process by discussing alternative choices and their possible outcomes. However doctors saw it as more important that midwives support them in their decisions.

And the one thing that actually came out of the meeting with the GPs and midwives, they said that they thought it was very important that the doctor and the midwife have a united front about what is going to be done. They don't think it is very good for us to be arguing with the woman in the middle as it were. Whereas we would say, "Why can't the three of us sit down and talk about it?" They say, "Oh no, no, no, we don't think it is a very good thing for us to be seen as disagreeing. We've got to go outside and decide what we're going to say, then go in and tell her," kind of thing.

(N.p9:2)

Nina was very aware that here the doctor was asking her to work with him/her rather than with the woman and thus retain his/her powerful position in the hierarchy of knowledge. She was clear that it was incongruent with her woman-centred approach and therefore she felt she had to spend time explaining that there were different ways of making decisions. This form of resistance in which people refuse to adopt or adapt to the ideologies of those in power demonstrates the ability of midwives to bring about changes by working from their own philosophical base. Unlike other studies (Hickson, 1988, Perry, 1985) where participants saw their ability to verbalise their ways of operating as a personal difficulty, Nina was able to look beyond the commonly understood ways of doing things. However she did recognise that she often acted in

ways which avoided undermining the perceived authority of the doctors while negotiating a different way of consulting with the women. As she responded to the doctors' expectations she became aware of the persistent hierarchical system which operated. When she accompanied a woman to a joint appointment with her doctor she found she was the one who adapted to the doctor's appointment schedule..

R. So when you meet, do you meet at their [the doctor's] rooms?

Yes in their rooms and we wait in the waiting room for however long, an hour or whatever. Yeah that's right.

R. You have an appointment with the woman at the doctors usual surgery times?

Yeah.
(N.p9:2)

Nina felt that she often responded to her perceived expectations of the doctors when working with them

..Whereas normally you'd just be sitting back just waiting kind of thing, you think, "I should be doing something. I'll listen to the fetal heart every minute." You'd think, "What would he want me to be doing? What would he be expecting?" Whereas the births I do with another midwife we both have commented on how easy it is, how relaxing it is, because we both practise the same. Whereas when it's somebody else, you have to consider their expectations.

R. So what do you do about that anxiety?

Chat to them. You know chit-chat. Like if you're waiting for the placenta and it's been an hour and you can see them getting really worried and looking at the ecobolics and things like that. So, you know, you say, "How's so and so?" You know, you try to delay so that you ease their discomfort, so that they'll wait.

R. So you actually almost become their support?

Yes.

R. You're actually saying to the doctor, it's okay?

Yes. It's all right.
(N.p7:2)

While Nina was able to negotiate on a personal level with those doctors with whom she worked, she was aware that medical personnel generally held the power and were seen as the experts in obstetrical matters. Nina was therefore anxious to be seen to be doing those things that the doctor expected, **"What would he want me to be doing?"** This accommodation (Street, 1992) of the dominant ideology means that real

change, in the power sense does not occur. While some peripheral changes may take place the basis on which power relationships rests, persists. In feeling that she must "**be doing something**" Nina demonstrates the way in which the dominant medical culture is embedded and embodied (refer Chapter three) in her midwifery practice in spite of her intent to practise otherwise. As discussed in Chapter One, *doing something* is part of the medical model and has to be unlearned so that an ability to be "**just waiting**" can take its place.

Power and Control

As outlined in Chapter Two, previous research (Moloney, 1992; Bassett-Smith, 1988; Hedwig, 1990) claimed that it was hospital structures that resulted in frustrating the practice of midwives and prevented them from working in ways which they saw as most beneficial to childbearing families. Those researchers suggested that working in the community most of the time, like Nina did, would create an environment in which midwives could practise autonomously and independently. However Nina was constantly aware that she had to be beyond reproach in order to maintain a practice that would bear up to constant scrutiny. She recognised that practising midwifery in the way she desired was not simply a matter of "**being there for the woman**" (N.p1:1). She knew from her own experience, from her colleagues and from the College of Midwives that it was not enough just to offer an alternative choice to women. There was a constant struggle to demonstrate that independent midwives were legitimate professional practitioners capable of practising in a way which was different but safe. Nina felt that midwives had not only to defend their individual actions but also their right to continue to practise autonomously.

Now I feel we are all under scrutiny and we've been told even through the College, "We've really got to go by the book." We've really got to prove ourselves because they're just waiting to come down on us.
(N.p6:1)

In acknowledging that doctors had the power (though not necessarily the right) to judge and criticise their practice, Nina recognised that midwives were in an invidious position as they tried to work within the power structures of the medical profession and at the same time practise in new ways. Furthermore midwives were treated differently than doctors when asked at combined clinical meetings by medical personnel to explain their practice actions.

They [the doctors] just protect each other. You see it time and time again. At the meeting, compared to the grilling I got from all of them...[the doctors get told], "You did the right thing."
(N.p5:1)

Such experiences meant that Nina felt compelled to use technological intervention more frequently than she saw as professionally justified. She was in the invidious position of recommending such things as ultrasonic scanning simply so that she could show that she had done everything that was technologically correct. She knew that this compromised her professional and recent research knowledge (Berkowitz, 1993), that such interventions could not be proven to be safe, yet she acknowledged that she needed to be *safe* by the medical definition of safety which meant employing technological aids freely. Thus when asked how she felt about women who requested or indicated the need for ultrasound she replied:

Yeah, quite relieved. I think whew, they're having that. I've got it in the notes... I've done quite a bit of research into the use of ultrasound and most of the literature says it shouldn't be used routinely. There may be unknown risks.
(N.p5:1)

Nina knew her actions were incongruent with her professional philosophy and was able to verbalise her frustration at feeling coerced into doing something which she would have preferred not to do. She complied with medical expectation so she could show she was safe in medical terms while knowing that her midwifery knowledge did not support this view. Such incongruencies added stress to a practice that was already demanding and required a high degree of expert skill and knowledge. Nina did not at any time feel that it was because she was not assertive enough to stand up for her practice principles. She was well aware that in order to protect her practice, compromises had to be made because of the power of the medical profession to judge her work. However when she used the technology routinely she denied her own knowledge base and reinforced what she considered to be the medicalisation of childbirth by her actions. This inability to resist ways of practising within the medical model meant that medical interventions were constantly visible and utilised in ways that made them appear to be the normal, natural way by which pregnancies and labours should be screened.

Nina noted that in several ways obstetricians still maintain their power by being able to define the parameters of 'normal' practice. Though midwives are sure that childbirth is for the most part a normal life event, they were constantly reminded that the obstetricians definition should prevail. The concept of the *risk list* was such an example (See Glossary). This outlines the clinical conditions of those women for

whom an obstetrician should be consulted. Nina pointed out that the 'list' was so broad, based on the assumption that childbirth was a medical event that only a few women would fall into the category of *normal* and therefore suitable for 'midwifery only' care. Nina recognised that the list was purported to be in the interests of 'safety', but it had the effect of ensuring that most women would be labelled as potentially abnormal. In turn this ensured that obstetricians would have at least one consultation with each pregnant woman, and that most women would be considered unsafe for homebirths.

You get the idea that they are trying to rope in as many things as they can by defining more and more things as abnormal.

(N.p3:3)

Nina felt that any confidence women might have, that their bodies were capable of delivering a live healthy infant was undermined. Furthermore Nina expressed frustration that the 'risk list' did not take into account the expertise of midwives to differentiate between normal and abnormal situations. She gave meconium stained liquor as such an example.

Yes, meconium would be a good example of that. There are all sorts of grades of meconium ranging from very thin and watery, brown, tan coloured meconium, to a thick green, pea soup sort of meconium. If there is any meconium in labour you are supposed to ring up the specialist and continuously monitor the woman, whereas we would say if it is old thin meconium it is as good as clear liquor. But if it is thick pea soup then yes, that needs to be looked at. So there are a lot more grades than they say.

R. So in a way all these definitions of normal are denying your experience? So in a way you are trying to redefine what is normal?

Yes that would be right. What happens during labour and birth if it's left as an entirely natural process? You don't see it unless you just sit back and just watch. Because your hospital practice is so much that it should be this way and if that doesn't happen then something must be done.

(N.p4:3)

By insisting on the interpretative nature of various clinical manifestations Nina was claiming specialised knowledge in the way described by Turner (1987) in Chapter Three and could be effective in maintaining power/knowledge. Nina was aware that midwifery knowledge was ignored when medical knowledge insisted on its model of prescription and intervention. Such a model gave an aura of predictability and control which Nina knew was not congruent with her practise experience. The medical model from which most doctors practised had the authority of presumed scientific truth. The "high hard ground" (Street, 1990, p.1) such as this, gives a false impression of control and certain knowledge.

Medicalised Birth as the Norm

As part of maintaining up-to-date knowledge Nina frequently went to meetings attended by obstetricians, general practitioners and midwives who discussed cases which had less than the desired outcome for either mother or baby. The overt purpose of these meetings was to discuss strategies to manage better or prevent, deviations from norm. However Nina suggested that the hidden agenda of these meetings was to legitimate technological and medical practices.

And it's the same for GPs as well as us. They feel the same way. They sit in those meetings and they listen to the most horrendous stories of mothers and babies dying and things and, "Oh gosh,".... You do think, "If birth is like that!..." Then it does make you afraid. And yes, I think that is very much the effect, even though it's not the purpose of the perinatal mortality meeting it's very much the effect.

R. It's their hidden agenda?

Yes I think so..... And G.Ps often say afterwards, "Oh I hope I never get one like that!" Of course everyone hopes that, but they don't equip you with anything that would help you to deal with the situation.

(N.p2:2)

Nina feels "**afraid**" but realises that the meeting did not serve its educative purpose of giving information that "**would help you to deal with the situation.**" Nina had explained that the midwives were aware that the meetings could be much more educative in their approach and had asked the convenor to change the format so that an exchange of ideas and opinions might take place. This illustrates that these midwives were constantly aware of the effects that meetings, structured ostensibly to improve practice, could also be used to legitimate the practice philosophy of those in power and so reinforce a belief that doctors with their technological knowledge, are the only ones to practise safe childbirth.

Asked why there wasn't more discussion about preventative measures for high risk clients Nina replied:

They want us to think, to feel that they are godlike. That we can't do without them... Because otherwise you know all these people [women] would be haemorrhaging to death all over the place. Yeah I'm sure it is that. That they want to maintain the power. And they instil fear in both other practitioners and the women too. That's very much how they operate with their clients.

(N.p2:2)

Nina believes that the abnormal cases are constantly discussed to reinforce the belief that dangers are inherent in all childbirths. She believes that this ensures that both clients and health professionals involved in childbirth are fearful of what should, for the most part, be a normal life process. As a result routine medical surveillance and interventions are justified and perpetuated even in those instances where they have been shown not to improve birth outcomes as discussed in Chapter Two.

Legitimising Midwifery Practice

In order to maintain her ability to practise in a way which was women-centred, Nina gave women choice by maintaining an assumption that pregnancy and childbirth was, for the most part, a normal, natural event. Nina and other midwives set up what might be described as counter-hegemonic structures (refer Chapter Three) whereby they legitimised their knowledge and practice. She met with fellow midwives, read research and attended homebirth meetings that reconfirmed common understandings about midwifery practice.

That group of women we work together, we work really hard. And it's also the one time when you think, "Ah, I don't have to explain myself." It's like being with close family and friends, you don't have to explain. Everybody understands what you are thinking.
(N.p7:1)

We discussed with whom Nina shared her experiences and became aware that these were mainly colleagues with whom she felt safe. This led us to consider whether midwives perpetuated their invisibility by not discussing their midwifery knowledge openly. Medicalised childbirth is legitimised through open discussion, publication and dramatisation (such as television drama). In this way it becomes the taken-for-granted ideal for birthing. Nina and I were able to consider how the relatively private worklives of midwives maintained normal childbirth as possibly rare and unusual. Nina acknowledged that the invisibility was a problem but she was also aware of the risk of exposure to a less than respectful medical profession.

I think often when you are in medical circles you often get laughed at unless you have really researched and you can back everything up with scientific, quantitative research stuff. And so much of what we know in practice hasn't been researched in that way, and so we can't throw Lancet articles and British Medical Journal articles at them for a lot of the practice. But they have got all this research that shows this and this whereas we haven't got the counter-research. No doubt they would pick holes in it even if we did. As midwives we can talk about these things quite readily but not in formal circles.
(N.p10:3)

Nina had felt that midwives were unwilling to have midwifery practice available for public scrutiny. She recognised that the medical comments about midwifery knowledge may be biased toward medical ideologies of technology, quantitative research and the empirico-analytic way of thinking. Theory and knowledge grounded in and arising from experience would not be seen as legitimate without the accompanying empirico-analytical research. In this way midwifery knowledge, although grounded in practice, could be discounted and thus remain invisible and marginalised.

Exploring the Reasons Why

Whereas Hickson (1986) found that the nurses she interviewed considered much of their professional constraints to be personal failings, Nina's awareness of the socio-political context of her practice, enabled her to identify ideological structures impinging upon her practice. For example, when asked why she thought women did not endorse the midwifery model of practice by having more 'midwifery only' care, Nina said:

Well that's the whole social thing, the whole medicalisation of birth, lots of women say to me the only thing they've heard about birth are horror stories that their mothers have told them, and their friends and they only tell them the horrible bits. Well, things like the frontline programme on television last year. We've had a lot of people comment on those. You know that they definitely wouldn't have a homebirth because it's not safe, the midwife may not get them into hospital in time.

R. In fact all of those things on the programme happened in hospital didn't they?

Yes, that's right and under the care of doctors. So it's a whole social conditioning thing, reinforced by medical people for various reasons.

(N.p3:2)

In exploring why doctors appear to reject midwifery knowledge as legitimate Nina was able to locate it in terms of masculine power structures and thus take a feminist perspective. We discussed why doctors appeared to be so threatened by independent midwives.

Why is it so threatening? That is a very good question because we can't see what is wrong with that. I wonder if it's a female/male thing and being a predominantly male occupation. And obstetricians are constantly trying to understand female things and

they can't. Or trying to control women. Yeah, maybe that's it. Those whole issues of control and power. They constantly talk about *managing* labour, *managing* women. That sort of terminology is very prevalent in their practice and I wonder if that's it. Because our practice isn't controlling and we don't let them control us. Well, we try not to let them control us. That's the issue behind it. Power and control.

(N.p1:2)

In avoiding defining the issue as a personal or individual one, Nina was able to explain the constraints on her practice as being socially constructed and embedded in patriarchal ideology. She identified how language both reflects and reinforces the dominant discourse.

Nina also discussed how the incorporation (refer Chapter Three) of some midwifery care within medical practice did not result in changes of attitude or philosophy. In this way doctors were able to maintain their medically based care and therefore their power/knowledge. Nina was aware that some midwives endorsed this medical model, thus undermining the struggle for a change to women-centred care.

They are really only just defending their own practice, defending it.the obstetricians pick up a midwife who does what they say and says, "Why don't you come and work for me and look after my patients?".... The midwife doesn't necessarily meet them [the clients]. Well, she might meet them once antenatally, she just looks after them for the birth and then they will have someone else looking after them postnatally..It's an abuse of the system I think and it's for the obstetricians' own ends. They still have a lot of interventions and things *he* likes.

(N.p4:2)

Nina describes here how the midwife works with the obstetrician within the medical model while giving the impression of providing the sort of care that those working within the midwifery model do. When Nina refers to, "**the system**" she is commenting on the changed socio-political conditions which enable women to have choice and continuity of carer with a midwife since the Nurses Amendment Act 1990. "**Abuse**" occurs when midwives do not continue care throughout the pregnancy, the labour and postpartum period but only attend the labour and birth. Nina understood the implications of obstetricians and midwives who worked together to accommodate consumer demand for midwifery care. She was dismayed that it was a token gesture with no real change to the philosophical thinking of the midwives and obstetricians who still maintained a 'birth as potentially dangerous' attitude to their practice. Furthermore, by splitting the childbirth experience into various phases they failed to recognise childbearing as a total experience.

Nina suggested that socialisation through a hospital based education was one of the reasons why these midwives aligned themselves with the medical profession and their medicalised childbirth.

They do tend to be the older ones. They've worked in the system for such a long time. I'm not sure how they would change now....
(N.p4:2)

Summary

Nina recognised that constraints on her practice were due to the dominance of the medical model as she constantly reflected on her practice in order to ensure she stayed within a midwifery philosophy. According to Fay (1986) this form of resistance, whereby the ideologies of the powerful group are deconstructed and then reconstructed in terms of a new philosophy and understanding that is in the interests of midwives and childbearing women is most likely to bring about a change in the power base. However Nina was not always able to practise in ways she believed she should. She realised that this was not due to personal failings but to the institutionalised power structures of the medical profession who judged and sanctioned her work. In order to maintain and authenticate her midwifery philosophy Nina shared her ideas and experiences with other midwives and women who had similar practice philosophies. However because this group felt unable to share their knowledge with others their practice is likely to remain invisible and therefore less socially acceptable than the medical model.

CHAPTER NINE

DATA INTEGRATION AND CRITIQUE

Introduction

Complex power relations exist between midwives and doctors, midwives and women, and women and doctors. Medicine gains power/knowledge from the assumption of superiority of technology as derived from empirico-analytical science or in Habermasian terms, technical knowledge (refer Chapter Three). Midwives in this study demonstrate a tension between the knowledge interests of midwifery based on the midwifery model and the knowledge interests of obstetrics, based on the medical model. Maternity care is not simply a neutral scientific activity but a socio-political one which embodies different interests and purposes of those involved in it. In representing an alternative model of care, the midwifery model challenges the assumptions of what is to be counted as legitimate knowledge, exemplary practice, and by what criteria. For example, midwifery takes into account the subjective experiences of women as well as the independent observation of practitioners. It does not assume that all scientific medical knowledge is cumulative and progressive but examines the unintended consequences which may arise from it. For example in Chapter Two, ultrasound was shown to change the social relations of birth attendants with women. Women's knowledge was discounted as subjective and the tactile interactions between the women and her caregiver were reduced.

The alternative paradigm questions and challenges the taken-for-granted authority of obstetrical knowledge and practices. This means that decisions about certain procedures, what is counted as accepted knowledge and what is considered to be the obstetric or midwifery scope of practice are continually being negotiated and contested. It is argued that the acceptance of a midwifery model of practice is an ideological struggle concerned with knowledge-of-worth.

Knowledge of Worth

Whereas the medical model of childbirth is based on a rational analytical paradigm which results in structured prescriptive practices designed to give an aura of predictability and control, the midwifery model is more holistic. It takes into account

the fact that birth is more than a physiological event; it is also a unique experience deeply embedded in the understandings of women and is therefore a social experience. It should be noted however that the models themselves are only guidelines. Neither model is practised in its absolute form by either midwives or doctors. What is important to this study is the different philosophical assumptions each embrace as outlined in Chapter One.

It was shown in Chapter Two that the authority of midwifery knowledge is grounded in midwifery practice and the experiences of women with whom they work. This connected knowing enables midwives to use their knowledge and skills to work with women and their families in a way which is women-centred rather than medically based. Research has shown that women-centred practice is effective both in terms of safety, as measured by infant and maternal morbidity and mortality rates, and in terms of client satisfaction (refer Chapter Two).

Because the midwifery model is still not generally accepted by those who endorse medicalised childbirth there is a tension for those midwives who work within the midwifery model. They are mindful that they must satisfy and meet the accepted standards of those medical personnel working from a Cartesian body-systems approach which has a physiological focus. This is especially so when doctors appear to be able to set limits, scrutinise and make judgements which affect the midwives' work-lives. These judgements are made against criteria which are congruent with the medical model. Midwives are aware that their practice experiences are discounted unless they quantify their claims to alternative knowledge by naturalistic scientific methods.

Chris relates an example from an encounter with a doctor in which she attempts to discuss a different understanding of the way medication affected birth outcomes. She based this understanding on her practice experience:

And I talked to the doctor about that and said it was something I had seen before and wondered if it was because of this. And he said, "Oh you can't make that judgement on one case." But I said, "No, it's not just one case that I'm making it on," but unless you have facts and figures its no use talking to them because you actually have to prove it.

Chris, 3:59.

This is an example of how the dominant discourse maintains power through prescription of what knowledge is legitimate and of worth. It also dictates by what method knowledge is to be seen as valid and authentic. Because studies involving large numbers of subjects are not available to midwifery, its knowledge is trivialised

and remains invisible (Sakala, 1988). Thus the benefits of midwifery knowledge are not freely available to other midwives or childbearing families. Medicine is thus able to maintain ascendancy in childbirth.

Nina is aware that medical knowledge should be considered against a background of clinical experiences, but she voices frustration that midwifery's alternative views are rarely considered because there is lack of quantitative research:

I think often when you are in medical circles you often get laughed at unless you have really researched and you can back everything up with scientific, quantitative research stuff. And so much of what we know in practice hasn't been researched in that way, and so we can't throw Lancet articles and British Medical Journal articles at them for a lot of the practice. But they have got all this research that shows this and this whereas we haven't got the counter-research. No doubt they would pick holes in it even if we did. As midwives we can talk about these things quite readily but not in formal circles.

Nina, 3:121.

Midwifery knowledge, based on practice experiences, can be readily dismissed as inferior by the dominant group because it has not been proven by *accepted* truth of objective value-free observation and scientific rigor. Such claims to a value free science deny Habermas' (1971) assertion that all knowledge is ideologically based and never free from values and interests. Endorsement of accepted rational analytical science enables doctors to claim that because they are able to make accurate predictions and control situations within medicine they can also make judgements about the philosophies of others. Medicalised childbirth is seen as a logical and predictable physiological process which, given the correct monitoring and appropriate intervention, will result in a safe mother and baby. However, this denies the uniqueness of each birth which needs to be supported and facilitated according to the family's circumstances within a particular context. Street (1990) draws attention to practice realities in which multiple, contextually based decisions need to be made with each individual case. These complex health problems "not only defy technical solution but are those problems of greatest concern to people" (p.14).

The midwifery model is holistic in that it recognises the uniqueness of each birth in context. It is from this midwifery model where midwives watch, wait and are *with* women, that midwives learn with and from the women and thus generate together, different realities and theories about childbirth. This is praxis; theory and practice informing each other and creating knowledge grounded in the experiences of those

participating in childbirth. For example it was Sue's experience that confirmed for her the normality of childbirth.

I keep looking back. When I'm really feeling concerned about something I keep thinking, "Do I need to consult? Do I need to do this? What might the consequences be?" I go back to my practice and the normality of birth is reaffirmed. Do you know what I mean? Rather than the other way around. I mean I don't go back and think, "Oh [expletive]". I go back to my practice and think, "Yes this woman can do this. Yes it's okay. Yes!"
Sue, 1:85.

In midwifery practice, the structured prescriptive approach of the medical model is replaced by a creative, intuitive one, grounded in the experiences of midwifery practitioners. Chris suggests this when she says:

I find that midwifery doesn't always do what you think will happen in obstetrics..... Just when you think you've got it all sussed something happens that is different from anything you've ever had before.....
Chris, 1:58.

For Chris, medically based obstetric knowledge is insufficient to predict and give all the answers to her midwifery practice. Practice realities inform her that each situation is different. The belief that the technical knowledge of medicine can reliably predict and control outcomes also leads to the belief that poor or unusual childbirth outcomes must be due to individual or personal deficiencies. In these circumstances there is an assumption that prescribed procedures and interventions are not followed by individuals. Unquestioning faith in the efficacy of prescribed procedures is problematic since it prevents the basis of knowledge itself from being questioned. Knowledge at this level serves the technical interests of medicine rather than the practical or emancipatory interests of women and midwives.

The presentation of childbirth practice as technical knowledge giving predictability and control denies the need for professional decision making within a specific context. There is however a paradox here. On the one hand, medicine makes claims to be able to define what is abnormal, yet on the other hand, denies that this is possible because birth is only normal in retrospect. The *risk list* is an example of this paradox. An obstetrical risk list states which women have the potential for unfavourable birth outcomes. Superficially, the risk list could be described as a useful tool to guide safe practice of those practitioners working with women. However, such a list is usually compiled by obstetricians for midwives and thereby narrowly defines what is normal.

Midwives claim that they need to make decisions in context. Nina illustrates this point when she explains how midwives respond to the risk list which states that meconium stained liquor is always indicative of an obstetrical risk. Midwives differentiate different sorts of meconium and make professional judgements based on their experiences and expertise.

If there is any meconium in labour you are supposed to ring up the specialist and continuously monitor the woman, whereas we would say if it is old thin meconium it is as good as clear liquor. But if it is thick pea soup then yes, that needs to be looked at. So there are a lot more grades than they say.

Nina, 3:119.

The midwives were constantly reminded of the powerful dominant medical discourse which impinged on and constrained their ability to work within the midwifery model. They recognised the power/knowledge of the *medical experts* who assumed the right to oversee and scrutinise the work of midwives and attempted to prescribe midwifery's scope of practice. The risk list is an example of this power and control. Such a list denies and nullifies midwifery expertise and experience. It also means that doctors are able to control and limit midwifery practice by insisting that since certain states of pregnancy are potentially pathological they must have medical supervision.

Chris gives an example from the risk list which claims that women over the age of thirty are at greater risk and need to have close medical monitoring and need to be delivered in the technology rich environment of a large base hospital.

Well, parity, age [are examples]. I'm so sick of women being told they are elderly primips over the age of thirty and they have to go to [a large base hospital] to have their babies, when I've had some very successful homebirths and local births with women of that age group. And I mean you're looking at women over thirty who are healthy women.....

Chris, 4:74.

Here Chris is claiming interpretative expertise which denies the possibility of midwifery knowledge being broken down into a series of routine tasks and rules. This is an important strategy for midwives as their professional knowledge claims are contested by the dominant medical discourse. According to Turner (1987) claims of interpretation contribute to validity claims of professional autonomy. (Refer Chapter3, p. 33).

Midwives can challenge the medical definitions of risk on the grounds that they are detached from the context and the unique experiences of women. Using a connected

epistemological approach (Belenky, Clinchy, Goldberger & Tarule, 1986; Moloney, 1992), midwives are able to reframe the risk list as non-authoritative on the grounds that it misrepresents connected knowers since it represents a separate epistemological position (Moloney, 1992). In contrast, doctors claims to legitimacy are on the different grounds of an objective, value free, document that claims risks in childbirth can be categorised and recognised without reference to complex individual situations.

Midwives demonstrated their awareness of the power relations which existed in medical, obstetrical practices by their ability to challenge the validity of the list. Through ideology critique they identified the *risk list* as a means of power and control, and were thus able to challenge its taken-for-granted objectivity.

..we have just had this pamphlet which has been put out by the New Zealand College of Obstetricians and Gynaecologists stating their recommendations. And they have put out these recommendations of when a specialist should be involved and it's about fourteen pages.

R. It covers everything in pregnancy including pregnancy itself?

Yep, you could hardly be a pregnant lady without having been referred to a consultant. Something in this list will cover you. And one of the consultants here has bought it up and wants to make it [states name of hospital], policy...We [the midwives] have just been through it and put down our objections to it and which parts we think are unreasonable and things like that.

Mary, 3:109-110.

It is argued that the medical risk list represents an example of medical attempts to dominate midwifery by confining its scope of practice. Midwives actively contest the validity of this document using midwifery knowledge and expertise.

Childbirth: Only Normal in Retrospect

The participants appreciated that their particular way of perceiving childbirth as a normal life process enabled them to interpret those processes that reinforced the pathology of childbirth as a form of power/knowledge. They discussed the way perinatal mortality meetings presented incidents that required medical interventions during childbirth. Independent midwives were directed to attend these meetings as part of their ongoing education and were a requirement for continued access to institutions administered by the Crown Health Enterprise. They found that these meetings were dominated by medical ideology and had the effect of reinforcing the image of all childbirth being fraught with danger. Nina and Sue discussed how they felt as a result of attending the meetings:

As midwives we come away from the perinatal mortality meeting thinking we must be crazy...nothing normal ever happens! As a profession they [doctors] keep reinforcing.. I know they use it as learning experiences but they're all really negative learning experiences all the time.

Sue, 1:84.

And it's the same for GPs as well as us. They feel the same way. They sit in those meetings and they listen to the most horrendous stories of mothers and babies dying and things and, "Oh gosh,"... You do think, "If birth is like that!" Then it does make you afraid.

Nina, 2:120.

At the meetings midwives, General Practitioners and obstetricians discussed cases ostensibly to improve practice outcomes. However the midwives were aware that the meetings were run on strict bureaucratic protocols with the emphasis on birth pathology. The presentation and discussion of birth pathologies is a valid method of education whereby health professionals can learn from clinical cases. However, the pathology focus of this teaching method is obvious when one considers that this is also how surgical and medical conditions, based on illness and sickness, are also learned. When maternity cases are presented in a manner similar to medical and surgical cases, they too are discussed as though childbirth was an illness instead of a normal life process. The effect of this is to reinforce a medicalised view of childbirth. Positive outcomes and natural birth options are not discussed at these or other medical forums so that the emphasis on normality is lost. Furthermore, the cases were discussed only in terms of their clinical manifestations. No attempt was made to put such cases in a social context. These midwives did not deny that childbirth has medical risks but their midwifery knowledge allowed them to focus on normality and nurturance.

Chris felt that the meetings were also used to reinforce the authority of medical practice to the detriment of midwifery practice. She described an incident in which her safety to practise was questioned at the meeting. To defend her actions she had then stated:

"I don't call that delayed second stage." And he [the doctor] said, "Well point taken," and didn't say anything more. So he certainly didn't say, "Well I'm sorry Chris I didn't realise." You know he just sort of grunted and said, "Point taken".... I [Chris] feel the baby was flat, not because of the delivery, but because of the heart problem.

Chris, 2:75.

Chris had felt the criticism was directed at her practice because she was a midwife. She felt that the criticism was unjustified and confirmed for her the meeting's hidden agenda which was to reinforce medical interventions and discredit midwifery practice. Working in an environment where they were challenged about their care was stressful. All of the midwives in this study talked of the stress of constant scrutiny.

Working in a Stressful Environment

Working in what they perceived to be a less than welcoming environment added to the stress. Mary, who worked in the community with pregnant and postnatal women, but attended their births in hospital, recognised that stress as "**political**".

I think a lot of it comes from the political stress. There's a lot of political stress and underlying currents that cause a lot of stress [laughs]. Just having to be on the alert the whole time... In a way you're sort of being on the defensive all the time ... you try not to be on the defensive but you've got to have your wits about you all the time, if you are working with anybody like any doctors or any hospital staff, and you also have to perform very, very well, because the slightest mistake you make, everybody comes down upon you like a ton of bricks..... Yeah, its quite a lot of pressure I think, to make sure you perform well, and you almost have to perform exceptionally well and just make sure you don't say the wrong things and things like that.

Mary, 1:94-5.

Chris also talked of the pressure to act in ways she felt were incongruent with her practice. She felt that to constantly emphasise all the risk factors associated with childbirth served to endorse medical interventions and lessen women's confidence in their own ability as childbearers. However, she felt she was forced to do this because of the various medical policies and protocols.

And if I don't inform her [the woman] I'm liable if something goes wrong. I could lose my contract, then I'd lose what I love doing. I'd have to go back to work at the hospital which I'd hate. And so I feel I'm sowing seeds of doubt in that woman's mind and I feel I'm almost causing the problem just because I feel that pressure.....

Chris, 3:67.

The midwives found that they were constantly under scrutiny to perform exceptionally well and do those things that met the expectations of institutions which endorsed medicalised childbirth.

And that's the pressure and there is this high risk list that we were all bought up with very devoutly. And I'm not convinced about the high risk list but by the same token, I have to acknowledge that it's there..... So it is a real catch 22 situation. How can I empower her [the woman] to do some thing which I'm going to get knocked on the head about if I don't tell her the bad things. It's very difficult.

Chris, 3:67.

The demands of the two paradigms of knowledge created a tension which the midwives in this study found stressful. While philosophically they wished to maintain a practice which emphasised normality and was women-centred they were constantly balancing their interests against the need to be seen as clinically competent within parameters of medical criteria. Sue talked of the need to use technology more than she would like:

Personally I know I put the toco [cardiotocograph] on because I know that that is what is expected. Whether I think personally that it has to go on or not I'll put it on. It might only be on for five or ten minutes rather than for the whole labour or something like that but I still do. Like it's sort of like covering yourself.

Sue, 1:82.

Nina stated that she was relieved when the woman had various tests and ultrasound screening even though she often felt it was not entirely necessary and was concerned about its hidden dangers.

I know that I'm not giving them a truly informed choice. It means I'm not practising midwifery the way I'd like to... And the reason I'm doing it isn't for the woman's good or the baby's good, it's for me. To protect myself.

Nina, 1:114.

Aware of the possibility of being harshly judged or reprimanded the midwives felt the need to "**protect**" themselves, (Nina) and "**perform exceptionally well**" (Mary); otherwise they "**come down on you like a ton of bricks**" (Mary) and you might "**get knocked on the head about it**" (Chris). As a result of their attempts to maintain a different model of practice, these midwives experienced a great deal of stress which aggravated their already heavy workload. They frequently found themselves having to make decisions about whether challenging medical decisions or building bridges of collegiality and communication was in the best interests of the women with whom they worked. They were aware that they would be judged by medical standards and had to prove themselves to be safe practitioners in medical terms. These midwives therefore saw that it was in their interests to sometimes practise in ways that they might not have done if different power relations had existed.

...Whereas normally you'd just be sitting back just waiting kind of thing, you think, "I should be doing something. I'll listen to the fetal heart every minute." You'd think, "What would he [the doctor] want me to be doing? What would he be expecting?"

Nina, 2:116.

As Fay (1987) points out, ideas and values do not exist only in external environments but become embedded and embodied in the lives and movements of actors. Sue reflected on how the hospital environment affected her actions:

You get that nurse walk and you get that nurse tone in your voice. Even if you don't put in the power points you're different to the midwife you are when you are not there [in the hospital].

Sue 1:83.

The difficulty these participants had in changing their embodied habits was shown in the way they walked the way they talked and the constraints they felt to be "**doing something**" (Nina) in the presence of medical personnel or within the hospital environment. They found they had to constantly examine their habitual repertoire of practice and knowledge in order to maintain their midwifery focus. There was also persistent tension caused by a need to "**protect**" (Nina) or "**cover(ing) yourself**" (Sue) fuelled by the belief that any error of judgement would be severely dealt with. This confirmed for them that the hierarchical hospital system reinforced and worked for the interests of doctors. These reflections demonstrated the ability of these midwives to consciously reflect upon the hegemonic structures which constrained their work. By a process of ideology critique they were able to surface the power relations which existed in their work-place, particularly when working in a hospital environment. They did not consider their anxieties to be personal failings but understood them in terms of competing ideologies and therefore social constructions. The midwives were able to contrast those constraints with the less oppressive atmosphere which midwives experienced when they worked together. Nina illustrates this point:

It was something we had talked about as midwives. If you do a birth with just a midwife you just [gives a relaxing sigh], "Wasn't that nice." You know. You didn't have to entertain the doctor as well.

Nina, 3:115.

That group of women we work together, we work really hard. And its also the one time when you think, "Ah I don't have to explain myself." It's like being with close family and friends, you don't have to explain. Everybody understands what you are thinking.

Nina, 1:121

In Chapter Two the works of Bassett-Smith (1988), Hedwig (1990) and Moloney (1992), suggested that midwives may be able to work in a less constrained manner if they moved from a hospital environment to the community to practise. It would appear that these midwives do still find the hospital environment constraining and constricting. However, even when working in the community, constraints of another sort persist. The risk list is an example. Midwives who work with others in a more collaborative environment are able to reflect on what the alternative might be and take some action towards change.

Forms of Resistance: Working In Another Way

The counter-hegemonic strategies that resist the medicalisation of childbirth have taken place throughout most of the Western World with varying degrees of success. In Chapter One an outline was given of the process whereby midwives had regained legal autonomy as independent practitioners in the form of the 1990 Nurses Amendment Act, by a process of conscious political and social action in partnership with their consumers. The participants in this study reflected that process in that they defined their practice as encompassing the midwifery model. In contrast to the medical model which has an assumption of pathology, midwives base their expertise on an assumption of wellness. They see their practice priorities as working *with women* rather than doctors.

I was there for the women and that was the main part of my philosophy and I remember repeating that time and time again to women, "I'm here to support you in the choices you make."

Nina, 1:113.

It's very much a relationship between the woman and the midwife. Midwifery to me is a woman having a baby and being in control and doing it her way.

Chris, 2:58.

...for me it means being with women in a way that strengthens them and makes them more whole, not just for that birthing but for later on as well.

Sue, 2:79.

These midwives were participating in a process of enlightenment, empowerment and emancipation through their action in which they reflexively (through thought and action) attempted to situate their practice in a new paradigm. Moloney (1992) states that, "By imagining the world differently and naming it, new and existential modes (ways of being), and structural forms are possible" (p.123). Midwives were able to

create different ways of working. They were able to *work with* women rather than *doing for* them and create a partnership or friendship rather than a patient/midwife situation based on hierarchical power relations. Their actions enabled them to establish an alternative structure which was empowering to both consumer and midwife. It had the effect of illuminating the traditional hierarchical model as being in the interests of doctors rather than women and was thus an overt challenge to the existing hegemonic structures.

The formation of an alternative model of practice is a strong counterhegemonic tool which enables midwives to resist the dominant medical discourse. Carr and Kemmis (1983) state that the emergence of such a new paradigm for practice can be most influential in changing the taken-for-granted dominant ideology. Along with other New Zealand midwives, the participants have changed the philosophical base on which their understandings, and actions are based and from which they can problematise medically based obstetrics. This was not an easy process. Because these midwives were attempting to establish a different way of practising within what was sometimes a hostile environment, they experienced considerable stress and lack of co-operation from the established order. The following is an example of how the participants considered that consulting with women was an essential part of midwifery practice.

R. So an ideal situation would be what?

Would be for you to have a meeting and discuss with the woman and all the practitioners involved and discuss what was going to happen and what everybody felt would be best.

Mary, 3:102.

...we would say [to the doctors], "Why can't the three of us sit down and talk about it?"

Nina, 2:115.

However midwives found that the doctors appeared to consider that their decisions took priority over the concerns and wishes of the women.

.. one thing that actually came out of the meeting with the GPs and midwives,...they [doctors] said that they thought it was very important that the doctor and the midwife have a united front about what is going to be done.... "We've got to go outside and decide what we're going to say, then go in and tell her,"...

Nina, 2:115.

It appeared that often doctors did not consider that midwifery expertise could have valuable input into decision making.

Well I think you have to assess each case as an individual but I don't get any say in it because I am a midwife. And the midwife seems to be on the bottom of the line really.... usually they, [doctors and specialists] just do things. Say things and do things.
Mary, 3:102.

Midwives found that because doctors were accustomed to a hierarchical pattern of decision making, they did not explore ways of working in a collaborative relationship.

Negotiating Relationships

Midwives found that the concept of an equal professional partnership between midwife and doctor was not easily established. The midwives dealt with doctors' reluctance to work in a more collegial relationship in several ways. Nina went with the women to their usual doctors' appointments when working in a shared care situation. Although she too was a busy health professional it meant that she had to wait with the woman until it was her turn to be seen by her doctor.

R. So when you meet, do you meet in their [the doctors'] rooms?

Yes in their rooms and we wait in the waiting room for however long, an hour or whatever....
Nina, 2:116.

This form of accommodation to the dominant order did not appear to be a form of false consciousness. The midwives were well aware of the power relations which operated and maintained their subordinate status. Midwives used various means to ensure they had some professional input. Mary used a passive means of relating to the doctors.

**I usually try to put it so that they're making the decisions. [laughs]
Like, "Do you think it would be a good idea for them to have some antibiotics?"**
Mary, 2:97.

This strategy has been described as the doctor/nurse game by Short, Sharman & Speedy (1993) and Street (1992). Hutchinson (1990) used the term '*responsible subversion*' in her grounded theory study in which nurses considered themselves acting responsibly in the best interests of their clients, by subversively bending or ignoring institutional policies. The nurse or midwife ensures the doctor feels he/she is dominant while she manipulates the situation so that the responses are congruent with her interpretation of the situation. This type of interaction highlights the inequality of the

professional relationships between midwives and medical personnel. Nina used a form of diversion to ensure a non-interventionist approach was maintained for her patient.

Chat to them. You know chit-chat. Like if you're waiting for the placenta and it's been an hour and you can see them getting really worried and looking at the ecbolics and things like that. So... you say, "How's so and so?"... You try to delay so that you ease their discomfort, so that they'll wait.

Nina, 2:116.

Sue's response was to challenge behaviour which she considered did not acknowledge her as a professional equal. However, it appeared that there was resistance by the consultant to this action.

Well I felt sufficiently angry that I made three appointments to see him at his rooms. And each time it was cancelled. I just really wanted to say to him that if we were caring for a woman together then I expected us to care for her in a professional way and if there was some discussion that needed to take place then we would do it together..... I just had no confidence in him.

... But I felt really betrayed by that.

Sue, 1:87.

The midwives in this study used a variety of methods to negotiate working relationships with doctors. This took energy and considerable negotiation skills. It is difficult to decide if these actions are a form of false consciousness or conversely, a form of responsible subversion. The actions of Nina and Mary support the notion that accommodation of existing hierarchical structures and relationships reinforces the taken-for-granted power relations that exist between midwives and doctors. They are therefore complicitous in their own oppression. However, if the outcomes are positive in terms of working with women, then nurturance/knowledge was obtained in keeping with midwifery philosophy. It would appear that Sue's assertive style was unsuccessful. It would be simplistic to assume that a more equal partnership would result once doctors got used to working with midwives as professionals rather than their assistants. Mary, who was optimistic during the study that by building bridges doctors would get used to midwives having autonomy, reflected ten months later that she agreed with my comment about naive hopes. She was less convinced that doctors would change.

Strength in Unity

Midwives, in working with each other in a collegial and collaborative way present an alternative non-hierarchical model within which they can practise. The sharing of knowledge assists them to co-create midwifery theories and frameworks which can be used to counter ritualistic medical practices. Moloney (1992) described the way in which midwives were able to discuss their work-lives and construct ideas and understandings of what midwifery might and should be. She suggests that:

Such dialogical relationships are essential for gaining new self-understandings which reshape our sense of the possibilities for what we do in the name of midwifery (p.137).

Sue discusses how she learned from a colleague that to share midwifery knowledge and name it was to strengthen its base and make it a visible force to contest taken-for-granted medicalised childbirth.

...as midwives we are very secretive about the little things that we learn on a personal level that have been helpful to us. And the person I learnt from was Joan Donley the domiciliary midwife. She started to bring midwifery out of the closet: not just in a professional way but also in practise and she has encouraged us in the last fifteen years to share our knowledge with each other...
Sue, 3:90.

By organising study days to upskill their care, sharing with each other informally and discussing practice possibilities and options at regional meetings, these midwives were establishing and confirming their particular way of caring for childbearing women. Such sharing empowers through support and creates a new language to articulate their practice. When asked to describe their midwifery role the participants were able to explore this in a language which best described what they did.

It's the mother, the whole family, the birth experience, the welcoming of that child into their family and it's the height of emotions involved in it, and midwifery is *being with* the woman as she goes through that experience. So there is all that whole *being witness* and partnership and facilitating of a positive birth for her and obviously their safety is a factor in that, but I don't think it is the basis of the practice, the way it is for obstetrics.
Nina, 1:113.

Chris describes her relationship with women as:

A friend who has a lot of information and can help them to make things as easy as possible for them. A partnership as you say implies an equal partnership and if you have a woman like this woman we had today who was very knowledgeable, well then you

are looking at some thing like a partnership. But when you have someone like a young woman I had and was completely poverty stricken and didn't know how to ring directory to get a phone number she needed, then how are you going to be a partner with her? You are more being a friend to her than a partner.

Chris, 3:65.

Sue struggled to find the words that indicated that she worked from an assumption of wellness while being mindful of deviations from the norm. She was best able to describe this by contrasting midwifery practice to that which is medically based.

....for midwives birthing is a normal healthy process and has nothing to do with being sick. And I think that that is the other difference with midwives and obstetricians and doctors.they've (the doctors have) got a pregnant woman and try and find out what's wrong whereas a midwife looks at a pregnant woman and says what's right. And then sees the things that are wrong only because they're not right..... Doctors look at a pregnant woman and try to find something wrong and midwives look at a pregnant woman and see what's right and when they see its not quite right then they'll pick that up.

Sue, 2:80

Mary tried to describe the broad range of activities that midwifery might encompass. Like Chris she concluded that the word "**friend**" best described her relationship with women.

Yes it covers a lot of things. You become a social worker, a counsellor, a midwife and you do some of the screening things a doctor does as well. If you are doing total midwife care you are doing much more than what the doctors do, and you become a taxi driver because often you take them places, and an educator, and all sorts of things, and a friend. A friend is really important.

Mary, 1:92.

In developing a language that gives meaning to their actions, values and beliefs, midwives are defining their practice as different to that of obstetrical medical practice. The terms *being with* and *continuity of care* and *guardians of normal childbirth* discussed in Chapter Two have enabled midwives to describe their practice in such a way that the focus on women-centred practice is maintained.

Nina recognises the power of language as she discusses how doctors describe their practice:

...Those whole issues of control and power. They [doctors] constantly talk about *managing* labour, *managing* women. That sort of terminology is very prevalent in their practice... Because our practice isn't controlling.... That's the issue behind it. Power and control.

Nina, 2:123.

Because the words used to describe practice are embedded in the language of dominant medical discourse, it is often difficult to unshackle one's thinking in order to make statements which better represent the proclaimed midwifery philosophy. Moloney (1992) states that, "by subscribing to conventional medical linguistic patterns midwives adapt to the 'correct' pattern in relation to social norms" (p.142), (Single quotations in original). Therefore it is important that midwives redefine and describe their work to legitimate and make visible their practice. Moloney's (1992) suggestion that more research is required which would, "illuminate how linguistic processes intersect with social structures and professional authority to produce particular representations of childbirth" (p.143) appears timely.

Visibility: Should We Tell?

The midwives were well aware that once midwifery knowledge was made public and visible it could be controlled and sanctioned by others. They were therefore careful with whom they shared their knowledge.

If they [doctors] take over certain aspects of midwifery practice then they could end up controlling that too and that would be another thing we wouldn't be allowed to do....

Chris, 4:73.

The positive and negative aspects of knowledge visibility were discussed in Chapter Three. For midwives to share knowledge among themselves and define it helped create an alternative language which would legitimate it as knowledge different to that of medicine or obstetrics. Once practices were made socially legitimate, midwifery could demand a voice, establish its credence and further question medicalised childbirth. However, midwives were unsure if their differences would be respected. They were concerned that their ways of knowing would be simply incorporated at a superficial level into the dominant medical discourse. Again Nina gives an example of how the midwifery claim of *continuity of care* is being used by doctors to reinforce their claim to childbirth care.

They don't like it when the woman decides to come to me completely..... it's a power thing. They say they give continuity throughout the whole of life... They don't realise how important it is for that woman to have that continuity of care for pregnancy labour and afterwards

Chris 1:74.

Chris was also aware that this was already happening. Having established that women were entitled to midwifery care on a continuous basis, she was aware that doctors were establishing practices with midwives who were likely to comply with their medical methods of managing birth. The women would get midwifery care but according to Chris it would not be the sort of care based on the midwifery model of practice and only selected features of the midwifery model were incorporated into the care offered. The midwife would not establish a relationship with the woman as midwives working within the midwifery model claim to do. Instead they would be working for the doctor rather than the woman. She describes how these midwives work in a more fragmented way.

The midwife doesn't necessarily meet them. Well she might meet them once antenatally, she just looks after them for the birth and then they will have someone else looking after them postnatally...It's an abuse of the system I think, and its for the obstetrician's own ends. They [the women] still have a lot of interventions and things he likes.

Nina, 2:123.

Here the problem of doctors' cultural knowledge/power is made visible. Women are most likely to first go to the doctor for confirmation of pregnancy. The doctor is then able to direct the woman to whichever midwife he chooses unless the woman has prior knowledge of the different options available to her. Doctors often exert their assumed authority and tell women they must choose the doctor's recommended midwife. It is only if the woman is steadfast in her decision that a true choice is available.

Some women have had it recommended [by the doctor] that they [the women] don't need a midwife but they've kept on with me, so it hasn't become an issue for me because the lady still wanted me involved.

Mary 2:107.

Working in Partnership With Women

In a working partnership, women and midwives share their knowledge in order to facilitate the best possible childbirth experience and outcomes. Participants in Moloney's (1992, p.91) study described this mutual exchange of knowledge as "power with" rather than "power over". The "power with" relationship endorsed a "woman-centred" approach rather than an authoritarian one. Flint (1993) claims that such relationships have mutual benefits for both midwives and women as they are able to empower each other (refer Chapter Two). This potential for mutual empowerment is recognised by midwives as they strive to work both for and with women. According to Flint (1993) midwives who maintain a continuity of care focus assist in this process.

This mutuality of empowerment appears to be what Chris was describing when she said:

.... if you find a woman who has read widely and has come to the conclusion that this is really what she wants to do, it really gives you the power to get on with it

Chris, 2:67.

In this way the woman's knowledge is not discounted and she is not alienated from her personal experiences of childbirth. This mutual empowerment is established on the basis of trust and friendship. It is similar to Street's (1992) nurturance/knowledge concept discussed in Chapter three. Chris empowers women by informing them of their choices.

You know when the doctor says, "Well it's your first baby and you have to go to hospital," there is someone [a midwife] who says, "Well that's not actually correct. It is actually your choice whether you go to hospital or not." If it is a high risk person then you might be saying, "Yes, well you do have to go to .." [large base hospital], but you might also be saying, "But you don't necessarily have to go under the team [hospital doctors]. You can go under a midwife who will look after you there and look after you afterwards."

Chris, 3:64.

Sue considers that making women feel strong is emotionally and psychologically empowering:

...it means being with women in a way that strengthens them and makes them more whole, not just for that birthing time but for later on as well.

R. Its reaffirming women as women?

Mmmmm. Yeah, that's right.

Sue, 2:79.

The midwives found that because sometimes women did not know about midwifery options available to them it was difficult to work in partnership with them. Due to cultural hegemony women saw medicalised childbirth as their only option.

Yes, because they think of the doctors as the authority too and it takes quite a lot of work on your part to have them thinking of you as a resource rather than an authority figure....I mean there are a lot of midwives who are authority figures and it takes effort on your part to try and prevent that from happening.

Chris, 3:65.

Chris is aware that working in partnership is not something some women are used to. She is also aware that it is easy for midwives to use power/knowledge rather than nurturance/knowledge in a relationship. Instead of empowering women midwifery then becomes another form of oppression for women. Their knowledge being used to dominate and prescribe childbirth practices.

It is clear to midwives that doctors and midwives work differently. While midwives claim to seek to empower women it appears to midwives that doctors disempower women by emphasising the negative aspects of childbirth and maintain their power/knowledge by fear.

..they want to maintain the power. And they instil fear in both other practitioners and the women too. That's very much how they operate with their clients.

Nina, 2:120.

Street's (1992) concept of nurturance/knowledge appears to best describe midwifery's use of knowledge (refer Chapter 3). By the sharing of their knowledge these midwives assist women to understand and make choices about their birthing process. In this way it is the women, not the midwives, who maintain power and control of their childbearing process.

Gaining Recognition

Overt resistance at a national and local level was maintained by belonging to and participating in the activities of the New Zealand College of Midwives. The setting up of Midwifery Standards of Practice is another example (New Zealand College of Midwives, 1993). Midwives and consumers worked together to decide what constituted good midwifery practice. This facilitated the formation of practice guidelines which are based on the philosophy of the midwifery model and are women-

centred. Through the local Homebirth Association, midwives have maintained consumer involvement in the assessment of their midwifery care. This is a deliberate move which ensured that an alternative evaluation of practices was established which involved consumers and midwifery colleagues. Such activities ensured that midwives and consumers work together to co-create assessment criteria that maintain the focus on the total childbirth experience. This avoids relying on the narrow medical outcomes of numbers of interventions, and mortality and morbidity rates to assess practice as used by the Obstetrics Standards Review Committee of Crown Health Enterprises.

As Chris points out the medical model of assessment is based on quantitative data.

You have to give them your statistics of how many births you've done, how many caesarean sections, how many this, how many that and then they look at that and two people interview you if required. And of course all the midwives got interviewed last year.
Chris, 1:69.

The assessment which is instituted by Crown Health Enterprise and in which no consumers are involved is based on technical knowledge. That an alternative form of assessment takes place to the one which Chris describes above, makes a statement about other factors that should be counted in evaluating those who are involved in childbirth practices.

The fact that the midwifery based evaluation process for domiciliary midwives was not accepted by the Crown Health Enterprise demonstrates that the hospital based administrative structures are not yet willing to concede the authority to the midwives as a profession capable of self monitoring. The Crown Health Enterprise continue with their own evaluation system based on the medical model. They therefore support and confirm the power and authority of medical knowledge by using criteria aligned with the interests of medicine.

Summary

The debate involving the two models of maternity care is not just an activity which neutrally decides which has the better outcomes for childbearing families. It is a political activity involving the attempt to legitimate a model of care which challenges the ascendant taken-for-granted medicalised view of childbirth. Inherent in this struggle are questions about how knowledge is to be validated, by whom and for whose purpose. The medical model is not just one way of delivering maternity care. Inherent within it is positivistic masculine thinking which delineates what is to be

counted as valid and therefore truth. Positivism has an assumption that knowledge is gained by a rational objective process reached by independent observation. Such knowledge is regarded as capable of producing facts which will give prediction and control. However there is a failure to recognise that such technical knowledge cannot adequately solve complex human problems such as those that arise for childbearing families.

Midwives are creating a different knowledge base from which informed practical judgements can be made and directed towards quality childbearing experiences for women. Its underlying purpose is to understand, describe and facilitate the childbearing process in the best interests of women. In the past the value assumptions of medicalised obstetric care have been concealed within an aura of scientific neutrality. The midwifery model challenges the purposes of the rules, routines and protocols by which obstetrics is practised. For example it claims that the risk list serves the technical interest which are supportive of medical hierarchical structures. The medical profession has been challenged to justify and defend its underlying epistemological assumptions on which the justification for medicalised maternity care is based. This has resulted in a less than co-operative working relationship between independent midwives and doctors. Compliance of women is obtained by engendering fear of the consequences of choosing a birth within a different paradigm. In this way scrutiny is deflected away from the underlying assumptions of medicine. The midwifery model has thus surfaced the power relations which exist within maternity care.

The success of a process of enlightenment whereby midwives clearly came to view and define themselves as possessing different practices and knowledge than doctors has enabled them to take action in order to maintain a particular practice focus. All the participants had undergone a "paradigmatic shift" (Street, 1990. p.7) which allowed them to work within and have confidence in, the worth of their expertise and knowledge within a midwifery model. To accomplish this midwives were establishing a language which was congruent with their practice. However, it is clear that the struggle to legitimate independent midwifery practice has not ended with a law change. The participants constantly confronted or were constrained by hegemonic structures which challenged their authority to practise autonomously.

While the medical model of childbirth, with its emphasis on technical knowledge, remains the dominant discourse, *doing to* instead of *being with* will remain the legitimate practice focus. The midwives were frustrated by the dominance of taken-for-granted obstetric practices, especially in the use of technology when their practice

experience showed that the interventionist approach was often inconsistent with positive childbirth outcomes. This meant that midwives were often obliged to use technology such as ultrasound and medication such as ecbolics, even when they perceived it to be contrary to their non-interventionist philosophy.

Midwives are seen as requiring greater scrutiny than the medical profession. Midwives find this scrutiny both stressful and frustrating. When such scrutiny takes place the criteria of the medical model prevail. When midwives make public their knowledge they run the risk of being ridiculed by an unsympathetic and unreceptive medical profession. Furthermore, they fear that the dominant medical profession may attempt to enforce rules and regulations which inhibit or forbid that practice without adequate opportunities given to debate its efficacy.

While all of the midwives were unanimous in their aim to have their midwifery model of practice available to all women if they so desired, the ways of doing this differed somewhat. For one midwife, the strategy of building bridges was important and so she concentrated on building up a climate of trust with the doctors so that they would accept her alternative modes of practice. This midwife was willing to play the doctor/nurse game in order to obtain the best care for the women with whom she worked. Another midwife said she used a strategy of distraction to delay the doctors who were about to intervene in what she saw was a labour progressing quite normally. On occasions a confrontational stance was taken as midwives challenged assumptions about how they practised.

Participants were able to examine and critique the medical model against their own values and criteria of midwifery practice and thus move from the "powerless position of objects in the world and to become subjects in their real-life drama" (Street, 1990, p.10). They could thereby resist the dominant medical discourse and work within an alternative model which they believed was in the best interests of both midwives and the childbearing families with whom they worked.

CHAPTER TEN

CONCLUSIONS AND RECOMMENDATIONS

Introduction

This research explored the work-lives of four independent midwives in order to uncover the personal and structural socio-political constraints on their practice. Implicit in research using a critical social approach is the goal of emancipation, by which a process of reflexive dialogue explicates new ways of acting in order to bring about change. The process by which midwives attained the legal right to attend and support childbearing families on their own responsibility was outlined in Chapter One. New Zealand midwives had already undergone a long process of social and political education prior to the passing of the Nurses Amendment Act 1990.

This study had three aims. The first aim was to explore the socio-political context of independent midwifery practice. Through a process of self reflection and social critical reflection, the participants were able to surface those existing hegemonic structures which prevent the exercising of professional autonomy and self determination by midwives. The midwives in this study were then able to critique the way their personal and social worlds needed to be reconstructed to better meet their interests and the women with whom they work. Therefore, the second aim of the study, which was to analyse the social construction of their practice in order to make it explicit and open to critique and reconstruction, was met. Specific factors relating to practice expectations emerged. These clarified those embedded and embodied actions which persisted in the face of a commitment to work in alternative ways. The third aim sought to consider actions which might be taken to maintain and further advance midwifery autonomy. The midwives reflected upon how midwifery knowledge might be shared to increase its visibility. The significance of language and working with women in a process of mutual empowerment was considered. The major findings of the study were as follows.

Major findings

Embodied and Embedded Action

This research indicates that while the legal responsibility to practise autonomously had been won, a complex web of socio-political structures still remain to constrain the work-lives of midwives. Through critical self reflection these midwives surfaced action and dialogue unconsciously supporting the current medical discourse which was not in their own interests or those of their clients. The difficulty of unshackling the dominant paradigm, which had become embodied and embedded in midwifery practice, was a significant finding of this study. Although the participants had charted a course which embraced the language, values and standards of the midwifery model of practice, each midwife found the experience of working within the dominant medical model both stressful and constraining.

Medical dominance

It was clear that even though midwives are legally entitled to conduct deliveries on their own responsibility, the taken-for-granted power/knowledge of the medical profession means that doctors assume that they have the right to oversee, scrutinise and restrict midwifery practice. Although midwives have their own New Zealand College of Midwives Standards of Practice and are subject to New Zealand Nursing Council discipline, assumptions that medical knowledge has precedence over midwifery knowledge means that midwives are frequently confronted with reviews, criticisms and restrictions premised on the medical model of obstetric practice.

Dilemma of Choice for Women

The stated belief that midwives will work in a manner which is empowering and which gives choices to women has surfaced a dilemma for midwives. Although consumer support of midwives ensures that women now have several birth options, participants were aware that often the choices women made were incongruent with midwifery beliefs and practices. Because some women's understanding of the birthing process was based on medicalised management of childbirth, these midwives were often obliged to practise in ways which were in opposition with midwifery ideals but in line with women's choices. In so doing they perpetuated a model of care (such as the use

of ultrasound and ecbolic drugs), which they were consciously trying to change. Midwives found that the concept of informed choice was problematic because often the very act of giving information, such as the dangers of post-partum haemorrhage, tended to reinforce the medicalised view of childbirth as one which is fraught with danger. In contrast midwives wish to inculcate women into the belief that birth is, in most cases, a normal process for which their bodies are eminently designed. A further problem arose of how an emerging ideology which claimed emancipatory action as its goal, may become coercive and disempowering. Tensions between the interests of midwifery and the interests of informed choice for the client were surfaced but by no means resolved by the study. It is significant however that these midwives are aware of the potential for conflict between their interests and those of the women they sought to empower. Further research is required to address the problems of these tensions. Studies focusing on transformative actions which meet the interests of women would be illuminating.

Resistance

The ability of midwives to maintain the impetus of change and develop strategies which resist and challenge the dominant obstetric discourse is significant to a profession which is attempting to establish an alternative way of delivering care. Midwives' readiness to formulate a language which better describes their practice, and to discuss practice experiences with colleagues in a supportive environment, is an important counterhegemonic strategy which allows them to reaffirm their practice. Partially as a result of this study, a means of sharing positive experiences and practices was instituted at meetings of midwives. This counterbalances the practice of medically driven meetings which focus on pathological birth outcomes.

That alternative midwifery practices were made public, and therefore open to scrutiny, produced a dilemma. While the midwives wished to share their practice knowledge and expertise, they were also aware that it would not be judged by criteria that midwives would themselves use. Decisions about what knowledge to make public and with whom to share it displayed a tension between the desire to reflect upon and debate different practices and the concern that practices would be discredited without reasoned critique. As the researcher I was anxious not to make public those tentative discoveries which would make midwives vulnerable to further constraints and scrutiny. An awareness that medicine might incorporate midwifery practices into their domain on a superficial level was a further concern. This might mean that the power relations between women and childbirth caregivers would remain unchanged.

Implications for Health Practitioners

This research has surfaced the dilemmas of a subordinate health group attempting to establish their authority, credibility and recognition within an established medicalised health care system. It is significant to midwifery practice on three counts. First, midwifery has already established important counter-hegemonic strategies. These include legal, educational, economic and social actions. However these actions have not established independent midwives as socially legitimate autonomous practitioners in the eyes of medicine or indeed some members of the public. Midwives need to be continually mindful that they need to work together in establishing midwifery knowledge which will survive rigorous critique by sharing and reflecting upon their practice. Secondly, there is a need to promote and maintain midwifery visibility while at the same time being aware that exposure increases vulnerability in terms of incorporation and control. Language is an important factor in distinguishing an alternative model which has a women-centred focus. Careful selection of language, which is inclusive of women's experiences and midwifery aspirations, will assist in the establishment of a visible midwifery practice. Thirdly, midwives need to continue to work and dialogue with women and seek to understand their birthing needs so that they might continue to empower each other.

In the changing political environment of health, nurses are being urged to establish autonomous practices. The nursing profession would do well to examine midwifery's strategies for recognition and resistance so that it too might learn from them. In a similar manner to midwifery, nursing could start this process by critiquing their historically frozen understandings so that they might surface those personal and social hegemonic structures which constrain their professional autonomy.

While this thesis did not seek the opinion of consumers it clearly has implications for women. Midwives offer an alternative choice for childbearing women. Midwives have already been supported by women to maintain their practice. It is important for women and midwives that the midwife-women partnership remain an egalitarian one. Each must contribute to evaluating midwifery's effectiveness in empowering women. Each must be constantly vigilant that this alternative birthing option results from nurture/knowledge and does not become a coercive and prescriptive ideology based on power/knowledge.

Limitations of Study

A critique of the social critical approach, and therefore this study, is the absence of an explicit feminist perspective. As discussed in Chapter Three, Street (1992) shows that whereas power/knowledge is essentially a masculine concept, the concept of nurture/knowledge derived from feminist thinking better described the activities of her nurse participants. It was clear throughout the study that the gendered nature of the medical and midwifery professions created a tension which could be analysed in terms of feminist frameworks. The way in which midwives coached doctors through unfamiliar experiences and took on the role of relationship builders with their medical colleagues is an example of this (refer p. 137).

A critical social approach has enlightenment, empowerment and emancipation as its goals. A group study is advantageous in this endeavour as it facilitates collective reflection and transformative actions. This research did not realise the goal of collective empowering actions partly because of the use of individual case studies. Further constraints were due to the time limitations imposed by the academic requirements of a Master's Degree. While the design of individual case studies meant that these four midwives did not participate as a group, at the completion of the study all of the participants expressed a wish to meet together. However time, place and the unpredictability of midwifery work meant that this was logistically impossible. Hegemonic structures may have been more readily identified and the process of enlightenment and empowerment more rapid with the use of group discussions. At the participants' request each was identified to the other members of the group to allow collective informal dialogue to take place. Collective political action is on-going both locally and nationally through the College of Midwives.

The individual case study approach enabled the participants and myself to critically reflect upon their everyday worklives. The four midwives found participation in this research personally empowering and were enthusiastic about the opportunity to reflect on their worklife situations.

While common concerns and constraints surfaced, wider more generalised statements cannot be made about midwives and their practice. Contextual and face value validity was achieved as each participant re-read and further reflected on our dialogue. Final case study reports enabled participants to confirm and further clarify with me as the researcher, the findings of the study.

Future Research

Further studies to explicate the differing perceptions and interests of women and doctors, as well as midwives, may prove illuminating. Acceptance of the midwifery model may offer further research opportunities as midwives become more established in their practices. It will be particularly interesting to assess if the midwifery model will gain equal recognition with the medical model or if only those aspects of it that do not threaten the dominance of medicalised childbirth are incorporated within the medical model

The importance of language as an important factor in creating midwifery knowledge that is congruent with women-centred practice was discussed. Language is not a neutral tool for conveying information. It is embedded in and perpetuates the dominant discourse and ideologies while at the same time silencing expressions which better represent the interests of women and midwives. Research which explores the linguistic capital of medicine and midwifery would illuminate how language is used for resistance and/or control.

It was suggested in Chapter One that one of the transformative actions midwives had taken was to successfully lobby for the introduction of direct entry midwifery education. Evaluation research which demonstrates the effectiveness, or otherwise, of the two pilot schemes needs to be commenced. It is important that such evaluation is not merely a cost-benefit study but looks at wider issues of establishing midwifery knowledge through the socialisation of students into midwifery rather than medical models of care.

Concluding Statement

This research has been successful in explicating the socio-historical constraints of the practice lives of four midwives. It has highlighted the ways in which resistance and action can push the boundaries of powerful dominant discourses and contribute to choices and options for women. As a researcher I am left with admiration and respect for the courage of those who daily challenge the taken-for-granted ways women are expected to give birth. Midwives are pioneering health care alternatives by working with women to establish appropriate health care for childbearing families.

APPENDIX A

Example of Initial Contact Phone Call

My name is Colleen De Vore and I wish to work with midwives in a research project I have proposed for my Masters thesis. This initial phone call is to ask if you are interested and if so to arrange a time to meet with you and explain what I hope to achieve. A copy of my research proposal can be sent to you in advance if you wish.

Example of Information Given at Initial Interview

- Aims of the study.
- The interviews will be conducted at a time and place chosen by the participant.
- The participants will be available for 3 or 4 interviews lasting 1-2 hours. These interviews will be recorded on tape. The purpose of the interviews is to reflect on aspects of the participants practice. Some interviews will require the participant to read previously transcribed scripts, and to explore their implications and meaning with the researcher. The participants will also be asked to review draft copies of the research document and comment on their authenticity and the researcher's interpretation.
- The researcher will observe the practice of the participant at least once during the study. The purpose of this is to have access to factors which the participant may be unaware. The purpose is not to judge or appraise the midwife's work skills in any way but rather to gain information about the practice setting in which the midwife works. The midwife and her clients will have an opportunity to refuse or terminate this observation at any time. Accepted protocol for informed consent and confidentiality will be observed for the midwife's clients.
- Tape recordings and interview notes will be available to the researcher, her supervisor(s) and the typist.

- Tape recordings and script transcriptions will be kept in a safe place and always be identified only by pseudonyms. Tapes will be erased at the completion of the study. The participant may request recording to cease at any time during the interview.

- The final study will be submitted as a research report for thesis requirements and may be used at research or education seminars or as the basis for papers published in journals.

- The researcher will be available for clarification of any aspect of the study by phone or in person.

APPENDIX B

Independent Midwives: a Critical Social Approach to Their Practice

Consent to Participate in Research

I.....give my voluntary consent to participating in this study. I understand the nature and purpose of this study. I have had all question I have asked answered to my satisfaction. I understand that I may withdraw at any time.

Signed.....Date.....

Witness..... Date.....

I give my consent to the use of tape recording under the following conditions: All tapes will be kept in a safe place while in use and will be erased upon publication of this study. The tape recorder will be turned off at any time that I request. The only persons having access to the tapes will be the researcher, her supervisor and the tape transcriber unless specific permission is given to do otherwise.

Signed.....Date.....

Witness.....Date.....

APPENDIX C

Information Sheet for Prospective Participants (Clients) of Research Titled: Independent Midwives: a Critical Social Approach.

NAME OF RESEARCHER Colleen De Vore
(Address and Phone number supplied)

AIMS OF THE STUDY

- To explore with independent midwives the socio-political context of their practice. (For example the issues of power and decision making as they carry out their practice in consultation with other health professionals).
- To analyse the social construction of that practice in order to make it explicit and therefore open to critique and reconstruction. (For example to ask the question, in whose interests was this or that done?).

PARTICIPANT INVOLVEMENT

- The researcher wishes to observe the practice of the midwife participant at least once during the study. The purpose of this is not to judge or appraise the midwife's work skills in any way but rather to gain information about the practice setting in which the midwife works. Your personal details or name will not appear in the study. As a client of a participating midwife you will have an opportunity to refuse or terminate this observation at any time. Your approval will be sought if any comments are made during this observation which the researcher wishes to quote verbatim in the final report.
- Participation or non-participation in this study will not affect your midwifery care in any way.

USE OF DATA AND CONFIDENTIALITY

- Tape recordings and observation notes will be available to the researcher, her supervisor(s) and the typist. The typist(s) and the supervisor(s) will be required to preserve the confidentiality of the participant.
- Tape recordings and script transcriptions will be kept in a safe place and always be identified only by pseudonyms. Tapes will be erased at the completion of the study. The participant may request recording to cease at any time during the interview.
- The findings of the study will be submitted as a research report for thesis requirements and may be used at research or education seminars or as the basis for papers published in journals.
- The researcher will be available for clarification of any aspect of the study by phone or in person.

APPENDIX D

Independent Midwives: A Critical Social Approach to Their Practice

Consent of Families Involved in the Research

I(We).....

voluntarily consent to participating in this study. I(We) understand the nature and purpose of this study. I (We) have had all questions I(we) have asked answered to my satisfaction. I(We) understand that I(we) may withdraw at any time without prejudice.

Signed.....Date.....

Witness.....Date.....

I give my consent to the use of tape recording under the following conditions: All tapes will be kept in a safe place while in use and will be destroyed upon publication of this study. The tape recorder will be turned off at any time that I request. The only persons having access to the tapes will be the researcher, her supervisor and the tape transcriber unless specific permission is given to do otherwise.

Signed.....Date.....

Witness.....Date.....

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