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**FOR JOANNA**

**WHO HAS CHANGED OUR LIVES FOREVER**

**MAY YOUR LIFE BE A CONTINUAL SEARCH FOR  
KNOWLEDGE AND WISDOM.**

**MAKING DECISIONS: FOCUSING ON MY BABY'S  
WELL-BEING**

A grounded theory study  
exploring the way that decisions were made  
in the  
midwife-woman relationship.

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

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## **ABSTRACT**

This thesis presents a study using a Grounded Theory methodology to explore the way that decisions were made in the midwife-woman relationship. The purpose of this study was to explore the woman's experience of the way that decisions were made, to gain an understanding of it and finally to present a description of the way such decisions were made when women utilised midwife-only care within the New Zealand maternity setting.

Ten women were invited to participate. A diverse sample of women with different birth experiences and from different cultures was obtained. The sample was obtained using the tool of theoretical sampling which highlighted, through data analysis, the need for participants with different characteristics. All women who were interviewed were asked to describe their pregnancy and birth experience, their relationship with their midwife and the way they believed decisions were made during their pregnancy and birth experience.

Data analysis was performed using the constant comparative method. Results showed that women acted in ways to ensure their baby's safety. Women initially acknowledged their pregnancy and as a result, they selected a maternity carer and participated in self education. To ensure their baby's well-being women undertook procedures and followed instructions from their midwife. Whilst they planned for their birth and made decisions that effected themselves and their unborn child, the primary goal behind these actions was their baby's health. The women trusted their midwives to endorse actions that would lead to a safe outcome. At times the women wanted midwives to make decisions for them. Choice, continuity and control are important to women but safety is vital.

## **ACKNOWLEDGEMENTS**

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## **CHAPTER ONE**

### **ORIENTATION TO THE STUDY**

#### **1.1 Introduction**

This thesis presents a description of the way that decisions were made within the context of 1996 midwifery practice in New Zealand. In this study women who received midwifery services for their pregnancy and birth experience were interviewed and the way that they perceived that decisions were made has been described. This description is taken from the words of the women who participated in the research. It is a description of their stories and the process that they followed in determining the path of their pregnancy and birth experience.

Chapter one provides an introduction to the study. Within this chapter is a discussion on issues that were relevant to my midwifery practice and provided the impetus for the research. The aim of this study is also presented and the chapter ends with an overview of the content of this thesis.

#### **1.2 Situating this Research**

The idea for this research came from the practice of independent midwifery. As different women have different requirements during their pregnancy, the role of the midwife in assisting to fulfil these requirements differs with each woman.

New Zealand midwifery has attempted to promote shared decision making in the care provided to birthing women within New Zealand (New Zealand College of Midwives inc., 1993). As midwifery practice grows and responds to women's expectations it is imperative that care provided to women is evidence based. Members of the midwifery profession within New Zealand are stating that care that is provided is focused on equal decision making (Guilliland and Pairman, 1995). It is important therefore, that women's experiences of decision making during pregnancy and birth are examined.

The need for this study also arises because of the differences between midwifery and medical aspects of care. The medical profession is described as having an inherent need to control childbirth and all those who participate in it, be they women or midwives. A midwifery profession that actively promotes and encourages shared decision making and responsibilities provides an alternative perspective to the control stance generally taken by those in the medical profession (Bryar, 1995). Midwives, through empowering women, are able to educate them about their right to self determination, so enabling them to question their maternity care. To gain an understanding of how decisions are made within the midwife-woman relationship, it is imperative that women who have selected midwife only care are interviewed and their thoughts and experiences explored.

### **1.3 Decision Making**

In a woman centred philosophy of practice the woman is the focus of care. If given information it is believed that the woman can make choices that will enable her to

control her pregnancy and birth experience. One of the roles of the midwife in this situation is to listen to the woman and to provide her with the information that she requires, so that the woman can make informed choices. The care that is provided is dependent on the midwife's belief about birth and how she envisages the relationship she will have with the woman. The nature of the care is also strongly dependent on the type of relationship the woman wants with the midwife.

According to Hillan (1992, p. 274)

Few women view pregnancy and delivery as a series of biological events over which they have no control and increasingly they are demanding a more humanistic approach to obstetric care and a greater share of responsibility in decision making related to the care that they receive.

Midwifery is one of the many health professions that exists within today's society. Whilst the profession may have existed for many generations there has generally been a lack of research into all aspects of practice by midwives. This has changed somewhat in recent times and the increase in midwifery journals and publications is testimony to this (British Journal of Midwifery; Midwifery; MIDIRs midwifery digest; McCormick & Renfrew, 1996; Simms, McHaffie, Renfrew & Ashurst, 1994). Further attempts are needed to incorporate the research culture into midwifery practice (Hicks, 1992; 1994; 1995; 1996; Rees, 1996; Sleep, 1992). An analysis of the way that decisions are made between midwives and women can aid in enhancing the way midwifery practice is delivered and therefore developed.

Other professions have attempted to uncover the way that decisions are made. Literature is available that looks at the decision making process from a managerial perspective. To utilise this literature is both relevant and necessary for a comprehensive understanding of the process of decision making. McCall and Kaplan (1990) describe the classical managerial decision sequence as being “careful definition of the problem, an exhaustive search for information, generation of numerous alternatives, and a calculated choice among the alternatives.” (p xvi - xvii). This quotation has relevance for midwifery practice as there are many decisions that need to be made during the course of a woman’s pregnancy and birth. The sequence of events as described by McCall and Kaplan may be those used by midwives and women. However the interplay between the woman and her chosen health professional adds an extra personal element to this process. Discovering and understanding the woman’s perspective of this decision process was seen as being important for enhancing the midwives’ knowledge and understanding of the concept of woman-centred care.

#### **1.4 Midwifery Practice**

There are many legal statutes that must be followed and adhered to in order to practice as a midwife within New Zealand. These statutes exist to protect the midwife and the woman. Decision making in midwifery practice is therefore dependent upon the right to practice as a midwife and the legal constraints of such practice. For example, the right to prescribe medications is a legal right that has been bestowed upon midwives by the Medicines Act 1981 and the Misuse of Drugs Act 1975. The midwife has an obligation to learn about the drugs that she may

prescribe and the decision to prescribe drugs is that of the midwife. The decision to utilise the prescribed medications, however, belongs to the woman. The midwife needs the necessary legislation to be in place so that she can offer a full midwifery service and can act within her scope of practice. A midwife is defined as:

A person, who having been regularly admitted to a midwifery educational programme duly recognised in the jurisdiction in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and or legally licensed to practise midwifery.

The sphere of practice: She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.

She has an important task in counselling and education - not only for patients, but also within the family and community. The work should involve ante-natal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care.

She may practise in hospitals, clinics, health units, domiciliary conditions or any other service.

(World Health Organisation, 1996)

During the twentieth century the midwife's legal right to practise within the New Zealand context has been legislated and controlled. The 1971 Amendment to the Nurses Act made it a statutory requirement that all births be attended by a doctor, the 1983 Amendment to the Nurses Act prohibited midwives who were not also nurses from entering domiciliary practice. As a consequence of such constraints to midwifery, medical practitioners took control of childbirth (Abel 1997; Donley, 1986; Fleming 1995). An important difference between the medical and midwifery models of maternity care is described by Bryar (1995). Bryar believes that in the medical model the doctor is perceived as being in control of the care and most importantly that information given to women about aspects of care is limited. With limited information the question arises about issues of informed consent. Literature is available that describes the doctor-patient relationship and how informed consent can be and is incorporated within medical practice (Goodyear-Smith, 1991; Jaiyesimi & Ballard, 1992; McKinstry, 1992; Weil, 1993;) . Informed consent promotes the exchange of information. However, any threat to the control of information can also be seen as a threat to medical control. The idea of informed consent and practices that promote information sharing, empowers people to refuse prescribed treatment. Informed choice and information sharing are elements of midwifery practice, yet the midwife's ability to provide women with such information will be limited by the midwife's practice and by her knowledge.

Within her practice each midwife will have her own 'speciality' or 'pet interest', be it for example breastfeeding or labour care. For each practitioner there will be some facet of care that she excels in and others in which she has a general understanding. It would seem impossible to expect that every midwife is a specialist in every aspect of midwifery care. Yet each midwife's experience and philosophy will influence the information and choices that are given to women. Immunisation is one subject in which we may unnecessarily impose our values and beliefs upon women, Vitamin K is another. Providing biased information is not ethical but it may be a consequence of individual practice. To state for example, "discuss immunisation with your practice nurse", allows the midwife the luxury of thinking that she has brought to the woman's attention the topic of vaccination and that she can tick it off the care plan. The discussion that the woman has with the practise nurse may just involve receiving the Ministry of Health's pamphlet on vaccination and this can hardly be regarded as allowing the woman to make an informed decision.

The information provided by the midwife is one aspect that can assist women to make decisions during pregnancy and childbirth. The question remains: How do women make decision about their pregnancy, labour and birth, and the postnatal period?

### **1.5 Aim of this Study**

The aim of this Grounded Theory study is to produce a rich description of the way that decisions are made between a midwife and the women for whom she provides a midwifery service. The term 'midwifery' is used as a generic term to depict the

substance of the midwife-woman relationship and to describe those activities provided by the midwife for the woman. Such activities include the antenatal, intrapartum and postpartum care of the woman and her baby and also the provision of information on which the woman can make decisions, therefore resulting in a safer woman-centred, midwifery service.

The desire to study the way that decisions were made arose from my own practice. I found to my horror that many of the women for whom I provided midwife only care often cringed at the amount of information given to them, and frequently had no questions or had no interest in issues that I felt were important topics for discussion. My initial concern was that perhaps I was blinding them with science, but the idea of sharing information to allow others to participate fully in the decision making process was important to me and from these experiences I began searching for ideas about the way that women want to make decisions. Midwifery philosophy of practice is aimed at providing information and empowering women to make decisions. However, I frequently began to see that this ideal was far from my actual practice reality. Acknowledging this as a potential bias I decided to find out how decisions are made between the midwife and the woman. It is acknowledged that as midwives, the physical midwifery care we provide (e.g. checking blood pressure, listening to the fetal heart) is essentially the same but the philosophy we apply to, and the emphasis that we place on, aspects of practice differ. I believed that obtaining a rich description of the way that decisions were made among a diverse group of childbearing women would answer the questions that had perplexed me, and would enhance or change my midwifery and information sharing practices.

## **1.6 The Significance of this Study**

This study has enabled me to undertake research into an area of midwifery practice that has generally been taken for granted by practitioners. Midwives have largely accepted the partnership model of practice (Guilliland & Pairman, 1995) and incorporated it into their own philosophy. Within this model are the concepts of shared decision making and also the woman being the main decision maker. In this research the experiences of women who utilise midwife-only care have been studied. Knowledge about the role of the midwife and the focus of the women in making decisions can aid the enhancement and direction of midwifery practice.

## **1.7 Overview of the Content of this Thesis.**

In **Chapter One** the background to the current study is presented. Here an attempt has been made to place this study within the context of New Zealand midwifery practice.

**Chapter Two** provides the literature review. In this chapter the use of literature in a grounded theory study is discussed. A brief history of midwifery, with particular reference to New Zealand, and new forms of practice are presented. Finally, issues that are relevant to the midwife-woman relationship are discussed.

**Chapter Three** is the methodology chapter in which Grounded Theory and its application to midwifery research is examined. The importance of symbolic interactionism is discussed. Finally, the specific method utilised within this study with emphasis on the ethical underpinnings that guided the research is presented.

**Chapter Four: Acknowledging Pregnancy.** This is the first data chapter and here the process that a woman follows for confirming her pregnancy is examined. After confirmation of her pregnancy there are various options available to women and choices that they must make. This chapter looks at these initial choices and the way that the women made such decisions.

**Chapter Five: Acting to Ensure my Baby's Well-being:** The second chapter of data analysis looks at the way that women acted during their pregnancy and birth experience. It describes some choices that they made and their focus during their pregnancy and birth experience.

**Chapter Six: Trusting my Midwife.** In this the final data chapter, the women discuss the relationship they had with their midwife. This chapter contains a discussion about the women developing trust in their midwives and their professional knowledge.

**Chapter Seven** presents the overall description of the way that decisions were made. The central theme of this study has been that women act in ways, and make decisions, to ensure their baby's well-being. This chapter ends with presentation of the discussion, recommendations and limitations of this study. A concluding statement is presented.

The APA (1994) referencing system has been used throughout the thesis.

This study is part of the body of research into midwifery practice that is slowly building up within New Zealand. To the best of my knowledge this is the first study that has looked specifically at the way that decisions were made by women within the context of the midwifery relationship. Parcell (1995) has presented a description of decision making, but the focus of her article was on midwifery clinical decisions and therefore is different to this present study. Similarly Smythe & Kerins (1994) describe their study that attempted to look at the reality of decision making again from the midwife's perspective. This current research will be of use to midwifery practitioners by helping them to understand how women derive information and the individual needs women have with regard to making informed decisions.

### **1.8 Summary**

In this chapter I have provided a brief discussion on what stimulated this research and the prior understanding I had about the subject under study. I have introduced the philosophical position related to decision making and informed choice within current New Zealand midwifery practice. Justification for the current study has also been presented, as has an overview of the content of this thesis.

In Chapter two the role and importance of literature within the context of a grounded theory study is examined. Issues relating to midwifery in New Zealand are discussed, with reference to research and theoretical literature.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

Literature is an important source of knowledge in any study. In a Grounded Theory study literature acts as an additional data source. Therefore, the relevance and significance of literature has a different focus within such studies.

In this chapter I will initially discuss the role and importance of literature within a Grounded Theory study. The history of midwifery, both internationally and within New Zealand, will be discussed as will current models of midwifery practice specific to New Zealand. The literature review ends with a discussion on informed decision making and the importance of midwifery knowledge in facilitating this.

#### **2.2 Literature in a Grounded Theory Study**

When undertaking research, the documented procedure is to look at the established body of literature available on a specific topic in order to place the current study within the context of a wider body of knowledge (Hicks, 1996; Wilson, 1985). The researcher who undertakes a Grounded Theory study however, has a different focus on the literature. Within a Grounded Theory study literature is viewed as another data source, something that can be utilised to enrich the theory that is being developed. "Remember when reading that what the author presents as his knowledge is, for the grounded theorist, data in a perspective." (Glaser, 1978, p. 33)

Hence, whilst the researcher generally gathers information about the process and procedures involved within a Grounded Theory study, they do not initially perform an in-depth review of current literature on the topic being studied. Rather literature that is reviewed is carried out as an ongoing process. The shape and path of the review is determined by the codes that emerge through data analysis. Glaser (1978, p. 31) states: “When the theory seems sufficiently grounded and developed then we review the literature in the field and relate the theory to it through integration of ideas”.

The aim of this literature review is not to place this study within the context of existing research that describes the way decisions are made in the midwife-woman relationship. Literature is reviewed to add a richness to the codes which have been discovered during the data analysis. Literature review is performed in an attempt to focus the theory on the categories that emerge and not to force the analysis based on studies already completed.

Literature is presented at the beginning of the research to introduce the reader to concepts that are important to the researcher at the onset of this study. I have also provided the reader with a discussion on the background knowledge with which I approached this study. The scope and direction of the subsequent literature review has been brought about by the data analysis. Within the subsequent review, a large range of literature has been presented from the areas of medicine, midwifery, nursing and women’s health.

Researchers, who are also midwives, begin their studies with knowledge and experience of aspects of midwifery. As stated by Jackson, (1996, p. 7) “A midwife researcher cannot pretend that there is no background of experience and knowledge, or some familiarity with the literature and midwifery setting which in turn influence the research conduct and outcomes.” This idea was also discussed by Christensen (1990) who believed that to be a midwife/nurse and to undertake grounded theory was compatible. However, Christensen recognised that the researcher must “acknowledge that the study is ‘grounded’ within current nursing <midwifery> theory and knowledge” (1990, p. 234). By acknowledging that the researcher is a practising midwife and has a pool of underlying midwifery knowledge, this study will be grounded in the words of the women and within the practice of midwifery.

In the methodology chapter the components of grounded theory will be further described, including its application to the present study about the way that decisions were made between the woman and the midwife. Literature focusing on both the midwife-woman relationship and the concept of informed decision making is presented within Chapter Two.

In order to understand the midwifery context of this study a brief historical overview of midwifery, both nationally and internationally, will be given. In this background discussion I will look at the history leading to changes in practice within New Zealand. Partnership, choice, control and decision making within the midwife-woman relationship will be introduced as fundamental concepts underpinning the way midwifery is practised in New Zealand.

### **2.3 Historical Background**

The profession of midwifery has evolved substantially over the past two centuries. Advances in health care that have affected all practices of medicine have also affected midwifery. Historically and internationally, the traditional place of birth has been the family home, where women were tended by the local midwife. Sometimes these caregivers were formally educated; often they were educated by another midwife. Others had no training, and cared for women in labour by default (Tew, 1990).

Traditionally, doctors have not always attended women in labour. In the 19th Century members of the medical profession started to develop an interest in the care of pregnant women. Women paid for labour and birth services and they were therefore seen by the doctors as a potential source of revenue. Doctors attending births in the 19th century were originally barber surgeons. They used their surgical techniques in attempts to save a labouring mother from death.

As time passed competition for the care of pregnant women increased. A smear campaign depicting the midwife as “hopelessly dirty, ignorant and incompetent” (Ehrenreich & English, 1973, p. 34) helped to promote medicine as a safe alternative to midwifery care. The doctor had his technical knowledge, something that the midwives did not possess. Women who could afford it would use a doctor for their care. The ‘unsafe’ midwife was left to care for the poor.

In attempts to improve morbidity and mortality, doctors began to coerce women into giving birth in the hospital. This again was seen as enhancing the safety of childbirth. In hospitals doctors could offer women pain relief for labour and this was another means used to entice women to give birth in hospital. Medical specialisation developed with obstetricians rising to dominate the care of pregnant women. Care was based in the hospital under the doctor's control. As medicine established itself in the forefront of obstetric care the place of work for the midwife shifted from the community, where she was the sole caregiver, to the medically organised hospital, where she became the subservient helper.

The policy of the increased hospitalisation of birth advocated by doctors, allegedly to improve the welfare of mothers and babies was in fact a very effective means of gaining competitive advantage by reducing the power and status of midwives and confirming the doctors ascendancy over their professional rival.

(Tew, 1990, p. 7)

As care of pregnant women was taken over by obstetricians, midwifery practice gradually became assimilated into the medical model. Midwifery education in some areas was based on the medical model of childbirth (Myles, 1981), becoming fragmented, both in the organisation of care to coincide with shift work and in the composition of care. Pregnancy and birth were separated into modules depending on the nature of the service that was required e.g. antenatal care. The midwifery services were provided to the woman by strangers, and procedures and protocols were often determined by medical need and hospital administrators.

In New Zealand, midwifery was assimilated into the medical model of childbirth, closely following changes that occurred internationally. However, since legislative changes in 1990 New Zealand midwives have regained their independence and their ability to provide care for women independent of medical control.

## **2.4 Midwifery in New Zealand**

New Zealand closely followed the rest of the world in setting up a hospital based system of pregnancy and birth care for women. The rise of the medical profession in New Zealand closely mirrored that of other countries. Donley (1986) describes how the development of the New Zealand College of Obstetricians and Gynaecologists led to the further domination of midwifery by the medical profession; the care of pregnant women moving deeper into the New Zealand hospital system.

New Zealand midwifery was predominantly an obstetric controlled profession. In the 1970s a medical practitioner had to, by statute, attend and supervise the care of women during birth. Medical control was at its peak and midwifery was on the road to extinction. Some midwives had developed a reliance on medical practitioners to plan women's care and direct them in their practice. Midwifery was a passive profession, the doctor was in charge and the midwife took the handmaiden role and followed instructions. Midwifery autonomy was non-existent and the midwife believed she was accountable only to the doctor. Women's rights and choices featured little within New Zealand obstetric or midwifery.

It was not until the 1980s that women became despondent with the medical system and began to voice their disapproval. Political lobbying, was undertaken by women and midwives, which led to changes in legislature that gave midwives statutory and professional independence (Abel, 1997; Fleming, 1995). Following the 1990 Nurses Amendment Act, women could now choose a midwife as their sole caregiver during their pregnancy and birth experience.

Much has been written about the forces that led to the changes in the Nurses Amendment Act 1990 (Abel, 1997; De Vore, 1995; Fleming, 1995). Parliamentary support was essential for midwives to achieve the necessary legislative changes allowing them the right to practice independently. This support was provided by the then Minister of Health, the Hon. Helen Clark. In 1990, the Nurses Act, and necessary related acts and regulations, that allow midwives the right to work and be paid as independent practitioners were amended. Midwives could now prescribe medicines for women and babies within their care, they could access diagnostic services and claim the same payments for their services as medical practitioners. Whilst these changes occurred with much opposition from the medical profession, midwifery in New Zealand had regained its independence.

As a result of the regained independence, New Zealand midwives had to establish an identity that separated their practice from that of doctors. The term partnership has been used to describe the way in which many New Zealand midwives work with women when providing midwifery services.

## **2.5 New Zealand forms of midwifery practice.**

Since 1990, opportunities have arisen for differing types of midwifery practice. These opportunities have resulted from midwifery statutory independence and include midwifery led care, shared care with other health professionals and fragmented care where the midwife works in the hospital environment providing one aspect of midwifery to women on a shift basis.

Midwife only care is an option available to women where the midwife takes ultimate responsibility for all the antenatal, intrapartum and postpartum care for “low risk” women. Care may be provided by groups of midwives organised into teams or it may be provided on a caseload basis. Within the team midwifery model the woman meets all members of the team and when she goes into labour contacts the on call midwife. In caseload midwifery the woman has a specific midwife who is responsible for the woman’s maternity care. Page (1995, p.13) believes that “the majority of midwives should carry caseloads instead of staffing wards and departments. This requires that midwives take full responsibility for the midwifery care of a number of women, being the lead professionals in a proportion of cases.” Page sees this as being part of an expanding professional role for midwives. She feels that the care for women will improve through this development because “better care comprises more continuity, more emotional security and more flexibility but without compromising the medical safety” (Page, 1995, p.52).

Care that is provided in the New Zealand context may represent a combination of the above types of midwifery care. Hospitals have developed midwifery teams to

provide women with continuity of care. Groups of independent midwives may work in either the caseload mode or the team mode of practice. Each midwife has her own philosophy of the best method of care delivery be it team or caseload midwifery.

Shared care is another type of practice that has evolved. Here the woman may have both a midwife and a medical practitioner involved in her antenatal and intrapartum care. This has meant that midwives have been able to provide complementary care for women in conjunction with other practitioners. There are potential drawbacks to this scenario as, unless practitioners effectively communicate, there are no clearly defined lines of practice and responsibility with the risk that the woman receives duplicate care or no care at all. This shared care is seen as allowing doctors to continue their control of childbirth and midwifery practice. However, this type of care allows women the flexibility of continuing with their medical practitioner as well as developing a relationship with their midwife before labour. It also means that high risk women who must go to a specialist for their pregnancy care can meet and know their midwife before they go into labour.

Fragmented care, as provided within the hospital system, remains evident throughout New Zealand. Midwifery care provided by strangers, on a roster basis, still exists and is seen by some practitioners as being an appropriate way of providing midwifery. This is often a personal decision as many midwives with personal commitments cannot realistically provide one to one care for an unknown time period. Here the woman may be cared for by many different midwives throughout the whole childbirth experience. A mix of different staff may mean that

the woman does not receive midwifery care, but receives care from enrolled or obstetric nurses<sup>1</sup>. Such nurses have not received the education of midwives and often do not practice with a woman centred philosophy.

In this study I have focused on midwife only care. One of the main differences between midwife only care and other forms of midwifery practice is the nature of the relationship between the woman and the midwife. Within New Zealand the term “Partnership” is often used to describe the model of practice implemented and subscribed to by midwives.

## **2.6 Midwifery Models of Practice**

The entrance of New Zealand midwives into the development of midwifery models of practice has been recent. Models of practice that relate specifically to New Zealand midwifery are those presented by Fleming (1995, 1996) and Guilliland & Pairman (1994, 1995) and Lauchland (1996).

Fleming (1996) used an analogy of homespun wool to describe the intricate nature of the midwifery relationship. She describes midwifery practice as a unique relationship between the woman and the midwife with the major component of this model being interdependence. Whilst describing this relationship as being unique, she also presented issues that were common to the women. Fleming was of the opinion that “this seemed to exemplify the spirit of midwifery in that as midwives

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<sup>1</sup> A nurse who has received a maximum of 18 months education and who must work under the direction of a Registered Nurse or Midwife.

we attempt to cater to the unique needs of each client but maintain some commonality between clients” (Fleming, 1996, p. 3). Within this relationship the woman and the midwife are seen as being influenced by many social, cultural and environmental factors which included education, friends, the woman’s colleagues and her own personal beliefs. Fleming (1996, p. 4) described these factors as being “invisible in the final product but nevertheless bind it together.”

The major themes that were evident in Fleming’s study were attending, presencing, supplementing, complementing, reflection, reflexivity and reciprocity. Each theme apart from reciprocity was looked at from either the woman or the midwife’s perspective. Reciprocity is described as “the essence of all successful midwife/client relationships” (Fleming, 1996, p.9). It occurs at all stages of the relationship and through this process ongoing development of the relationship occurs. Fleming sees her work as being incomplete and believes that it will continue to be so as the social, cultural and environmental influences that affect women’s lives are in constant change.

The second model examined is the partnership model developed by Guilliland and Pairman (1995). Guilliland and Pairman cite four ideas that they believe form the basis of the midwifery partnership. These ideas are that

- midwifery practice is woman centred.
- pregnancy and birth are normal life events
- the midwife has professional independence
- continuity of midwifery care is provided.

Page (1991) also proposed five similar principles in her discussion on modern midwifery practice. Her principles were - “continuity of care, respect for the normal, enabling informed choices, recognition of birth as more than a medical event and finally family centred care” (1991, p. 251). There are similarities between the model proposed by Guilliland and Pairman and the principles proposed by Page. However, Guilliland and Pairman address the issue of midwifery independence, an important issue for New Zealand midwives as they attempt to maintain their professional status, whilst Page focuses on midwifery needs for women - continuity, choice and family involvement in the birthing process.

Guilliland and Pairman present the following three concepts as being components of a midwifery partnership :

- Individual negotiation. This is where both the woman and the midwife bring their own ideas to the relationship, each thereby making a valid contribution to the relationship. Individual negotiation is described as being “the ongoing process by which the woman and midwife work through issues of choice, consent, decision making, power sharing and advocacy, mutual rights and responsibilities, as they arise within the partnership.” (p.45)
- Equality, shared responsibility and empowerment. Both members of the midwifery partnership are described as having equal status. The role of the midwife in this relationship is “one of empowerment towards self determination rather than advocacy.” (p.45)
- Informed choice and consent. Within the partnership model it is the woman who makes the decisions that pertain to the pregnancy and birth experience. “If the woman is to be an effective partner within the relationship she must make her

own choices. The Midwife's responsibility is to provide enough information to enable the woman to make an informed choice and decision." (p. 49)

This partnership model as proposed by Guilliland and Pairman (1995) has been adopted by many midwives in New Zealand and there is a belief among practitioners that this is the way that midwifery care should be provided. Guilliland and Pairman did not derive their model from the data obtained in a research study. They draw on quotes from other writers but this proposed model of practice is their description of how some midwifery services are provided within New Zealand. Pairman (1996) is currently undertaking research in an attempt to evaluate the Partnership model.

## **2.7 Partnership**

The word partnership is used by the New Zealand College of Midwives (NZCOMi), (1993, p.10) to describe the nature of the relationship between women and midwives. Partnership is seen by the College as being the midwife's responsibility to her client. Partnership is a phrase used frequently by many New Zealand midwives as it has evolved into a widely used method of practice.

There has been some debate, however, about the NZCOMi's philosophy and the Guilliland and Pairman model (Churcher, 1995; Clotworthy, 1995; Rose, 1995). This debate arose because of statements made during the explanation of the model that indicated those midwives who provided fragmented care within the hospital setting were not practising midwifery. As stated by Rose (1995, p.6)

This paper <Guilliland and Pairman (1994)> serves to reaffirm the opinions expressed in the Wellington NZCOM conference, that the college is focused on the interests of the independent practitioner. There is no recognition or acknowledgement of the work and commitment of the many midwives that are employed in hospitals.

The concept of a midwifery partnership was generally accepted and acknowledged by midwives (Gilkison, 1995; Lauchland, 1996; Martis, 1996; Taylor, 1996 ).

Fleming (1995, p.155) also looked at the issue of partnership during her interviews with midwives and women. She states that "through the medium of independent midwifery practice, women (both as midwives and as clients) have come together in partnership to counter the hegemony of the medical profession in the childbirth arena". She believes that "how midwives and clients work together within the knowledge/ power nexus forms the partnership in action" (Fleming, 1995, pp. 155 - 156). Therefore the question arises as to what characterises a partnership and how these midwifery partnerships are formed and developed. This question was also raised by Lauchland (1996) who presented her personal view of the midwifery relationship. Lauchland saw this as being a shared journey between woman and midwife, however she also believed that the formation and development of such a partnership needs further research.

Literature published for midwives by the New Zealand College of Midwives inc., e.g. *Midwives Handbook for Practice* (1993), highlights the nature of the partnership

relationship. According to the Handbook for Practice a midwife is described as working in partnership if she :

- recognises shared and individual responsibilities,
- facilitates open interactive communication,
- shares all relevant information within the Partnership,
- identifies her midwifery philosophy and Code of Practice and freely shares this information with the woman,
- does not impose her value system on others, and
- is culturally safe. ( NZCOMi, 1993, p.15.)

The above six ideas point to what the NZCOMi view as being the elements of a partnership with the woman. From the text it appears that this partnership may be a one sided relationship. Whilst it states that the midwife recognises individual and shared responsibilities it also states that the midwife shares all relevant information. Yet, who stipulates what information is relevant? The information that the midwife shares with the woman will depend on her belief about the nature of the partnership.

The NZCOMi definition of the midwifery partnership appears to give little or no credence to the role of the woman. It is focused on the role of the midwife. It states what care or attributes the midwife must have, but it does not look at the individuality of women. For example, the idea that the midwife facilitates open interactive communication is a great ideal. However for some women and in some cultures open interactive communication may be inappropriate. The woman may not want to share responsibility. She may see the midwife as guiding her through the pregnancy and birth experience and the woman may want the midwife to help her

make the decisions that are necessary throughout the childbirth experience or even to make them for her. The Midwives Handbook for Practice therefore does not appear to present the woman's perspective of the partnership. Whilst it is a handbook for midwives, consumers are active members of the NZCOMi and acknowledgement of their expectations could be assumed relevant and worthy of inclusion into such important midwifery documents.

Guilliland and Pairman (1995), when presenting their ideas on the basis of the partnership model of midwifery practice, consider the partnership to be a shared journey between the woman and the midwife. They see the focus of the partnership as being the woman who works with the midwife and makes decisions. The woman's focus is on the baby.

Midwives practising within New Zealand and attempting to work in some type of partnership with women have had to address issues relating to practice. These issues relate to concepts of continuity of care, informed choice and control over the woman's childbirth experience.

## **2.8 Continuity of Care**

By utilising a continuity of care philosophy an open and honest midwifery relationship can develop. This type of relationship may help to remove many of the difficulties women experience during pregnancy and childbirth. Continuity of midwifery care proposes that the woman has only one midwife and has the opportunity to spend time and develop a relationship with her during the pregnancy.

Therefore the midwife and the woman do not have to try to establish an understanding relationship during labour.

Page (1995, pp. 18 - 19) describes continuity as

... <giving> women real choice and control. We provide continuity so that there is someone, (...) who works with the woman and her family, one to one, getting to know her needs, giving information in a way that she understands and supporting her in making up her own mind. (...) We provide continuity to make sure there is someone the woman knows, who can be with her and comfort her and encourage her at times of need...

Midwifery needs to be consistent with the woman's expectations. Walton & Hamilton (1995) discuss the implications of the Changing Childbirth report on midwifery practice within the United Kingdom. Continuity of care is an issue that was paramount in restructuring the British maternity services, and Walton & Hamilton (1995) and Page (1995; 1993; 1991) discuss its implications for midwives. Research has found that midwives providing continuity of care can experience greater satisfaction with their midwifery role (Hundley et al 1995).

In New Zealand continuity of care was discussed in the Coopers and Lybrand (1993) report into the maternity services and was seen as being desirable by women. Yet the Regional Health Authority (RHA), within the context of the 1996 notice concerning the provision of Maternity Services (Section 51 of the Health and Disability Services Act), stipulate within the care plan that discussion is required

concerning how continuity will be achieved. They do not define however what continuity is and continuity of midwifery service is not discussed within the notice at all. Continuity is seen as an important and positive aspect of midwifery practice internationally. It is the focus of much debate both in New Zealand and overseas. However, whilst the Health Authorities mention the concept of continuity they do not go so far as to ensure that women receive continuity of midwifery caregiver. There is therefore no emphasis on this practice from the health purchasers and women, as a consequence, may not receive continuity of midwifery care. This has important ramifications for women as, by receiving continuity, women have been described as being able to have some control over their pregnancy and birth experience. Control therefore is another important element of the midwife-woman relationship.

## **2.9 Control**

The Code of Ethics of the NZCOMi state that “Midwives accept the right of each woman to control her pregnancy and birthing experience.” (1993, p.10) Control is defined in the Concise Oxford Dictionary (Allen, 1990, p. 250) as “the power of directing”. Within the context of the midwifery relationship, control of the birth experience by the woman is perceived as being one of the outcomes of an open, honest and equal partnership. Midwifery philosophy promotes women having control of their pregnancy and birth and consequently making decisions that affect this experience.

Control of the birthing experience is one of the components of the midwife-woman relationship. If the woman is in control of her pregnancy and birth experience then her decisions can actively effect the way that the path of her pregnancy continues.

For a woman to be in control of her pregnancy and birth experience, she must be given information on which to base her decisions. Renfrew (1989, p.201) states that “knowledge works and you gain strength from being informed.” This quotation has implications for midwifery practice and also for women's care. A woman who has the knowledge to make a decision despite pressure from opposing factions must be strong. Yet she must feel confident that this decision is right for her and her child. The midwife, working in partnership, has a responsibility to support the woman in her decisions. However, she must also ensure that the care she provides the woman does not put the woman or her baby at risk. The implications of decision making are long lasting and have many ethical dimensions. The way that decisions are made in the midwife-woman relationship needs to be explored and described. It is a vital element of midwifery practice and crucial for the safety of women's birth experiences.

Guilliland and Pairman describe the midwife and the women as having equality within this professional relationship. The role of the midwife is to empower the woman. Accordingly she,

supports decision making as a shared responsibility between herself, the woman and her family, but the woman is recognised as the primary decision maker. The midwife remains accountable to the woman and to the midwifery

profession for the professional knowledge and skills she provides and cannot abdicate responsibility for her own actions simply because the woman is the ultimate decision maker.

(Guilliland & Pairman, 1995, p. 47)

Hence the midwife shares her knowledge with the woman. Guilliland & Pairman regard the woman as being empowered and as a consequence she has some control over her maternity care and any decisions that are made that effect her and her baby. Inherent within this statement is the responsibility of the midwife to provide relevant factual information and care that ensures the health and well-being of the woman and her baby. Midwives must provide women with information that allows them to actively participate in their care planning while providing the opportunity to make informed decisions.

## **2.10 Informed Choice**

The New Zealand College of Midwives have a consensus statement relating to the topic of informed consent: "It is the midwife's responsibility and moral obligation to uphold each woman's right to informed decision making throughout the childbirth experience." (NZCOMi, 1996, p. 16).

Within this consensus statement proposed ideas about informed decision making are presented. This is the NZCOMi's position on the idea of informed consent and is presented for use by practitioners and women in the interest of best practice.

Therefore as part of the development of a midwife-woman relationship the process of informed decision making is important as is the process of informed choice and therefore informed consent.

Flint (1986, p. 15) poses the following questions with regard to women making choices in their pregnancy and birth experience:

Why do we think that it is important for women to have choices? Does it really matter? Can't we just get on and decide what is best for these women and tell them? At least we would be secure in the knowledge that we have given the advice we thought was the best, at least we would be comfortable - or would we?

Flint has written this statement to illustrate that as midwives we do not necessarily know what is best for the women for whom we provide services. Whilst we may be able to guide women and empower them, we cannot decide for them. To make decisions for women would be to remove their autonomy and to deny their right to informed consent.

The idea of informed choices was discussed by Schott (1994, p. 3) who looked at the idea of women making decisions for themselves and stated that:

If, instead of giving advice or instructions we give women factual research based information about the risks and benefits of all their options, they will be in a better position to

make an informed choice and to feel in control, and they will also be more likely to develop confidence and self esteem.

Johnstone (1995) discusses and describes the need for and process of informed consent. Whilst her book is written from a nursing perspective, it has relevance for midwifery practice. Johnstone, (1995, p. 222) identifies that “doctors have not always used their authority wisely, much less to the benefit of their patients’ interests. In some cases ... doctors have made and implemented decisions against their patient’s expressed and considered wishes.” She states that the notion of informed consent directly threatens the power and control of doctors.

An initiative has been implemented in the United Kingdom in an attempt to remove some of the perceived inequality and to allow for informed decisions to be made. Women are provided with “informed choice leaflets” which are designed to “enable childbearing women to exercise informed choice by making explicit their available choices during pregnancy and childbirth.” (Rosser, 1996, p. 272). Rosser continues by saying that:

The informed choice leaflets will be thoroughly evaluated in a major multi-centre randomised controlled trial. The trial will tell us whether giving such information to women does empower them and whether it can serve as a way of getting research findings into practice.

(Rosser, 1996, p. 273)

Informed choice therefore is an integral aspect of midwifery practice. In New Zealand the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations (1996), explicitly states the rights of patients in health care. This stipulates within the midwifery context that all women are entitled to make informed decisions about their midwifery care. Yet the information that the woman receives from the midwife is dependent on the midwife's knowledge and experience. Midwifery knowledge therefore has implications with regard to the woman's ability to participate in informed decision making.

### **2.11 Midwifery Knowledge**

Midwifery is an old profession but a relatively new academic discipline. Midwifery's philosophical position and practice is different from that of nursing. Theory development specifically for midwifery is scarce. Yet if midwifery is to state that it is a discipline that provides evidence based care, practitioners need to be researching aspects of care. The experience of midwives and women making decisions through pregnancy and birth is one aspect of the midwifery relationship that practitioners can explore.

Nursing and midwifery have at different times been seen as either related professions or quite separate disciplines. The political climate and medical profession have both exerted their influence over the independence of midwifery. The Nurses Amendment Act 1990 not only allowed for the independence of midwifery practice, but it also made provision for a separate direct entry education

system for people who want to become midwives. Direct entry midwifery provides education for midwives that is based on a midwifery philosophy and where pregnancy and birth are viewed as normal life events. To depict midwifery practice using nursing based models of care is unacceptable to midwifery practitioners and students who philosophically view themselves as belonging to a quite different profession from that of nursing.

As a separate academic profession the opportunity exists for theory generation in midwifery. If midwifery practice is to expand and also have a definite philosophical and academic base clearly divorced from nursing, then theory development specific to midwifery is needed as a crucial element in allowing such a separation to occur. Bryar (1995), as previously described, has attempted to bring theory for midwifery into the forefront of practice. Price and Price (1993) describe the importance of having midwifery theory that is relevant to midwifery practice. They believe that as midwives we can learn from the pitfalls of nursing theory as we attempt to develop a specific relevant body of knowledge that pertains directly to midwifery.

The idea that the midwife and the woman come into the relationship with different ideas, backgrounds and beliefs is indeed important. The personal knowledge base of each midwife is different. Her knowledge, both practical and theoretical, will depend on many factors including her beliefs, her experience, her theoretical base, her setting and the needs of the women that she cares for. Each midwife, therefore, has a different knowledge set to offer the women that she cares for. Whilst education provides midwives with the basis for safe practice the experience that

midwives have alters their perceptions and provides them with experiential knowledge that is an essential part of practice.

According to Smith, (1992, p. 2)

Knowing is the weaving of threads of conceptions, perceptions, remembrances and reflections into the fabric of meaning (...). Our sources of knowledge may be both similar and different and the threads we select from these sources are personal choices... In this way all knowing is fundamentally and primarily personal knowing.

Aspects of midwifery knowledge and therefore practice can differ legitimately between practitioners. The care that women receive will be different depending upon the individual practitioner, the woman and the midwife's philosophy of birth. The woman, too, is influenced by many factors in her environment. The choices that she makes depend also upon her knowledge and experiences and this may include her previous birth experience or family and social influences.

The midwife and woman work together in a unique and dynamic midwifery relationship. The relationship is unique because there are aspects of the woman's pregnancy and birth that have special importance to her. The midwife, with her personal and midwifery knowledge, works with the woman in an attempt to provide her with the ability to make informed choices and consequently informed decisions.

## 2.12 Decision Making

Decision making is a fundamental aspect of modern health care. Yet who makes the decision is also an important issue that needs to be addressed. One could question the appropriateness of different parties making decisions on an aspect of an individual's treatment, pregnancy or birth. As stated previously in this chapter the focus of midwifery within the New Zealand context is to empower women to make decisions that positively affect their experiences. Parcell (1995) provides a discussion and pictorial representation of the way she believes decisions are made within the midwife-woman relationship. She provides a discussion of the ethical components of midwifery decision making and discusses accountability, an aspect of midwifery practice that she believes is crucial now that practice is independent.

It has become apparent to me that perhaps we take decision making in midwifery practice for granted. How often do we stop and reflect on how we arrived at a particular decision, what influences effected the decision and are we able to measure and define the outcomes of the decision made.

(Parcell, 1995, p.21)

Decision making within the context of midwifery practice is a pertinent issue. If, as has been discussed earlier, midwives are said to work in partnership with women then the issue of decision making is indeed relevant. The context of decision making may change as women become more autonomous and empowered. This study attempts to look at the way that decisions are made between a woman and her chosen midwife within the current New Zealand setting.

### **2.13 Summary**

In this chapter I have provided a discussion on issues that pertain to the provision of midwifery practice and decision making. The use of literature as a data source in a grounded theory study has been highlighted and further literature used as a result of data analysis is included within the data chapters.

A discussion of midwifery practice within the New Zealand context has been provided. While independent practice is only a recent area in which midwives can work, it has been grasped wholeheartedly by midwives, much to the anguish of the medical profession. For women in New Zealand, midwifery is a valid, legal option for their maternity service. Different philosophies and practices may exist, but the central theme of a midwifery partnership that provides continuity of care and enables women to actively participate in their care is seen as being evident in practice today.

In the next chapter a discussion of the Grounded Theory methodology and its application to this study will be presented.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 Introduction**

This qualitative study uses a grounded theory method of data collection and analysis in order to develop a description of the way that decisions were made between midwives and women. In this chapter, I will examine Grounded Theory methodology, and also provide an overview of Symbolic Interactionism. The actual method employed in the current study will be presented in detail, and the ethical concerns addressed in this study to protect the researcher, midwives and participants are also discussed. The chapter ends with concluding remarks on the reliability and validity of the results.

#### **3.2 Grounded Theory**

Qualitative research looks at people's life experiences and the meaning that they attribute to them. Grounded theory originated in sociology with Glaser and Strauss (1967) introducing their idea of theory development from emerging data in "The Discovery of Grounded Theory". Whilst originally developed as a methodology for sociological research, grounded theory has been utilised by health science researchers in both the midwifery and nursing fields. (Jackson, 1996; Patterson, Freese & Goldenberg, 1990; Pursley-Crotteau & Stern, 1996; Walker, Hall & Thomas, 1995; Waterworth & Luker, 1990).

As stated by Streubert and Carpenter (1995, p.45)

Grounded theory is an important research method for the study of nursing phenomena. The method explores the richness and diversity of human experience and contributes to the development of middle-range theories in nursing.

Midwifery research texts (Hicks, 1996; Rees, 1997) discuss qualitative research, but specific mention of grounded theory as a method of midwifery research is not discussed. Yet the importance of human experience is crucial to understanding the experience that women have during their pregnancy and birth. Therefore Grounded Theory is as valid a research methodology in midwifery as it is in nursing.

In the limited amount of literature discussing the decision making process between the midwife and woman the woman's perspective has not featured as the focal point (Fleming, 1995; Guilliland and Pairman, 1995; Parcell, 1995; Smythe & Kerins, 1994). Grounded theory therefore was the chosen methodology as it allowed the resulting description to develop specifically from the woman's perspective, being a unique approach in comparison to existing research which is focused from a midwifery perspective.

Grounded theory has developed since its discovery, with Glaser and Strauss having subsequently published different versions of the grounded theory process (Glaser, 1978; Glaser, 1992; Strauss & Corbin, 1990). Whilst Glaser and Strauss do have a different method of data analysis, the difference, as presented by Glaser, is of allowing a theory to emerge from data, as opposed to forcing data into preconceived

ideas. Glaser is of the opinion that Strauss' method forces data to fit preconceived ideas. It is important, however, that the method used leads to a theory that has fit and relevance to the underlying data, in order to depict the social process that is occurring. Robrecht provides a description of Grounded Theory:

Grounded theory is a method of constant comparative analysis based on the thesis that social science theory can be built from data systematically obtained in a social setting. Grounded Theory method offers a rigorous orderly guide to theory development in which data collection and theory generation are seen as two parts of the same process.

(Robrecht, 1995, p.170.)

In this thesis the Grounded Theory method as outlined by Glaser (1978) was utilised.

### **3.2.1 Symbolic Interactionism**

Grounded Theory is based on the idea that people give meaning to experiences that they incur throughout their life. This is known as symbolic interactionism and the properties of it are discussed by Blumer (1969). The main concepts of symbolic interactionism are that :

Human beings act toward things on the basis of the meanings that the things have for them... that the meaning of such things is derived from, or arises out of the social interaction that one has with one's fellows,... and that ... these meanings

are handled in and modified through an interpretative process. (Blumer, 1969, p. 2.)

It follows that as a consequence of action and experience, people will behave in specific ways. That is to say, experience shapes and influences their lives. As life progresses and people expand and develop their social interaction, the individual will alter their social characteristics and the way they react or interact in certain circumstances. “The model of the person in symbolic interactionism is active and creative rather than passive. Individuals plan, project, create actions and revise them” (Holloway and Wheeler, 1996, p. 99).

In order for a researcher to gain an understanding of what is happening in a situation the researcher must look at the interactions that take place between individuals. In a Grounded Theory study, the context of the interaction is important. Hence by living through and experiencing pregnancy and birth within the context of independent midwifery practice, the experience of the woman may change her perceptions of the birth experience. An understanding of the context in which, and process of how, decisions were made is imperative in formulating a grounded theory, as is clear insight into the interaction between the midwife and the woman.

There are certain key concepts that relate to grounded theory. These are the concepts of theoretical sampling, constant comparative analysis, categories and core variables. Each concept is vital for the development of theory that has fit to the underlying data, that works, i.e. “the theory should be able to explain what happened, predict what will happen and interpret what will happen” (Glaser, 1978,

p. 4). The concepts are needed to ensure that the theory has relevance to the area being investigated and that the theory can be modified when new issues and ideas become relevant. The concepts of theoretical sampling, constant comparative analysis, categories and core variables are also crucial to the data collection and data analysis performed in Grounded Theory studies.

### **3.2.2 Data Collection in Grounded Theory**

Data Collection in a grounded theory study may be undertaken by various methods including interview, observation or a mixture of both. All of these methods enable the researcher to gain insight into social interaction. Data are gathered and then analysed as they are produced, hence “grounded theory is the generation of theory from the data” (Holloway and Wheeler, 1996, p.100).

An important difference between this and other qualitative methods of research is that in a grounded theory study the researcher begins with an idea. Data are then collected, and the theory produced subsequently develops through the process of data analysis. The researcher looks at other data sources concurrently in order to enrich the quality of the analysis and such sources may include interviews, observation, hospital notes and a formal literature review.

It is important for the researchers undertaking a Grounded Theory study to acknowledge any preconceived ideas that they may have. The literature review as presented in Chapter Two, is a means of acknowledging these ideas. As stated previously and as discussed by Christenson (1990), being a midwife one has

acquired a body of knowledge that is specific to that profession. To undertake research in one's profession immediately means that the researcher comes into the data collection and analysis phases with specific ideals and ideas. This can serve to enrich the data analysis as the practitioner's aim is to utilise all sources of data available to them.

The ideas and direction that the study takes must be determined by the data that are collected and analysed. Therefore the theory that emerges "is grounded systematically in the data, is neither forced nor reified ... and will meet its four most central criteria: fit, work, relevance and modifiability." (Glaser, 1992, p.15).

### **3.2.3 Sampling in Grounded Theory**

As data are collected, the nature of the study and its direction is formulated. Grounded theory uses theoretical sampling in order to obtain as diverse a population as practicable. Theoretical Sampling means that the researcher collects the initial data, analyses them and then uses the analysis to decide upon the next area of data collection. Theoretical sampling is defined as "sampling guided by ideas which have significance for the emerging theory" (Holloway and Wheeler, 1996, p.103). Unlike quantitative and other qualitative methods, the grounded theory study can have no formal boundaries restricting data collection. Initially ideas can be formulated by the researcher that look at the macro concepts of the study. However these concepts do not focus on specific participant and data source characteristics, they are simply general guidelines. "Theoretical sampling is based on the need to

collect more data to examine categories and their relationships and to assure that representativeness in the category exists” (Chenitz and Swanson, 1986, p.9).

Data collection continues until saturation is reached. It is therefore impossible to predict at the onset how many participants will be necessary for a study. As the researcher transcribes and analyses the data, such analysis identifies ideas, gaps and direction for further analysis and development. Sandelowski (1986, p.31) states that “Sample size cannot, therefore, be predetermined because it is dependent on the nature of the data collected and where those data take the researcher.”

Whilst data analysis guides the need for further participants the concept of saturation determines when sufficient data have been obtained. Glaser and Strauss (1967) described saturation as occurring when no new data are being uncovered from the interviews that can enhance the properties of the existing categories. Once a researcher believes that they have reached saturation then data collection is stopped. Data analysis though, continues using the process called constant comparative analysis.

#### **3.2.4 Constant Comparative Analysis**

This is the method utilised by the researcher to analyse the data that are obtained. Glaser and Strauss (1967, p.105) describe what they see as the four elements of constant comparative analysis, being

- comparing incidents applicable to each category
- integrating categories and their properties

- delimiting the theory and
- writing the theory.

The process of comparing incidents and categories is aimed at finding the core category. This is described by Glaser (1978, p. 94) as being “the main theme, for what is (...) the main concern or problem for the people in the setting.” Through analysing the categories in an attempt to find the core category, it is hoped to uncover the basic social process that is imperative to the theory being formulated. In a Grounded Theory study, the researcher is interested in looking at real concepts, looking at people’s experiences and gaining an understanding of what they believe is going on in a certain situation. Through systematically breaking down the data into individual units and comparing each unit it is hoped that a social process will be revealed. Such a social process will fit within ideas of symbolic interactionism, where people act and are influenced by social interaction and the value that they place on it. The theory that is developed is seen as corresponding closely to the data, since the constant comparisons force the analyst to consider much diversity in the data.

### **3.2.5 The Core Category and Basic Social Process**

In a grounded theory study the data are analysed looking for a central or core category. From this core category a theory is derived. The core category is seen as being the “main concern or problem for people in the setting, for what sums up in a pattern of behaviour the substance of what is going on in the data” (Glaser, 1978, p. 94). Hence, the core category is described as being central to the issues that develop

in the study and it arises as a consequence of data analysis. The core category is central yet it maintains links to other categories that arise from the detailed data analysis.

From this core category a Basic Social Process (BSP) may be determined. Whilst all studies have a core category they need not necessarily have a BSP. "The primary distinction between the two is that BSP's are *processural* or as we say, they "process out". *They have two or more clear emergent stages*. Other core categories have not [sic] stages, but can use all other theoretical codes" (Glaser, 1978, pp. 96-97). In other words, if a basic social process is discovered within a study then clear stages exist that the participants within the study follow. As the theory emerges, other ideas that relate to the theory are discarded or integrated into the 'core' category.

Memos are the analysts thoughts and ideas that occur during data analysis and the process of writing memos runs concurrently with the data analysis and helps to enrich the analysis. They are a crucial aspect of a Grounded Theory study as they arise from the data analysis and raise the data to a conceptual level. Glaser (1978, p. 84) states that "theoretical memos are that stage of generating theory which serve to connect the data and final analysis explicitly by conceptually raising the analytic formulation of the codes." Memos are simply the researcher's thoughts and their elaborations on the data.

The use of the Grounded Theory is considered appropriate in conducting a study of an area of the midwifery relationship that has not been subject to intensive research.

Though midwifery research is currently still in its infancy, a discussion on such research which has been performed and is relevant to this study is required.

### **3.3 Midwifery Research**

Midwifery is a female dominated profession and the focus of midwifery is the care of women and their babies throughout the pregnancy and birth experience. The nature of midwifery research therefore should look towards enhancing the lives and experiences of women, whether they be the pregnant women or the female midwives. Oakley (1993, p.220) states “It could be argued that to produce work that comes out of, and hence resonates with, people’s lived experiences is the very essence of the feminist challenge to knowledge.” Midwifery is now internationally challenging the universal domination of medical practitioners in the birth place. Hence the time has come for midwifery knowledge to be well in tune with the women for whom midwives provide services.

Recent developments in grounded theory have incorporated feminist theory and thought into the analysis undertaken (Keddy, Sims & Stern, 1996; Wuest, 1995). Wuest (1995) looks at the idea of combining feminist ideals with the use of the Grounded Theory method. Her conclusion was that the two could be combined together. Wuest came to this conclusion because of the notions that “ Women can be knowers and their experience is a legitimate source of knowledge” (Wuest, 1995, p.128). Feminists have formulated the following principles for research, “Knowledge produced from the research should be useful for the participants, the method should not be oppressive and the method should be reflexive allowing for

reflection on both the intellectual traditions and the progress of the study” (Wuest, 1995, p.129). Grounded theory, with the underpinnings of feminist thought, can be combined in a study examining the relationship between the woman and the midwife. The focus is therefore to look at what is happening to the participants. The onus is on the researcher to ensure that during the study or the interview any method used does not result in the oppression of the participants. Women who participate in the study have the opportunity to comment on the findings, to read what has been transcribed and coded and to add inbuilt verification that the description is indeed representative of their experience.

Whilst feminist grounded theory is conducive to midwifery research, for pragmatic reasons it was not utilised within this study. However, the midwifery and feminist ideals that women’s stories are a valuable source of learning and the premise that research should not harm women, be it the researcher or the women who were interviewed, were held in regard at all times during this study.

### **3.4 The Method employed in this study**

In this study, grounded theory was chosen as the method that would produce a detailed description of the way that decisions are made between the woman and the midwife. The reports describing the way that decisions were made came from those women who had received midwife-only maternity care during 1996. Women were invited to participate in this study if they had chosen to use midwife-only maternity care. In all situations a caseload management approach was utilised by their

midwives. Before women were recruited into this study certain ethical issues needed to be addressed and ethical approval for the study was sought.

### **3.4.1 Recruitment of Participants**

Prior to recruiting research participants the proposal for this study had to receive ethics approval from the Massey University Human Ethics Committee and the Central Regional Health Authority, Wellington Ethics Committee. Initial proposals were forwarded to both committees and after discussion and minor alterations, approval was granted for the study to proceed, allowing participant recruitment to begin.

Not all of the participants were recruited at the beginning of the study with recruitment being an ongoing process that continued throughout the data analysis. The women were recruited as data analysis revealed a need for their experiences to be explored. For example, through analysis the need to interview women who had home birth or a caesarean section, women who represented different cultures and ages, and women who had had previous childbirth experiences utilising different health professionals, became evident.

I spoke to several groups of midwives about the study and asked if they knew of anyone who would be interested in participating. Midwives were given their own information sheet about this study (Appendix B) The midwives were asked to give interested women another information sheet about the study and to instruct the women to contact me directly. The information sheet (Appendix C) described the

study, its purpose and what was expected of the participants. One woman who did not have a telephone, asked her midwife to give me her contact details allowing me to contact this woman in person. This exception aside, the midwives had no further input into this study. The women recruited were of various ages, cultures and backgrounds. They had different experiences of and beliefs about the birthing process.

### **3.4.2 The Sample in the Current Study**

As this is a study of the way that decisions were made within the midwife-woman relationship, it was imperative that women in this study had chosen a midwife as their lead maternity carer<sup>1</sup>. The North Island of New Zealand has a diverse multicultural population. Women were not excluded from participating in this study on grounds of ethnicity. To do so would be to paint a picture of midwifery from an ethnically biased perspective. Selection criteria for sampling only pertained to the woman's ability to speak conversational English. Therefore women who had difficulty understanding English were not invited to participate. Women who had English as a second language and had a good understanding and command of English were eligible for inclusion in the sample.

Women were able to participate in the study regardless of where they had chosen to give birth. If they had temporarily transferred from midwifery to obstetric services during their pregnancy or birth experience (e.g. they required an antenatal obstetric

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<sup>1</sup> The Lead maternity carer (LMC) means the General Practitioner, midwife or obstetric specialist who has been selected by the woman to provide her comprehensive maternity care. (Central Regional Health Authority, 1996, p.72)

referral or they experienced a forcep delivery) they were eligible to participate as long as the midwife had remained as their LMC. Women who had been handed over to secondary obstetric services and had changed LMC from the midwife to an obstetrician were not eligible to participate.

After the initial interviews had been transcribed and analysed, I began to see which women I needed to talk to in order to obtain the descriptive data. Ten women participated in this study. Five were primiparous<sup>2</sup> and five were multiparous<sup>3</sup> women. The women in this study varied in age from their early 20s to late 30s. Three women had a homebirth, for two this had been planned, for the third it was unplanned. One woman had planned a homebirth but eventually had an induction of labour in the hospital. Eight women had normal vaginal deliveries, one woman had a forcep birth and one woman a caesarean section. For both the last two women the midwife remained the lead maternity carer. Women in this study had educational qualifications ranging from three years of secondary schooling through to completion of University Undergraduate Degrees. The women belonged to New Zealand, European, Maori and Pacific Island cultures.

To protect the rights of the participants within this study certain ethical principles had to be adhered to. Obtaining ethics approval is one way of addressing such principles, however, the process of ensuring such ethical principles are adhered to within the study is paramount in any study that involves human participants.

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<sup>2</sup> Primiparous - giving birth for the first time. (Silverton, 1993, p.113)

<sup>3</sup> Multiparous - giving birth for the second or subsequent time.

### **3.5 Ethical Considerations in this Study**

Undertaking research is a critical component of study within midwifery practice. Yet to participate in research and to be a researcher means certain ethical principles must be addressed. The Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, also provides research participants with their rights relating to participation in research. Those regulations were followed as they pertain to this study.

Wilson (1985) describes the four rights of research participants. These are

- The Right of Privacy, Anonymity and Confidentiality
- The Right not to be Harmed
- The Right to Self - Determination.
- The Right to Full Disclosure.

These rights are discussed with specific reference to this study.

#### **3.5.1 The Rights of Privacy, Anonymity, Confidentiality and Self Determination**

Women were invited to participate in this study with no compulsion for them to do so. During this study women were asked to describe their pregnancy and birth experiences and as a result the decisions that they had made and the process that they had used to make such decisions, was described. Within these stories women revealed names and discussed events that occurred during their pregnancy and birth experience. Whilst they told their stories to me and the stories became the data of this study, women had the right to expect that that they or the people discussed would not be identified.

After reading the information sheet and asking me questions, all women were asked to sign a consent form (Appendix D). These consent forms were signed prior to the interviews commencing. All consent forms were kept within the midwifery department at the university.

All women were asked to choose a pseudonym which they did except one woman, for whom I chose the pseudonym. All interviews were recorded with the women's permission. Women were advised that they could have the tape recorder switched off at any time. Occasionally tapes were turned off but this was so that the woman could tend to her baby. The women in this study were advised that they could have quotes removed from the transcript if they wished. All women received copies of both interview transcripts. Whilst some grammatical changes and minor amendments were made, nothing was eventually removed from these scripts.

The interview tapes were kept in a secure cabinet at my home with only the pseudonym identifying them. Nothing that could identify each woman was left with the tapes. However I kept a separate "first-names-only" identifying sheet. This was done to ensure that the correct woman received her own transcript. The transcripts remained in my home until the end of the project. All women were given the opportunity to have their tapes returned to them at the end of the study. No women have requested this, therefore the tapes will remain in my home for audit purposes for a period of five years. Whilst not a formal requirement of Massey University this is a guideline for data storage. All women are aware of this guideline and are happy for me to retain these tapes. At the end of the five year period, the tapes will be

destroyed. The only other people to hear the tapes were my supervisor and the typist.

It had been my intention to transcribe each tape myself, however due to difficulties placed upon me due to pregnancy it became necessary to employ a typist. Before the typist was employed ethics approval was obtained from Massey University Human Ethics Committee. I was advised verbally that Massey University Human Ethics Committee would advise Wellington Human Ethics Committee of this eventuality.

The typist signed a confidentiality statement prior to receiving any tapes (Appendix E). She did not know the name of any of the participants and had no access to any information about them. Prior to giving the typist any audio tapes, verbal permission was sought from the women in this study. All gave their permission for the typist to hear their tapes. On completion of the typing the tapes were returned to me along with the transcription. The computer files and backup copies of the data were destroyed by the typist when data analysis had been completed.

The transcriptions included the names of family, friends of the women, other midwives, obstetricians and anaesthetists. In order to preserve their anonymity they are just referred to as <my midwife> or <my mother>, for example. Within this thesis women are referred to only by their pseudonym. Any identifying facts about themselves have been removed or presented in an aggregated form.

To undertake this study in a small town or community within New Zealand would leave the midwives and women open to identification. To ensure confidentiality I

decided to use a city within the North Island of New Zealand to obtain participants for this study. Due to the nature of New Zealand midwifery practice, many midwives may travel long distances to attend clients in their home. This made the area for this study even larger as participants fell within the scope of four hospitals and birthing facilities, provided by two Crown Health Enterprises. There are in excess of fifty independent midwives working within the selected region (R Raynor-NZCOMi (personal communication, 24 March 1998)). There is no reference to the area where this study took place included within this document. Again this is to protect the participants and others who may have been named in this study.

### **3.5.2 The Right Not to be Harmed**

It was not envisaged that women would be harmed by participating in this study. In fact quite the opposite seemed to occur. Women talked about how they had enjoyed thinking of their birth stories and how the transcriptions that they had received had captured this story. Some had planned to give their story to their children.

From an ethical perspective it was decided not to interview women who had received their maternity services from midwives who work in the same practice as I do. The reason for this was to protect the midwife and me. Sometimes because of work schedules a woman may have been visited by me in my professional capacity on behalf of a colleague. It was decided that women who already knew me as a midwife would not be included in this study. Although ethically appropriate and necessary for this study, this was quite a hindrance as many of my colleagues were keen to assist with participant invitation.

Whilst I had envisaged that the stories of the women would cause them no harm, I had not expected that their stories would affect me. This is to say that I was not affected because of what the women had said about their experience and their relationship with their midwife. More the content of the woman's stories and their outcomes raised feelings of jealousy, loss and failure as I tried to come to terms with my own pregnancy and birth experience. These are issues that have been resolved with the passage of time.

Through participating in research, women have a right not to be harmed, they also have a right to understand fully what participation in a research study entails. To ensure full disclosure women in this study were given many opportunities to question the researcher.

### **3.5.3 The Right to Full Disclosure**

Women were given the opportunity to discuss the study with me and/or my supervisor, if they wanted, before their informed consent was obtained. It would appear that no women contacted my supervisor. Written consent was obtained by me before the first interview (Appendix D). Where possible the consent forms were countersigned by a witness, who was not involved in this study. Verbal consent was also obtained each time I visited the participants. All women were advised that they could withdraw from the study at any time just by telling me. They were also advised that they could ask me any questions about the study at any time, and that the tapes would be turned off at their request and that they did not have to answer questions if they did not want to. All received copies of their tape transcripts for

comment, alteration and deletion. All women were given the opportunity to decide the fate of the tapes after the completion of the study. One woman requested that she see her quotations before the thesis was completed. A letter highlighting those quotes used was forwarded to her after completion of the data analysis chapters. Whilst this is not necessarily a requirement of the Grounded Theory method, it is in keeping with feminist thought on the study of women's experiences in that it showed the women that the study was about their experiences and that their stories were valued.

#### **3.5.4 Use of the Data**

The content of the tapes remain the property of the participants in this study. It is a Massey University guideline that sensitive material be archived for a period of three to five years. If the material is not sensitive then the university guideline suggests that it should be stored in a secure place by the researcher for audit purposes. After this specific period of time, all tapes from this study will be destroyed according to the wishes of the participants.

The data that has been derived from the tapes is my property and it too will be archived. The thesis also belongs to me. The women in this study were advised of the uses of this data. Such uses include the development of a thesis, the writing of an article for publication and presentation of aspects of this study at conferences.

### **3.5.5 Conflict of Interest**

It was a concern to me that I would be seen by the women as a potential source of midwifery opinion. It was made very clear to the women both verbally and in the information sheet, that I was at their homes as a researcher and not as a midwife. All interviews took place after the six week check had been completed as the six week check is the end of the scope of practice of the midwife (Appendix A). This was done to protect both me and the midwife involved. I did not want to be seen as another clinical practitioner and I did not want to be faced with having to assess and assist in another practitioner's maternity service. Women were advised that I could not be utilised for a second opinion about aspects of midwifery. It was also made clear to the participants that I was there to gain a description of the way that decisions had been made and not to analyse what services each midwife had provided. I would not be commenting about their midwife's practices and I would not answer questions that the women had that related specifically to their midwifery care.

All women appeared to accept these issues. I was only asked one question about a nine month old child and I could not answer the question. I referred the woman to her child health nurse.

### **3.6 Data Collection**

Data were collected over a period of seven months. All women except one, who was not available for a second interview, were visited twice during the study. The first interview was a general discussion, where the women were asked to tell their

pregnancy, birth and postnatal story. It was hoped that the interview would be of an informal nature, with the women talking for the majority of the time. However, in reality this was not the case. Often the women were quite shy, or did not know what to say, or some said “I can’t remember” and looked for prompting from the interviewer. Whilst this had not been the intention initially, in some interviews this was the direction that was followed. Prompts included “so tell me about your labour and birth” or “what did you talk about when the midwife came?”. In the second interview the women were asked specific questions that related to the content of their first interview. For example, women were asked

- How they thought that decisions were made during their midwifery care. Did they feel at any time that decisions were made on their behalf and how did they feel about that.
- To describe how therapies such as homeopathy were introduced into their care and where they obtained information about their use.

All interviews were audiotaped with the women’s permission. Tapes were initially transcribed by me, however as stated previously, due to personal circumstances a typist was employed during the data analysis to perform part of this task.

After most interviews a field note was written describing my thoughts on the interview. After each tape was transcribed, I went through the documents line by line looking at what the women had said in relation to the topic under study. Notes were taken, memos made and then a follow up letter was sent to each woman asking her specific, focused questions about the text. The women received a copy of the

transcription with this letter for their comment. These documents formed the basis of the second interview.

At the commencement of the second interview all of the participants were asked if they were still happy to participate in the study. They were then given the opportunity to talk about the transcripts of the first tape. The second interview was again tape recorded with the women's permission. As each interview was proceeding, I wrote informal notes about the woman's behaviour during the interview. This may have been for example, "sitting in the kitchen", "breastfeeding baby" or "relaxed and comfortable interacting with baby". They were used as cues for me. They were made with the woman's permission and incorporated into the data.

Data collection continued throughout this study. Data analysis and collection proceeded concurrently. The analysis leading the scope and emphasis in further data collection.

### **3.7 Data Analysis**

After I had initially read and immersed myself in the transcripts, each transcript was analysed line by line. Using the words of the women, codes were then developed from the analysed transcripts. Such codes were integrated into like categories. Codes were constantly compared with the emerging categories and included or discarded where appropriate. Memos were written concurrently as the data were

being analysed which also served to shape the direction of the study and highlight the need to interview further participants with specific characteristics.

The coding in this study was performed using an “open coding” procedure where no preconceived codes were utilised. Glaser (1978, p.56) describes the role of open coding as allowing “the analyst to see the direction in which to take his study by theoretical sampling, before he becomes selective and focused on a particular problem. Thus where he does focus he is sure of relevance.” Open coding followed the guidelines provided by Glaser, (1978). These guidelines raised questions that I asked myself as the data were analysed, “What is this data a study of?... What category does this incident indicate?... and What is actually happening in the data?” (Glaser, 1978, p. 57).

The data in this study were analysed line by line. Each sentence was coded and constantly compared to the other data. The researcher in this study has performed her own coding. Alternatively a person to undertake such coding could have been employed or a computer coding package utilised, however I believed that to use such tools could result in the oversight of fundamental elements of the data.

Data analysis continued using the process of constant comparison and coding. I initially produced a second copy of each transcript and this was then analysed. Wherever I detected a key word or concept the transcript was cut and the excerpt taped onto a larger piece of paper. These papers were compared to one another for similarities and differences and then clustered together into categories. I initially had in excess of twenty categories but by constantly refining, these were reduced to

eight. These categories were then compared reduced and amalgamated into second level categories. These second level categories were held together by large bulldog clips and were kept in files. Initially I had five of these categories but after further refining three eventuated as being most relevant. From these categories one central or core category was discovered. This is described in Chapter Seven.

The first level categories were derived from the woman's words. For example, the use of words like "reassurance", "healthy", "all right" were coded as "needing to know". Others like "friend", "choice", "talking" were grouped into "developing a relationship". These categories were constantly evaluated, looked at, changed and added to. Second level categories stemming from this initial coding made the thesis more theoretical, these categories were - acknowledging pregnancy, acting to ensure my baby's well-being and trusting my midwife. From this data analysis the core category "Making Decisions, focusing on my baby's well-being" has been derived. Figure one on page 69 provides a diagrammatic representation of the links in the data.

### **3.8 Reliability and Validity of Results**

How representative of the general population are the results of this study and are they a true representation of the stories told by the women? Inherent in any qualitative research study is the premise that the results, or model, that is produced is only representative of the stories of the participants. To ensure some initial validity after developing my description I studied the interviews as a whole again. Three women's stories were randomly selected and their relevance to the description

was traced. Five women from the study were then contacted and the description was explained to them in order to gain their feedback. All women agreed that the description was indeed representative of their stories. For all women the focus on their child's well-being was central to their pregnancy and birth experience. After much thought and deliberation it was indeed reassuring to hear that the women could relate to this description. The ideas around this study were also discussed with other women who recently had experienced childbirth. Again they stated that their focus was the well-being of their child.

### **3.8.1 Saturation**

In a Grounded Theory study there is no preset number of interviews needing to be performed. Using theoretical sampling, data collection continues until saturation is achieved. Theoretical Saturation is described by Glaser and Strauss (1967, p.61) as meaning "that no additional data are being found, whereby the sociologist can develop properties of the category. As he sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated."

Faced with the time frame of a Masters thesis, a maximum number of participants was initially placed on this study. This did not appear to hinder data collection and analysis. Often whilst listening to the women's first interviews I heard ideas and issues that had been relevant to other women. After the completion of all the interviews I began to hear many similarities from the women in the study. Time constraints meant that the researcher could not proceed with any further interviews, however it was becoming obvious that the data were almost saturated and to

proceed with further interviews would not have added much to the analysis or the data.

### **3.8.2 Triangulation**

Holloway and Wheeler (1996, p.164) describe triangulation as allowing “the use of different approaches and methods in collecting data. For instance, a researcher could both observe and interview participants.” In the current study it was impossible for participant observation to occur as in this study women were describing their pregnancy and birth that they had already experienced. Interview was seen as the main tool for data collection, with observation of the woman’s behaviour during the interview also undertaken. Literature review was also used as a further source of data.

During the process of the interviews many women described their birthplans. It may have been beneficial to see the actual documents and to see the actual planning that the women had undertaken, however this was not to be. Of the women who had separate birthplans, none had kept these documents. Whilst it may have been appropriate to access clinical notes, this may not have been beneficial as the words in the notes are those of the midwife and this study was the woman’s interpretation of her experience.

The written and visual media often provide examples of health professional-patient interaction. Television and newspaper were often consulted when documentaries were listed that related to the process of giving birth. Unfortunately these often

depicted the decisions that were made between the woman and the doctor. Midwives, it would appear, are not the focus of such documentaries and on the television they appear to often have little say in the decision making process.

### **3.8.3 Confirmability**

This is also described as auditability. Confirmability refers to the audit trail that the researcher follows and the belief that “the materials compiled for the audit trail ... are as integral to the study as the data generated through observations of, or interviews with, the research subjects.” (Rodgers & Cowles, 1993, p. 219). Confirmability is an aspect of the data derived by the researcher when formulating the description of their study. In the current context, field notes about each interview and my perceptions of how the interview had progressed were kept. As ideas and important concepts became relevant to me throughout the study, memos were written. Such memos were frequently referred to and examined in relation to the unfolding data analysis.

There are many issues that relate to the reliability and validity of research analysis and results. This section has addressed issues that relate to data collection. Issues that are relevant to data analysis and the results of the study are presented in Chapter Seven. Within qualitative research the aim should be to analyse the data to gain an understanding of the problem or issue as it is described and perceived by the participants in the study.

### 3.9 Summary

In this chapter I have presented an overview of Grounded Theory methodology and its principles and procedures that are used in qualitative research.

Through a process of theoretical sampling a diverse sample of women have been interviewed and their perception of the way that decisions were made in their midwife-woman relationship has been obtained. Through the use of the constant comparative method of data analysis, categories and codes have been derived. Such codes represent issues that were pertinent in the woman's experience. Interviews were utilised as the main method of data collection and the direction of further data collection was dependent on the ongoing data analysis. Through constant comparison three codes were seen as being relevant to this study. They were acknowledging pregnancy, acting to ensure my baby's well-being and trusting my midwife. The core category in this study was "Making Decisions focusing on my baby's well-being". Figure one on page 69 presents a diagrammatic representation of these categories. The presentation of the findings of this study begins with an explanation of the category, "Acknowledging Pregnancy".

## **A Guide to the Data Chapters**

In the following Chapters Four to Six, verbatim quotations are included within the text. The following is a guide to the presentation of this data.

The Participants' speech is recorded in *italics*.

The Researcher's speech is recorded in normal type.

Following from each quotation the woman's pseudonym, the interview number and lines within the transcript are recorded, e.g. Caitlin, i1, 15 - 18 represents Caitlin's first interview, lines 15 to 18.

Diagonal brackets <> indicate where text has been altered to preserve anonymity or add clarity.

Parentheses (...) indicate where part of the text has been removed, or where pauses in the speech occur.

● Core Category

Making Decisions: Focusing on my Baby's Well-being

● Level Two

Acknowledging Pregnancy

Acting to Ensure my Baby's Well-being

Trusting my Midwife

● Level One

Confirming my Pregnancy  
Enlisting Midwifery Services  
Learning about Pregnancy and Birth

Needing to know my Baby's All Right  
Following Instructions from my Midwife  
Controlling my Experience

Developing a Relationship  
Trusting the Midwife's Knowledge

**Figure One: Diagrammatic Representation of the Links in the Data**

## **CHAPTER FOUR**

### **ACKNOWLEDGING PREGNANCY**

#### **4.1 Introduction**

During pregnancy there are certain socio-cultural expectations that inhibit women performing specific tasks and that result in them acting in a certain manner. By acknowledging that they are pregnant, most women, advised by their friends and family, seek out a health care professional to assist them throughout this experience. Women may also develop an interest in what is happening to their body. They rely on friends, family and their midwife to provide them with information about pregnancy and related topics.

In this chapter I will discuss the process of women acknowledging their pregnancy. This begins when the women actually address the issue of being pregnant by seeking medical confirmation. Following confirmation, the women look for a health professional to facilitate the path of their pregnancy and birth experience. Finally, as the women accept their pregnancy and birth, they seek knowledge on topics that are relevant to them.

The process that women utilise in acknowledging their pregnancy and the discussions outlined in Chapters Four to Six are presented in a linear way. It is important to state, however, that the progress from one aspect of pregnancy to another was not linear. Issues may have been recognised at one point of the woman's pregnancy, e.g. finding a midwife, but aspects of this issue may not have

been important until another point in the pregnancy e.g. trusting the midwife. Hence, each woman moved through her pregnancy and birth experiences at her own pace and in her own way. To clearly discuss the elements of this thesis the documentation of the woman's pregnancy progression and priorities have had to be presented in a linear way. However the relationships between the midwives and the women were dynamic and individualised and played an important role in the decisions that were made during the pregnancy and birthing experience.

#### **4.2 Confirming My Pregnancy**

The start of the woman's pregnancy and birth experience is when she acknowledges that the signs and symptoms that she is experiencing may indeed mean she is pregnant. By seeking confirmation women then have choices they must address and decisions they must make.

All women who participated in this study saw a doctor as their first contact for their pregnancy. Most of the women who had given birth previously, knew intuitively that they were pregnant but went to the doctor for final confirmation.

*I knew I was pregnant before I went to the doctor, I wasn't getting any period. And I couldn't smoke and eat properly. Yeah, so I went to the doctors and I was, I knew I was pregnant but I was shocked. I got shocked for some reason.*

Shayne, i1, 4 - 8

*Getting pregnant wasn't something that we had programmed or had thought would be part of our lives. I found out I was pregnant. I did a pregnancy test from the chemist before I saw the doctor (...) and sort of we talked about what some of the options may be. (...) I felt really good about the discussion I had with him (the doctor) and basically I came away from that and talked to some family and a couple of close friends and made the decision about continuing with the pregnancy.*

Joy, i1, 7 - 19

For two women, going to the doctor was the confirmation that their partners needed. Even though a home pregnancy test showed a positive result, there was an element of uncertainty until medical confirmation of the pregnancy was obtained.

*So I showed him (my husband) the test and because it had gotten to night time he couldn't see the blue line. He said "I don't think you are" and I said "hold it up to the light you can see it" and he said (...) "you had better go to the doctor and get it checked out".*

Sarah, i1, 25 - 31

*Oh I said to <my husband> "if you really don't think I'm pregnant I'll go off to family planning and then I'll have a test". And I had a test and sure enough I was pregnant .*

Caitlin, i1, 55 - 58

Women spontaneously discussed their feelings about being pregnant. Comments ranged from feeling shocked as previously stated by Shayne, through to excitement. Some pregnancies were planned. Others, as cited by Joy, were not. In the following quote, Jessica describes how she felt when finally obtaining a positive pregnancy test result.

*I was sort of mentally preparing myself for the fact that I might have to have a hysterectomy and every time I went to have the pregnancy test and it came up negative it was like, Oh God, I'll just go for this one last time. I went to family planning and that one came up negative as well. And she said "Come back in a week's time and we'll see if there's any change". And I came back and I was pregnant! (...) I'd taken my husband this time because I was really worried about it (...) and we were both really excited .*

Jessica, i1, 10 - 23.

Caitlin too describes her husband's reaction when learning about the pregnancy.

*I (...) started to have funny little signs and eventually figured out that I was pregnant. Rang <my husband> up and said "hey guess what" and he was at the other end of the world going "yeah" . Sort of yowling his head off.*

Caitlin, i1, 17 - 22.

The reactions as described above were as a result of the women receiving positive confirmation of their pregnancy. Regardless of their initial reactions, once the

pregnancy was confirmed, the women selected an appropriate health care professional to facilitate their pregnancy and birth experience.

### **4.3 Enlisting Midwifery Services**

Midwifery is a profession solely concerned with the care of women before, during and after a childbirth experience. As has been described in Chapter Two, trained midwives as opposed to lay or untrained midwives, have been present within the New Zealand birthing context in various forms since Europeans colonised the nation. Midwifery has been controlled, manipulated and its focus changed by medical practitioners. However, new found independence was achieved in 1990 with midwives now able to provide comprehensive pregnancy and birth services for women without medical supervision.

All women in this study utilised the services of an independent midwife. Yet they all discovered the option of midwifery in differing ways. The women in this study all had differing needs and expectations of their midwives. Some of the women were enrolled in a Community Health Service that employed independent midwives. Women in this service could, at the time data were being collected for this study, chose to see both the midwife and the doctor or only the midwife.

*I went to the doctor's to have a pregnancy test, and then the doctor suggested I use a midwifery service, and they've got their own personal midwife service. So what happened then?  
I went home and then <a midwife> rang up and then we had*

*an appointment with her.*

Christine, i1, 1 - 4

*I went to see the doctor and that's when I had my first visit and then he told me that if I wanted to keep on coming to him or if I wanted to have a midwife to come and meet me at my house. I thought seeing as I have a 1 year old child so I thought it was best if she comes here to see me. So I told him that and he arranged everything for me and he said that "my midwife would be < her name >" and so he sort of said to me "in about a month if she doesn't call me then I have to come back and see him". So she came before that, so that was good.*

Whitney, i1, 12 - 22

Some women decided to use a midwife because of what their friends had told them; they were looking for an alternative to 'medicalised' care during pregnancy and birth.

*By 12 weeks after the results I got in touch with < my midwife > (... ) I was recommended her by another friend.(...) I had a GP the first time with my daughter and I thought it would be really good to experience a different birth from a midwife and I had heard good things about midwives from friends.*

Hannah, i1, 30 - 42

Having a doctor that did not provide antenatal care meant that one woman had to look at other health care professionals.

*My doctor didn't do antenatal stuff and all that, and then I had a mate come around and she'd not long given birth and yeah, (...)my midwife and all that <the other midwives in the practice> were her midwives and actually she recommended them so I rang them that afternoon I think.*

Tessa, i1, 17 - 23

For some women, however, finding midwifery care was not easy. Two women found that there was a presumption that a doctor would provide their maternity services.

*So naturally when my doctor said "you are pregnant" he did the blood tests and said "I will be doing your antenatal care". And I knew that he used to do obstetrics, he used to deliver but he had given that up, he got sick of being called out in the middle of the night. So he said to me that "I would have to see a colleague of his and I'd at least have one appointment with this colleague during the course of my pregnancy and then I'd get a hospital midwife".*

Sarah, i1, 44 - 53

Sarah was given no choice in her maternity options. She was offered a type of practice that she eventually decided was too fragmented. Through discussion with other women she learnt about independent midwifery.

*I was actually talking to a neighbour who was also pregnant and she had a private midwife and (...) she was going on about how her midwife did this and her midwife did that and I was thinking Oh that's so wonderful. And I said to her "How can I get one of those?" and she told me that you know I was entitled to have one and gave me her midwife's card. And so I contacted her midwife and (...) she came out and presented me with my options.*

Sarah, i1, 60 - 70.

When Caitlin received confirmation of her pregnancy, a "form" stating that she had a positive pregnancy test, was written for her doctor. Not having a doctor she was concerned as she had no knowledge of how to access the midwifery services that she needed.

*They <family planning> just gave me a form to take to my doctor! Which I thought was really odd cos I don't really have a doctor. I go to a homeopath and this sort of assumption by everyone that you have a GP (...) and that was sort of it. It was a real sort of anticlimax, I thought you'd get inundated with information and so I sort of said "well what do I do now"?*

Caitlin, i1, 62 - 69

Other women in this study, also did not receive any options or information about how to employ a midwife. Anne describes how she felt when she had just received

confirmation of her pregnancy and was looking for guidance about selecting a midwife.

*Went ... to my doctor's surgery and had a pregnancy test. Felt completely flat when I came out of there, not with the pregnancy, but I felt that they were no help whatsoever...  
<with finding a midwife>*

Anne, i1, 7 - 11

In fact in desperation Anne, i1, 17 - 19,

*Came home, looked in the yellow pages and chose a midwife.*

Joy too, had difficulty choosing and locating a midwife as she moved to a new town in the middle of her pregnancy.

*I was working full time and some people <midwives> would say yes my clinic is open until 4 o'clock, you know that sort of thing and I just couldn't work out how I was going to do that (...) There was no way I could get off at 4 o'clock once a month, or something like that. So looked at advertisements... didn't feel I had the full range of options so much. I mean I looked around here what was around this area and basically rung and spoke to a few people who had advertised here and then looked at one (midwife) who was actually local and she, because I was already six months pregnant at that time, she was unable to fit me in at that time so I went to the next one.*

Joy, i1, 33 - 46

Women in this study actively chose the maternity care option of midwifery. Choices, when given, were examined and midwifery care was decided upon by the women. However, as described above, limitations existed as to actually employing a midwife. The issue of a lack of true choice was addressed by Gregg (1995). In her study she found that many women believed that they had not made the best choice available to them about caregivers, but rather that they had taken the best option available to them at that time or given their specific circumstances.

Moves had been made by the now obsolete Central Regional Health Authority (CRHA) to remove the lack of choice that women receive about their childbirth caregiver. In the 1996 Notice issued pursuant to Section 51 of the Health and Disability Services Act 1993, concerning the provision of maternity services, practitioners are paid a fee to provide women with their options of care. Part A, Section 3.3.1 of this document clearly specifies the role of practitioners in providing this information to women.

The document states

3.3.1.1 The Authorised Practitioner will meet and provide information to the woman regarding possible options of care, choice of Lead Maternity Carer, importance of registering with a Lead Maternity Carer, options for pregnancy, childbirth and parenting classes and options regarding place of birth.

3.3.1.2 The basis of this discussion will be the RHA brochure called "Your Choices in Childbirth" or such other document that may be produced by the RHAs from time to time. A copy

of this brochure should be provided to the woman at the time of discussion...

3.3.1.3 The woman will be given time to discuss her options with her family or whanau<sup>1</sup> before registration with the Lead Maternity Carer of her choice.

(CRHA, 1996, p.12)

The RHA went some way to stipulating what information women need to be given in order for them to make an informed choice about their maternity caregivers. The person who provided the women with this information about choice was entitled to claim a fee of \$10 from the government; this funding has now been abolished (Health Funding Authority, 1998). All women who participated in this study were registered with midwives before the provisions of this document came into place, and so had to rely on other sources of information to find their midwife.

There were many reasons why women decided to utilise a midwife as their maternity services provider. Convenience was one of the main reasons for this choice. When women already had young children at home, difficulties arose in attending an antenatal clinic. Having the midwife come to their homes at a time suitable to them, was more convenient for these women. Another reason for choosing midwifery was for continuity of caregiver. This means that the woman has one care provider throughout her childbirth experience. They were therefore not relying on unknown midwives when in labour. Other reasons for choosing midwifery included having both a woman and a health professional who is open to

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<sup>1</sup> Whanau - Family and extended family

the use of alternative remedies. Hotchin (1996) also found that women were keen to utilise midwifery because of the midwife's approach to alternative therapies. Joy and Anne discuss alternative therapies:

*My understanding was from talking to people that midwives were much more open to alternative methods and therapies.*

Joy, i1, 55 - 57

*They were very much into homeopathy, so they gave me things to take. Say like my blood pressure shot up so I was on the garlic tabs and within 2 days my blood pressure was down. Echinacea because I was tired and I got the flu so I was on the vitamin c, echinacea and the garlic, just to boost me up.*

Anne, i1, 102 - 108

But apart from all these practices, it was the midwife's beliefs, experience, philosophy about birth and her approach to women that were important to women who decided to utilise midwifery services. Caitlin and Jessica describe how they believed they and their midwives held similar philosophies.

*We seemed to click completely and it was sort of like I agreed with her totally about most of the things...*

Caitlin, i1, 222 - 224

*The reason why I got on so well with her is because I've got a medical background as well,(...) and she used to work in a*

*hospital, (...) and she was very down to earth.*

Jessica, i1, 153 - 159

Joy describes how she believed that the midwife again practised with a similar philosophy of birth to her:

*Our midwife was very experienced, (...) has been doing it for a long time, knows what she believes is best, knows what she believes she'll get the most pleasure out of from her point of view, and that was really consistent with how we saw it.*

Joy, i2, 290 - 295

Christine followed her friends' advice and utilised midwifery. She saw midwives as being different to male doctors, and that the midwives let the birthing process proceed naturally:

*A lot of my friends have had babies in between my (...) gap and they've all told me it's a lot better with midwives (...) I don't know doctors are busy people. And with a man it's like "open your legs", yeah (...) "Lie on the table and open your legs", you know. With midwives, they don't really do internal checks very often, they just let everything go smoothly.(...) I think it's really good, I'd have a midwife again.*

Christine, i1, 144 - 154

This last quote provides a good example of midwifery practice, a totally different picture from that described by Grayson (1995). In Grayson's book a woman is

talking about her first experience of birthing in 1988. Here she describes her final birthing moments:

By the time I gave birth I was a screaming wreck, kicking the nurses and midwife away from me as they were trying to give me an internal examination while I was bearing down to push my baby out. Meanwhile the midwife in charge took it upon herself to slap me back into reality.

(Grayson, 1995, p. 88)

This quotation depicts the midwife as being someone less than caring. It is in stark contrast to the philosophy of practice and the portrayal of independent practice in New Zealand society today. Yet this is an actual account of one New Zealand woman's birthing experience. It is a portrayal of an act of violence against a woman at a most vulnerable time in her childbearing experience. One would question the lack of professionalism that was evident in this birthing event.

Haldorsdottir and Karlsdottir (1996) studied women's experiences of "caring" and "uncaring" encounters with a midwife during childbirth. The "caring" midwife was described, in this study, as being an indispensable companion on the journey throughout labour and delivery and her acts were empowering to the women. The "uncaring" midwife, however, was seen as having a lack of confidence, having a genuine lack of concern and respect for the women and having negative character traits. Caring in this instance has been described as empowering the woman. Women acknowledging midwifery's independence is a way of empowering midwives.

Acknowledging midwifery as an autonomous profession gave one woman power and confidence, when advising her family, who believed that doctors were the only legitimate maternity caregivers, that she had chosen the option of midwife-led care.

*My parents are great believers that doctors are gods. You know, you go and see a doctor for everything, and of course my sister having had the specialist and rabbitting on and on about her specialist and how wonderful he was. You know the minute everyone found out I was, pregnant they'd say "so who is your specialist?"(...) Eventually they found out I had this midwife. "Oh how can you have a midwife?" and I said "That's what she is trained to do" (...). "Oh but you should be having a doctor and you should be having a specialist", and I kept saying "Hang on a minute, I'm pregnant, I'm not sick. You know there is no need for me to see a specialist like an obstetrician with me or the baby" , and I said (...) "A midwife is a specialist, they are specialised for midwifery care."*

Sarah, i1, 163 - 187

Caitlin too discussed the influence that her mother had in her pregnancy and birth experience. In her first introductory meeting with her midwife, Caitlin's mother, as well as Caitlin's husband, met and interviewed the prospective midwife. This idea that family members want to be involved with pregnancy choices was also discussed by Gregg (1995, p. 48).

Women's prenatal choices, including the choice of a health provider and the choice of a birthplace, often are scrutinised or judged by friends, family members, and strangers. <Two women> described the censure they faced ,..., and anticipated, ..., from family members regarding the potential choice of a home birth.

It appears that family members may play an active, if sometimes unwanted, role in women's maternity experience.

Women chose to use midwifery services for a variety of reasons in this study. Whatever their reason all women appeared to be happy with the choices that they made. As a consequence of enlisting midwifery services, women were taking steps that led them to further acknowledge their pregnancy and the impending birth of their baby. They tried to further enhance their knowledge by learning about their pregnancy and the life changes that it brings.

#### **4.4 Learning about Pregnancy and Birth.**

During their pregnancy women discovered that they had questions regarding pregnancy and birth. The women discovered that they had information needs and they acted in ways that enhanced their knowledge acquisition.

*When I started going through my pregnancy I had been given*

*some books and I started reading and I started asking questions.*

Anne, i1, 337 - 340.

*<My husband> and I, (...) we'd read so much, and like I just took out so many books, on, on labour and everything, (...) and I had charts around <the room> of the stages <of labour> and what's going to happen and stuff so we felt sure, because we were going to have a homebirth.*

Jessica, i1, 200 - 206

The midwife was often seen as a source of information by the woman who initiated the questioning. When asked what happened when the midwife visited Shayne stated

*We talked a lot about pregnancy because I didn't know anything, not a thing. I didn't know anything about pregnancy. And she done all my things (...) and the tummy thing and the heart rate thing, yeah it was really neat. And she showed me (...) all you know that piece of paper that you get with your records on it(...). She gave me one (...) cos I kept on asking "Can I look through my file? Can I look through my file?" She was like, (...) "I'll get you this piece of paper, this booklet thing and you can keep your own records."*

Shayne, i1, 37 - 53.

Jessica describes how her midwife filled her knowledge gaps.

*<My midwife> knew that I was (...) quite down to earth about wanting to know everything... and she just basically told me everything she knew... and I could ask any questions and felt comfortable in that.*

Jessica, il, 167 - 174.

Sometimes the initiator of the information sharing was the midwife. There were issues during their pregnancy that midwives believed women should learn about and provided them with such information.

*Our children are older so we didn't know what the trends were and those sorts of things and I really found that midwives dealt with that. (...) The number of decisions, I mean there was the Vitamin K injection. There was a number of other things where they said "This is <where> you can make this decision, here is the information, this is the current reading or the current material we have on this." You know, "Take it this week and in a fortnight we'll come back and pick it up again and you can tell us what you <think>, ask any questions or tell us what you think". So often did offer advice and also documentation of sort, written material and then said "well, weigh that up." So I felt really good about that and certainly there weren't any decisions as I can recall during the pregnancy where I didn't feel like I was given an*

*option to make that myself and <the decision was> usually supported with other information.*

Joy, i1, 91 - 106.

Sarah describes how her midwife provided her with information about her choices.

*And it wasn't <my midwife> saying this is what you do. It was if you want to have a scan you can and if you don't it's not a problem and here's all the information to help you make that decision.*

Sarah, i1, 260 - 264

The midwife's initiative in providing information was seen by the women to be anticipatory and no trouble for the midwives. In addition the midwife appeared to be willing to access more information if she didn't know the answer to the woman's questions.

Anne describes her midwives sharing information with her:

*Information was always forthcoming, easy access. If I had any questions (...), even now if I've got any questions I can still phone and ring them(...). Anything I wanted to know <it> was no trouble for them, if they didn't know, to find out.*

Anne, i2, 175 - 181.

Information provided may have been in the form of pamphlets, through verbal discussion or technical information, e.g. a midwife showing a woman how to put the baby onto the breast.

Patterson, Freese and Goldenberg, (1990, p. 28), described women's expectations of prenatal care.

At some point in their pregnancies, most of the women searched for prenatal care. For these women, the role of prenatal care in achieving safe passage was viewed as being sufficiently central for them to search for care. Commonly held expectations were that prenatal care could provide information, reassurance, medications and early detection and treatment of problems.

The midwife was not the only source of information that women utilised during their pregnancy. Many women read books on pregnancy and took the initiative to learn from friends and family. Women come into pregnancy with some knowledge and beliefs about pregnancy and childbirth, as there is a body of knowledge that is circulated within the community about the experience of childbirth. By confirming their pregnancy and advising others of this, a new area in the woman's life must be explored.

Women in the current study gained an understanding of the information that they received and then made decisions that affected their pregnancy and birth experience. Yet for all the women, the type and amount of knowledge that they needed differed.

For some women it was vital that they knew as much as they could about this experience.

*I made notes from that book and this book and this book and then I compiled all the notes together, so everything about artificial membrane rupturing, everything about placenta praevias, everything I could find, the information I got, I summed it all together and then from that I basically made my birth plan.*

Caitlin, i1, 556 - 561

Anne provides the opposite example. Whilst she had talked about procedures involved with pregnancy, her belief was that her pregnancy was very much a trial and error situation. When asked where she received information and options about pregnancy, even though she had read some pregnancy books, she believed that she did not make decisions about her care and options:

*I went totally blind <into my birth experience>(…). There were no expectations at the end of it.*

Anne, i1, 312 - 315.

However, when Anne was asked if she felt that she was guided through this experience by her midwife, she believed that she most definitely was and that:

*<She, Anne> had no idea of what was available or how things should go, and things worked out really well.*

Anne, i1, 321 - 323.

For other women an important source of information was from the community.

When asked what information her midwives provided Tessa, (i1, 195 - 196) states

*A few booklets and they asked me if I wanted to go to antenatal classes.*

However when asked where she learnt about pregnancy and birth her reply was

*My sister - in - laws, the neighbour, my family.*

Tessa, i1, 281

Christine also cited discussions with her friends as being a source of information for her.

*I'd already discussed that, <ways of giving birth> a lot of times with my friends after they'd had babies.*

Christine, i2, 80 - 81

Clark & Affonso (1979) discuss the developmental tasks of pregnancy. Tasks that are relevant in this context include

- Pregnancy validation - Of which, seeking prenatal care is described as a validating tool. Women in the present study all addressed the idea of seeking prenatal care. They all eventually chose midwife-led maternity care.
- Fetal Distinction - Whereby the woman seeks out information that allows her to care for herself and her baby. As has been described above women sought out information from midwives and friends, in an attempt to learn about pregnancy and birth.

- **Role Transition** - Where the mother develops an interest in knowledge that relates to her pregnancy and birth experience. Women in this study began to learn about issues relating to their pregnancy and birth experience. They used their midwife as a source of information.

Completion of these three tasks and seeing oneself as a pregnant woman within society, may explain why women take action to select caregivers and seek out information about pregnancy and birth.

Once women have confirmed their pregnancy and enlisted the services of a midwife the reality of being pregnant begins to develop. As a consequence of this, women start to learn about the changes that are occurring within their body and about the process of labour. Sources of information include their midwife, their friends and books about pregnancy and birth.

#### **4.5 Summary**

When women discover that they are pregnant there are many “tasks” that they must complete. For the women in this study, they first obtained confirmation of their pregnancy. Following from this they all selected a midwife. Their reasons for choosing midwifery were many and varied. Midwifery was viewed as being an alternative option that was woman-centred and convenient. Women in this study then began to learn about pregnancy and birth. Their desire to learn and their midwives propensity to provide information, led them to develop knowledge about their pregnancy and birth experience.

As women develop an awareness of their unborn baby and as they start to discover the changes occurring within their body, they act in ways that promote their babies' health. Women in this study had a need to know that their child was physically well and they planned and made decisions that promoted their goal of a healthy baby. The following chapter discusses how women act to ensure their babies' well-being.

## **CHAPTER FIVE**

### **ACTING TO ENSURE MY BABY'S WELL-BEING**

#### **5.1 Introduction**

After a woman has acknowledged that she is pregnant by having her pregnancy confirmed, enlisting the services of a midwife and learning about pregnancy and birth, she starts to act in a way that ensures her baby's well-being. For women in this study, this began with a need to know that their baby was healthy. Women looked at options available to them, to ascertain the physical and genetic health of their baby. They made the decision to utilise technology that is available specifically for this purpose. Women also "Follow Instructions" throughout their pregnancy and birth experience. These instructions were often given by the health care professionals who instructed the woman to undergo certain blood or screening tests or instructions were given to assist the women in times of need.

The women in this study all believed that they had some control over their pregnancy and birth experience. They planned for the birth of their baby and they made decisions that affected themselves and their unborn or newborn baby.

#### **5.2 Needing to Know My Baby's All Right**

Within the context of this study women had general and specific issues that they needed to address. Certain issues related specifically to each woman's individual situation, be it due to personal circumstances or because of a specific obstetric

problem. Women needed to find answers to these additional stressors for their own peace of mind.

Many tests were performed during the pregnancy to ensure that the woman's baby was well. Many women addressed the idea of routine uterine scanning of the baby. An ultrasound scan of the foetus at between 16 - 20 weeks gestation has become regular practice within New Zealand society. The majority of women in this study had at least one ultrasound scan in the antenatal period. When asked why they had decided to have a scan, "reassurance" and "seeing the baby" or "being nosey" were some of the replies. One woman had questioned if scans were all right and another flatly refused an ultrasound because of her belief that the risks outweighed the benefits. Generally, the feeling was that the women needed to know their baby was all right and by deciding to have a scan, a health professional can advise them that this is in fact so.

*Reassurance that everything is there (...) I mean during the scan they point out the brain and all the organs (...) If the limbs are all there. Yeah I think that's quite important, reassuring, because without a scan there's no way a doctor or midwife can detect that in many other ways.*

Hannah, i2, 271 - 278

One woman talked about needing to know her baby was physically healthy because if there was a physical problem with the baby then she would contemplate termination of pregnancy. However, for the majority of the women reassurance was the key to having a scan.

*I have always known that I would have to weigh things up like that <continuing or terminating pregnancy> and it just would not be fair to everyone so I knew that I would have a scan for my own peace of mind, knowing that I was carrying a healthy child.*

Sarah, i1, 1233 - 1238

Sarah is the only woman who looked at the scan from the perspective of finding an abnormality, which is the reason that health professionals suggest the use of an ultrasound.

Many women do not see scanning as a screening test, but it is looked upon as the highlight of their pregnancy. It is important that the women are informed that it can pick up certain abnormalities and are not told that it is to 'make sure the baby is all right'. There are many conditions of the foetus that cannot be detected by ultrasound. The type of abnormalities that can be picked up, or suspected should be described. Making sure the baby is all right implies that if it is not all right the condition can be rectified.

(Proud, 1994, p.23)

Most women in this study however, actively chose to have an ultrasound scan to ensure that everything was "all right" with their baby.

*I wanted to go for a scan (...) I wanted to see if everything was all right.*

Tessa, i1, 48 - 50

Christine too decided to have an ultrasound to have a good look.

*I had a choice <about a scan>, but most people say yes anyway.(...) Not many people turn down a scan*

Why do you think that is?

*Just to be I think.(...) To have a look.*

Christine, i2, 125 - 131.

Following a bleed early in her pregnancy, Anne insisted on having a scan for her own peace of mind

*I pushed for a scan. (...) My midwives weren't keen for me to go because I had a bleed when I was 16 weeks (pregnant).*

*(...) And they were a bit worried that having a scan might dislodge something. But, I wanted to know whether the baby was still there or not. (...) So I pushed for the first scan. (...)*

*And then I went for the normal scan at 20 weeks.*

Anne, i2, 76 - 87.

Ultrasound scanning was the most popular means used by women to ensure for themselves that their baby was physically well. Yet, it was not the only procedure that women were prepared to undertake in order to ensure foetal well-being. Invasive tests like Amniocentesis, “withdrawal of a small amount of amniotic fluids from the amniotic sac round the developing foetus to enable chromosome, DNA or biochemical studies to be done” (Abramsky & Chapple, 1994, p. 213) and Chorionic Villus Sampling, “the sampling of tissue from the developing placenta

(chorionic villi) in order to do chromosome or DNA studies” (Abramsky and Chapple, 1994, p. 214.) were contemplated by some of the women in this study.

*I am a carrier of <a disease> (...) so I had to have a chorionic villus sampling test at 10 weeks and that was pretty horrible really because they stick a needle right through your uterus into the placenta to get cells. The cells weren't coming off very easily so they had to stick about 6 needles through, and I wasn't under any anaesthetic or anything, so that was quite horrible. Then I had to wait three weeks until they got the results and at that stage they didn't know if they had enough cells from the placenta so they thought they may have to do the test again. But anyway they had enough and they cultured it, and it turned out that it was negative, (...) which meant that I could continue with the pregnancy.*

Hannah, i1, 8 - 26.

Having test results and seeing the baby on scan were two ways that the women felt that their need to know that their baby was “all right” was satisfied. Yet Katz-Rothman (1994, p.7) reminds us of reality, “An irony in all this is that the technology still cannot guarantee a blue ribbon baby.”

Part of the midwifery routine, the physical aspect of maternity care, also provided some encouragement that the pregnancy was progressing normally and that the baby was well.

*Cups of coffee, we chatted... they did the urine tests, blood pressure, had a listen (to the foetal heart). Any questions that I wanted to know, I could ring them 24 hours a day without a problem.*

Anne, i1, 65 - 68

*She'll tell me if the baby's head is in the right place or if its bodies are all there and that sort of thing and she feels my tummy and she knows where the baby's head is and sometimes she listens to her heart. She'll say that it's a little bit funny and then when she goes around to find a better spot where she can hear it then she says everything is all right.*

Whitney, i1, 81 - 87.

Sarah describes an incident when she contacted her midwife because she was concerned about her baby and wanted reassurance at this critical point.

*I hadn't felt the baby move as much as she normally did. She never used to stop moving and I panicked and rang <my midwife> up and said "The baby's not moving" and she said "come down to the hospital and we'll put you on the monitor". So she put me on the monitor and needless to say we go on the monitor and the baby kicks frantically for half an hour.*

Sarah, i1, 497 - 503

Women had a need to know that their baby was well, but one woman, Caitlin, refused to utilise technology unless there was a medical need. In the following quote she describes why she would only allow her midwife to use her foetal stethoscope for auscultation of the foetal heart.

*Got into the bath and <my baby> all this time, whenever you know, we had our little ear thing <fetal stethoscope>. Cos that was another thing, I didn't want any of those ultrasound thingies because (...) the one's you use on the stomach, <to hear the foetal heart>, are actually more intense than the ones they use in the labs when they do the big scan. (...) So I read in my information. And I said "I only want the trumpet thing." (...) Sometimes it was very interesting <my midwife> trying to sort of lean under me to try and get it in a position to listen. But it was good, because her heart beat was always really strong, it was like boom, boom, boom, boom, boom.*

Caitlin, i1, 916 - 928.

Caitlin was a very active participant in the decision making that was necessary during her pregnancy. She stated that she had an intellectual pregnancy and undertook a large amount of involved reading about pregnancy and birth.

*I got that birth choice book out which (...) I think is great. I think that book's great because it outlines all the recent research. (...) I even read books which were more designed for midwives. I read one statistical <birth> book.*

Caitlin, i1, 540 - 550

Whilst she did not state in her interviews what would have happened if the midwife had detected a problem with the baby, she talked to me in a subsequent conversation about her willingness to participate in ultrasound screening and other procedures if there was a problem with the baby. In fact, whilst the only procedure she was adamantly opposed to was episiotomy, she stated diplomatically in her well researched birth plan

*I am happy for you to do this <refers to certain procedures>  
in this case only.*

Caitlin, i1, 561 - 562.

The developmental tasks of Clark and Affonso (1979) are also relevant here. With regard to the issue of undergoing procedures to ascertain foetal well-being this is seen as

- Foetal Embodiment - Whereby concern about loss of the developing foetus may be an issue for the women. In the present study, no women appeared to discuss the issue of loss of the developing foetus. However as described they began to act in ways that promoted their baby's well-being

Women in this study had a need to know that their baby was healthy and they participated in screening tests and obstetric procedures to obtain some peace of mind. Their midwives facilitated these decisions by providing midwifery, liaising with other professionals, organising necessary tests of their own volition and at the woman's request and by being available if the women had any concerns. Women looked to their midwife to enhance the path of their pregnancy and often followed instructions they were given.

### 5.3 Following Instructions from my Midwife

When asked if they were in control of their pregnancy and birth experience the women in this study stated that they were. Yet the data are filled with instances where the women followed the instructions of their midwives and other health care professionals.

The women talk about the routines of pregnancy. Most women did not question or discuss certain tests and procedures because they saw them as being the routine.

*When I first found out that I was pregnant (...) I had to go off and have those blood tests. (...) I thought it was just routine and I was happy about that, it was just the routine blood tests that you had.*

Hannah, i1, 62 - 69.

*So I took <my midwife> on as my midwife and she wrote the form out for me to have my scan, because I needed to have my scan before I saw her the following month.*

Sarah, i1, 120 - 123.

*It was just like they had their set routine, once a month for the first few months, met the midwife it was an instant liking, instant liking and when I had the bleed, that is when I met the other midwife, and ... they kept ringing and reassuring me*

*and just we went with their routine basically. (...) They came to me and it was great.*

Anne, i1, 55 - 61

Women appeared to follow a pattern that was promoted by their midwives. This consisted of following current clinical practice in the timing and frequency of antenatal visits and the necessity of certain procedures.

Yet there were other instances when the women looked to their midwife for assistance and guidance. At times women were happy to hand over the decision making responsibility to their midwife. The following quote describes such an occasion

*When she went out of the room to sort out the admission and the anaesthetists and everything, I was glad that she just went out and did all that and then came back and said "We're going to admit you"... after she'd gone and sorted it out, taken two minutes to do it all because otherwise if it was "Now do you want to have a Caesar or do you want to sit here for another hour or so", in pain and not know whether your baby's going to live or die! I'd... I felt that we knew one another well enough that I could give her some, of my responsibility.*

Jessica, i2, 274 - 284

Jessica was relieved by the midwife's actions and gave the midwife the responsibility for her and her infant. At this crucial time in her birthing experience she had needed someone to advocate for her and her baby. The midwife did this. Tessa too looked to the midwives in times of need. Tessa was admitted to hospital during her pregnancy. She stated in her interview that when she was in hospital the midwives took over her decision making. She was happy about this because she was scared and concerned about her baby:

*I didn't really know much about it so, and you know, didn't really understand it and I was just thinking of his <the baby's> health.*

Tessa, i1, 63 - 66

Whitney, too, felt that at times she was happy to hand over the decision making responsibility to her midwife. This was because she believed that she didn't have the knowledge to make certain decisions, and not to listen to the midwife would have been to her detriment.

*I know that it was the right thing to do, because sometimes I might say no and then she'll know that it's the right thing for me to do and I'm not doing it... So it's good that she's, to have somebody who knows about, more experience and knows more about it <pregnancy and birth> than I do.*

Whitney, i2, 50 - 57.

The quotations presented above describe the women as wanting proactive midwifery assistance because they see the midwife as knowing more about issues related to

pregnancy and birth. Rees (1996) discussed women allowing midwives to make decisions for them, because it was the woman's belief that the midwife knew best. Although the women above do re-emphasise this idea, they expressed no animosity towards their midwife for making these decisions. Rees (1996, p375) states that "by placing midwives in a position of power and authority, women lost out when it came to choice and control." Yet what if the women like Tessa choose to actively hand over their decision making responsibility to their midwives? One could argue that by doing so, such women actually remain in control. The use of the phrase "*Give her some of my responsibility*" as stated by Jessica (i2, 284) also expresses the control that the women had in this birthing experience.

Sometimes the women needed temporary assistance from their midwives and looked to them in times of need. This assistance occurred at times when the women felt that they were not able to make decisions for themselves. The extent of this assistance varied between all women, yet it was relevant to all women at some point in either their pregnancy or birth experience. The assistance that the women needed, may have been instructional or the midwives acted and directed the path of the experience.

*I was sort of pushing and not a lot was happening and so <my midwife> said "I think we need to get you off the bed". So I stood up got off the bed, went to the toilet and had a major push, a bit like the baby was coming out then and there and of course <my midwife> was there holding me so I got back on the bed and one push and he was out.*

Hannah, i1, 216 - 223

This quotation is an example of the midwife stepping in to assist the woman. It is positive and there is no forcing, no compulsion for the woman to move. The midwife is using her professional judgement and the woman responds accordingly.

Postnatally Anne talks about the midwives looking after her

*(...) I didn't have to worry about anything. They came in, they took over, they did everything, they looked after all three of us. <Anne, her baby and her partner>*

Anne, i1, 203 - 206

Whatever the situation, this assistance provided by the midwives, was always viewed positively by the women. In fact this was seen as being essential to some of the women. Sarah had planned a natural birth, but what eventuated and the interventions that she received were not expected. Her midwives had taken over and used their professional judgement to consult with an obstetrician and provide her with the assistance that she needed. They had not discussed their proposed plan with her, they presented their decisions and the obstetrician's plan to her after they had consulted.

*I think very good decisions were made(...) and were made at times when you know I couldn't make them for myself(...) So they were made for me which is the way I think it should be. You know it should never be left to a stage where you've got a woman whose tired and exhausted after being in labour and*

*saying to her well, here's half a dozen choices, what do you want !*

Sarah, i2, 235 - 244

Sarah raises an important issue of giving women choices when they are exhausted and perhaps losing some physical control of their experience. Sarah believed that her midwives acted in her best interest. They had spent much time together and had formulated a birth plan. Yet as stated her birth experience deviated from normal, but because she knew and trusted her midwives she felt comfortable when they presented her with their plan. She saw it as their plan with her best interest at the centre.

*You've gone through so much and you're thinking hell, my major concern was the welfare of my baby. (...) And whatever preconceived ideas I had about giving birth, they went straight out the window because she came first. (...) In that sense it was good that they took the decisions off me cos they knew that the baby's welfare was <my> priority.*

Sarah, i2, 124 - 133

Joy had been in labour and had been advised some time earlier by her midwife that she expected the baby soon. However some time progressed and Joy was beginning to become tired and needed to know when things could be expected to happen.

*I was not losing control when I think about it now, I felt like I was glad I was in the hospital because if I really couldn't do this any more then somebody could do something about it(...)*

*and it wasn't that bad but it was just that feeling that went through my mind and then that decision needn't necessarily have been mine and I would have felt OK about that at that stage.*

Joy, i2, 28 - 35

Sometimes other health professionals gave women little choice and instructed them on issues that pertained to their pregnancy. These instructions appear to have been followed without question, as the underlying concern for the women was the health of their child.

*She just kept crying and crying, and then the (hospital) midwife decided that we should give her the formula.*

Whitney, i2, 159 - 160

Tessa describes how her midwives directed the establishment of her maternity care

*Head midwife came over and that's when all the visits started I think.*

What did they do in the visits?

*(...) Just checked me over, (...) Made me go and see a doctor,*

*(...) Because I hadn't been checked out yet. Hadn't had any smears.*

Tessa, i1, 27 - 35.

Alternatively, one woman consulted with her midwives and formulated a different plan of action to that proposed by an obstetrician.

*And it was actually the specialist that wanted me to go back for another two <scans>... but I only went back for one. We <my midwives and I> discussed going back for another one and it just wasn't necessary.*

Anne, i2, 89 - 93

When asked why the specialist had requested that this woman go back for further ultrasound scans the reply was: *Don't ask me, he didn't say anything.* (Anne, i2, 95)

This quote implies that although some discussion did take place the woman was never informed of the reasons for the subsequent scans. The question is thereby raised "Could she have made an informed decision, if she did not know and was not presented with all the facts?" In this scenario the woman was asked by a specialist to return for further ultrasound scans. With her midwives she discussed returning for these scans but eventually decided against returning for the second. To not know the reason for this scan, meant that the woman could not make a truly informed decision. One must look at two issues here. Firstly the obstetrician: Did he tell the woman the reason why she had to return to him for more scanning? From the quotations it would appear that he did not. Shapiro et al (1983) found that women's needs for information and doctors' perceptions of those needs were indeed different. Weil also discussed how women's questions were not addressed by doctors, "Women as patients will state time and again that they are not heard, their problems are dismissed without evaluation, and they are rarely given explanation of their problems in the same manner as provided to men" (Weil, 1993, p.37). Whilst Anne

was not concerned about any perceived gender bias, her concern was the lack of information on which to base her decisions.

The second issue pertinent to Anne's scenario is consultation with midwifery care providers. If the obstetrician had wanted to perform serial scans one would assume that at the very least he would have informed the midwife of the reason. Together they could have discussed a possible plan of action. The midwife it is hoped, would then discuss this with the woman and by providing her with information, give her the ability to make an informed choice. However as stated by Ralston (1994, p.455)

Over the past decade, obstetricians have tended to dominate the care of the pregnant woman, and as a result, choice and control have not been in the hands of the woman, but with the attending doctor and the system of care itself. Mention the subject of choice to some obstetricians and barriers of hostility are immediately raised.

It appears therefore that the focus of midwifery care is the woman and empowering her by giving her information and the choice to make decisions that affect her pregnancy and birth experience. This focus is substantially different to that of some obstetricians. Women look to their midwives to provide them with guidance and some form of routine within the context of their midwifery care. Women often follow the instruction of their midwife without question. This is partly because they see some of the issues that the midwife presents them with as being routine, and partly because at times they needed their midwife's help and professional judgement.

The following section describes how women attempt to have some control over their pregnancy and birth experience. It describes planning that women undertook and the decisions that they made to ensure their own and their babies' well-being.

## **5.4 Controlling my Experience**

Women in this study have described how they took actions that ensured the health of their baby. They were happy to follow the instructions of their midwife and other health professionals if they believed that their baby would benefit. In this section, the idea that women planned for their birth and made decisions that affected their well-being will be presented. Whilst foremost in the women's minds was the health of their baby, women undertook such planning to give themselves some control over their pregnancy and birth experience.

### **5.4.1 Planning for the Birth**

Birth planning is nothing new to maternity care. The use of birth plans are commonplace and examples can be found in both midwifery and general literature (Beech, 1987; Bennett & Brown, 1993). Birth plans arose because of what women did not want to happen during their maternity care (Robinson, 1995). Indeed Beech (1987) states that

The idea of birth plans evolved from 'A letter to the midwife', a document prepared by the Association of Radical Midwives in response to the growing anger of the user groups to the way in which hospitals responded to requests for alternative treatment.(...) By ensuring that the letter to the

midwife was included in her case notes, she ( the woman) could check that the staff took notice of her wishes.

(Beech, 1987, p.72)

The women in the study all provide examples of planning for their birth experience. Again each woman had different issues that were important to her. Most thought of and discussed issues with their midwife; some of the women wrote formal birth plan documents.

*First of all I started off the whole home birth thing and (...) how I wanted <my husband> there, and that I was going to use oils and things and music and stuff and that sort of personal help. (...) Yeah, where I wanted to be during the stages. I don't know why I said that because you know, they sort of meld together and that (...) first stage I wanted to be in the bath, first and second and that I wanted the placenta to be kept if I had a home birth.*

Jessica, i2, 85 - 95

Joy discusses the process that she used when formulating her birth plan.

*We (Joy and her partner) had gone though a questionnaire with the midwives and sort of explained the sorts of things that we had wanted and how we wanted it to go and they each time they came out they sort of added a bit to that. Like the fact that <my partner> wanted to catch the baby as she came out and that we wanted the lights dim. You know the*

*sorts of things we just talked about some of the things that we thought would be really nice to happen and they suggested other things too. Like they said "So if you want the lights dimmed would you like some calming music" and some of those things which was really good.*

Joy, i1, 112 - 121

Planning, and advising the midwives of their plans, appeared to be an integral part of the birthing experience. Shayne, when asked, as a consequence of the interview, if she was happy for the midwife to guide her through her birth experience, stated that

*Yeah, All I told her was that I wanted to go to the hospital and hop in the bath ... cos, it was really really good the first time, yeah that was it.*

Shayne, i1, 344 - 348

Anne was also guided by her midwives. Whilst she had planned certain aspects of her care she followed their instructions to ensure she was prepared for her birth.

*I knew I wanted a home birth, so the midwife had told me what to do for the home birth. We'd actually decided I was going to have a water birth, so they arranged for the pool. But because it happened so quick, we didn't have time to set it up.*

Anne, i1, 210 - 215.

Christine's birth plan was initiated by the midwives asking questions about certain aspects of the birth.

*She asked what to do with the afterbirth, what we wanted to do with it. And we asked for it.*

Anything else she asked you?

*How I wanted to have the baby, what position. If I wanted anything like music (...) What else did she ask us? That's about all*

Christine, i1, 15 - 20.

An element of uncertainty also appeared to be evident. Some first time mothers were unsure what to expect either because they had not experienced birth before or because they felt that you could not really stipulate what you wanted until you were in labour. This led them to hedge their plans somewhat. Tessa, when asked if she had talked about a birth plan, stated that things were done at the hospital; this refers to her labouring in the way that she wanted at the time. She had not made any plans and had decided to follow the guidance and suggestions of the midwife at the time. When asked why she had not formulated even a loose plan her reply was that *I couldn't really say what I wanted until I was there* (Tessa, i1, 187 - 188).

Not knowing what to expect and not knowing about the birth process this woman had allowed the path of her birth to be guided by her caregivers. Hannah too, talked about not being able to make plans about the birth experience. She had discussed her wishes with her midwife, but she again hedged her plans until she was in labour.

*I guess I mean I don't think that you can make plans before you have a baby it just happens and you just do what, cos, if the birth had been really fast I may not have had time to get in the bath, you know. So I got to the hospital and I felt like getting in the bath and so I did.*

Hannah, i1, 268 - 274

Hannah believes that she had no plan for her birth. Yet, she still spent time in the antenatal period with her midwife, discussing what she would like to happen.

*We just chatted about births and what I went through when I had <my daughter>, I had a real thing about pain relief, I said 'I want everything'. After having <my daughter> I had experienced such a bad time.*

Hannah, i1, 109 - 113.

Caitlin produced a long involved care plan that included every obstetrical eventuality. Yet she still described an element of uncertainty within herself. Whilst she knew the way that she wanted her labour to proceed, her uncertainty led her to her midwives, with their professional knowledge, for clarification and final approval of her birth plan.

*I gave it to each of the midwives and said 'what do you think'? You know cos. I said "This is me basically looking at the info, but I'm not a midwife, I haven't had a baby I'm not a doctor, what do you think?" And they looked at it and they went through and told me bits and stuff, but they told me what*

*they thought and I didn't end up actually changing it because they agreed with most of it.*

Caitlin, i1, 592 - 598.

Caitlin's pregnancy and birth followed the path that she had hoped it would. The question arises about the validity of the birth plan if a transfer to hospital had been necessary. How binding are such plans and how much worth do they have when a third person influences the decision making? The idea of a birth plan arose because of the need for women to have some control over their pregnancy and birth experience (Beech, 1987). One could also argue that a woman who has researched all aspects of pregnancy and birth and has a detailed specific plan should be listened to and her plan followed. A difficulty arises, because the majority of women enter pregnancy and birth with a limited amount of knowledge. By reading women are able to empower themselves for their birth experience. Yet as described above each individual seems to want different amounts of control at different times. Do birth plans leave the midwife with scope for professional judgement and a certain amount of room for variation in case there is a deviation from normality? The principle of autonomy or self determination is relevant here. Rogers and Niven (1996, p. 12) state

Autonomy or self determination is a value of great importance to society presently. It is important to remember that it has not always been valued, or possible and that it is not universally prized. Autonomy, in terms of individual centred upon self, single person, decision making, is foreign to the many cultures in our society who emphasise the group.

In many situations, therefore, self determination may follow a group - family - whanau consultation; in others it may develop as appropriate for those involved.

This principle of autonomy, therefore, is important when addressing the individual's desire to be involved in the decision making and the emphasis that many women place upon their involvement. For women who viewed themselves as being autonomous and centred upon themselves, their priority was to formulate plans and to control their birth experience. No women in this study cited group decision making as being a priority. Two of the women in this study were in the Maori and Pacific Island cultures where family or group decision making is more prevalent. However neither discussed this issue. Two women referred to their partners when making decisions.

*I waited until my husband came home and discussed it with him. (...) Basically he said to me "You do what you feel is right, because you are the one who is pregnant. You are going to have the majority of time with this person and they are going to be there at the end". And I said "I want <a specific midwife> to be my midwife", and he said "OK then".*

- Sarah, i1, 88 - 95.

*<My husband> basically has always said "That it's my decision, especially in this case <Anti D injection>, because I am the one who's getting it", but also with the home birth.*

*He was very, very reluctant about it and very scared.*

Caitlin, i1, 412 - 415.

One woman discussed disposal of the placenta with her husband as burying the placenta in the earth is a Maori tradition.

*The midwife asked (...) what we wanted to do with it <the placenta> after the birth. (...) Well her <the baby's> father said that he wanted to keep it*

Christine, i2, 179 - 185

Rogers and Niven (1996, p. 12) address how individuals may make decisions that affect their health care:

We now expect that the locus of control for treatment decisions has moved away from health professionals, to those affected. Not all patients will wish to take this responsibility, and the moral action may be to facilitate the decision making process most appropriate for those involved.

Individualised care it would seem is relevant and indeed an integral part of midwifery practice and autonomy. If the woman is the focus of care and her rights and wishes are respected then her autonomy allows her to have the control that she wants over her birth experience. By planning for her birth she has documented what her wishes are for this experience. However as the following quote describes, birth planning where the woman has unknown caregivers may not always be viewed

positively. Jaiyesimi and Ballard (1992) discuss the use of birth plans from the obstetrician's perspective. The authors state that :

Increasing numbers of obstetricians and midwives are being presented with birth plans. In no other profession does the client dictate the management approach to the professional and in no medical speciality other than obstetrics does the patient present the practitioner with a management option... The first and natural response of an obstetrician or midwife who is presented with a birth plan is probably that of resentment. Such women are thought to have an 'I know best' attitude.

(Jaiyesimi & Ballard, 1992, p. 170)

This article epitomises an approach to childbirth and women's health that underpins a resentment of someone other than the health professional being in control of the case. The language in this article shows the little value that these doctors give to autonomy. The philosophical stance by these doctors is also far removed from that of midwifery practice. Indeed as discovered by Bluff and Holloway (1994), some women see the practitioner as knowing best. No midwife or mother would argue that as stated by Jaiyesimi & Ballard (1992, p. 170) "Obstetricians, midwives and consumer groups have a common goal, that of a healthy baby and mother at the end of pregnancy" but they would argue that the process of achieving this outcome and the role of the mother and her rights and wishes must be listened to by health professionals.

Women in this study cited the health of their baby as being important to them. What they did and how they acted was focused around this well-being.

*It was wonderful because she was actually there, but I was looking forward to going through the process of <giving birth>. On the birthing video that we watched the woman gave birth on her hands and she reached down and touched the baby's head when it came out and I was looking forward to doing all sorts of things like that. (...) I didn't have any of that and it doesn't, I mean I could look at it now and say it didn't turn out the way that I wanted it to, but the way it went the way it was meant to obviously and at the end of the day it was what was best for her. I could have been as stubborn as I had wanted to, but it was only going to harm my baby and I wouldn't do that. I would never do anything to hurt my little darling.*

Sarah, i1, 1080 - 1096.

Hence whilst Sarah's plans may have deviated from what she was expecting, her focus was the health of her child. She listened to her caregivers and followed the plans that they formulated with this notion of safety being foremost in her mind.

Jessica too reiterates this. The health of her child was crucial. The natural birth experience that she had planned was secondary:

*I mean she knew how I felt and the most important thing apart from you know, having a natural birth wasn't, wasn't*

*the issue anymore, it was I want the baby to come out alive  
and that was it.*

Jessica, i1, 401 - 403.

Much of the practice and procedures of obstetrics are routine. Many of the practices are not scientifically evaluated and as research is being carried out many obstetric practices are being found to be either detrimental or of no use to women (Enkin, Keirse, Renfrew and Neilson, 1995; Goer, 1995). Enkin et al provide a list of practices which they state research has shown to be ineffective or harmful. This leaves the practitioner with the onus of ensuring that services that are provided are in fact research based and that the practitioner is working in the woman's best interest. Then women can make plans about their care that are based on good evidence and in their best interest rather than being based on options that are perceived as being correct.

Women therefore plan for their birth. Each woman in this study gave birth planning a different priority. The focus on the health of their child and an idea that you cannot plan for a birth until you experience labour, left a certain amount of flexibility within the women's planning. The principle of autonomy is important when midwives realise that each woman places a different emphasis on planning for her birth. Associated with this planning and self education are the decisions that the women actually made during their pregnancy and birth experience.

#### 5.4.2 Making Decisions that Affect me and my Baby

Central to the way that women act during pregnancy and birth and the plans and decisions that they make is the health of their child. Through analysis of the women's transcripts it became very obvious that there were many instances where they were the main decision makers throughout their pregnancy and birth experience. When efforts are being made to promote informed decision making in midwifery practice, to actually hear women talk of the decisions they made is a positive reflection on practice.

Women often stated clear examples of decisions that affected the path of their pregnancy and birth experience. Women in this study were certainly able to vocalise their own wishes and needs during labour. Often this related to either requesting or discussing pain relief.

*I was just exhausted, absolutely exhausted and I was almost in tears and I just said "oh," cos... it wasn't going quite how I wanted it to and I said "Get me the anaesthetist; I need the epi, I need an epidural" and they <my midwives> said "Are you sure about that?" and I said "Yes, yeah, I can't take it much longer; I need an epidural"*

Sarah, i1, 865 - 872

*I said to <my midwife> "I want you to do an internal because I don't want to go to the hospital and only be one*

*centimetre dilated. (...) So she did an internal and said I was four centimetres so I felt good about going to the hospital.*

Hannah, i2, 175 - 180

Hannah's quote looks at the issue of making a decision because there was a need to know. The woman would have delayed her decision to go to the hospital if her cervix had not been as dilated as it was. This woman needed to know her cervical dilatation so that she could decide how to proceed during her labour.

All examples of women's decision making did not relate to labour. The Health and Disability Commissioner Regulations (1996, p.3) state that "Every consumer has the right to information that a reasonable consumer, in that consumer's circumstances would expect to receive including (...) Notification of any proposed participation in teaching". Women have the right to refuse student participation in their care. As midwives there is an obligation to teach student midwives and without women's approval this cannot take place. The only woman who discussed student midwives did so in a positive light. The decision to include the student had definitely been hers.

*Yeah, I let her bring along a student.*

Tessa, i1, 321

This is an interesting use of language. "Let" in this situation implies giving permission, the decision was ultimately the woman's. As a consequence of letting the student come along this prospective midwife was able to participate in the woman's maternity experience

*We let her cut the cord (...) Did my blood pressure about twice I think and then <my midwife> did it again just to check.*

Tessa, i1, 327, 348 - 349

Often the decisions that women made were in the form of instructions to their midwife:

*I just told them to wait (refers to pethidine for labour pain relief), you know, because I didn't want it.*

Whitney, i2, 97 - 98

Joy describes how she instructed the midwife, when she wanted to go to hospital.

*We rang her at about quarter to four and said "They <the contractions> are starting to build up, they are four to five minutes apart and we want to get into the hospital. As much as they, <the midwives>, (...) felt that if it happened at home, that would be fine, we were not quite as confident about that.*

Joy, i1, 139 - 145.

When asked specifically who made the decisions during their pregnancy and birth experience all women believed that they did. However, they often stated that the midwife supported and facilitated their decisions.

*Decisions, well they were discussed with me and I had the final say... I was given all the you know, options and advice*

*about different methods and in the end yeah, I felt I made the final decision.*

Hannah, i2, 10 - 15

*We would talk about it and he <my husband> would tell me what he thought and the midwife would tell me what she thought and then basically the two of us <Caitlin and her husband> and sometimes myself made, made the final decision.*

Caitlin, i2, 20 - 23

*I would always make the decision and she would always add extra information from her experience.*

Jessica, i2, 242 - 244

The emphasis on women making decisions is seen as being a positive aspect of midwifery practice resulting in a positive experience for the woman. Schott (1994) addressed the idea of informed choices in midwifery practice. When discussing women making decisions for themselves she stated that

If instead of giving advice or instructions we give women factual, research-based information about the risks and benefits of all their options, they will be in a better position to make an informed choice and to feel in control, and they will also be more likely to develop confidence and self-esteem.

(Schott, 1994, p. 3)

Often the discussion on issues that pertained to the woman's experience related to issues of relevance to the baby. A major topic of discussion and decision making is Vitamin K. This is an issue that directly affects the baby as it is often the first injection that babies receive. Administration of Vitamin K is often the first decision that parents have to make for their new-born infant.

Intramuscular Vitamin K (Konakion) is given for the prevention of Haemorrhagic Disease of the Newborn. Enkin et al (1995, p. 333) state that

Until more evidence is available breast fed babies should receive vitamin K. Failure to administrate vitamin K to breast fed infants may predispose them to serious bleeding such as intracranial haemorrhage. Questions have been raised about the link between the parenteral administration of vitamin K and the development of childhood cancer but further observational studies have not confirmed this association.

Most women in this study had a discussion with their midwife on the Vitamin K issue. Most women were presented with information that allowed them to make an informed decision about this issue.

*The number of decisions I mean there was the Vitamin K injection. There was a number of other things where they said "This is really, you can make the decision, here is the information , this is the current reading or the current material we have on this. Take it this week and we'll come*

*back in a fortnight and pick it up again and you can tell us what you think, ask any questions or tell us what you think”.*

Joy, i1, 94 - 100

Sometimes alternatives were discussed.

*One of the other things that we had to make a decision on was Vitamin K and we decided that <My Midwife> said “If it’s sort of a difficult birth and if it’s this and if it’s that, we may need Vitamin K”. But (...) she’s happy if we, you know, want to use Arnica instead of it. And I got quite high potencies because that’s what my homeopath recommended.*

Caitlin, i1, 1193 - 1199

Sometimes final decisions about Vitamin K are made after the baby is born.

*When she was born they asked me if I would like to <give> her (...) an injection, a Vitamin K injection now or wait and have separate sips. But I said “give her the injection straight away”.*

Christine, i1, 179 - 181.

The above quotes highlight three issues relating to obtaining consent. Firstly in order that women feel in control and able to make decisions for their baby they need information on which to base their decisions. Secondly, providing information on alternative therapies and advice from other associated health practitioners gives women other options and alternatives to those offered by general medical practice.

Women, who may not necessarily be aware of alternative therapies, can choose to use these alternatives if the ideas are raised and addressed by their midwives. Thirdly, before a drug is administered permission should be obtained from the recipient or in this case, from the baby's mother. By asking her permission the midwives are allowing the woman to remain in control, as she is making decisions that affect her child's well-being.

## **5.5 Summary**

In this chapter I have discussed how women act throughout their pregnancy so as to contribute to their baby's well-being. Women have a desire to know that their unborn child appears healthy and may be prepared to undergo procedures so that their baby's well-being can be determined.

In order to ensure the continued well-being women listen to and follow the instructions of health care providers, be they a midwife or a doctor. They plan for their birth and they make decisions that they believe will positively affect themselves and their baby. Focused in the woman's mind however is the belief that she wants to do what is best for her child.

In the next chapter I will discuss how women develop a relationship with their midwife and how as a consequence of this relationship, the women trust their midwife's knowledge and expertise and so rely on the midwife to act in their best interest.

## **CHAPTER SIX**

### **TRUSTING MY MIDWIFE**

#### **6.1 Introduction**

Women chose to utilise midwifery services for a number of reasons which include a woman caregiver, convenience and a health professional who is open to the use of alternative therapies. As has been described in Chapters Four and Five, women follow instructions given to them by their midwife and they plan and make decisions that affect the path of their pregnancy, with the goal of ensuring their baby is healthy. They follow these instructions because they trust their midwife. As the midwife spends time with the woman, a relationship begins to develop. This relationship is described by the women as a friendship based on trust.

The relationship that develops between the midwife and the women will be explored in this chapter in an attempt to understand the need for and basis of such trust. Implicit within this is the need for women who have a preconceived focus to ensure their baby's well-being. The trust that they develop in their midwife means that they also develop a trust in the midwife's knowledge.

#### **6.2 Developing a Relationship**

The concept of trusting the midwife was found to be important in this study. However, in the initial phase of the midwife-woman relationship, trust was not discussed by the women. Trust was something that grew as the relationship

developed. It is therefore, viewed as a possible consequence or outcome of the midwife - woman relationship.

The concept of the midwifery relationship is an issue that is discussed by Flint (1986). The language and grammar of Flint's book portrays the midwife as having the attributes of caring and compassion.

Mothers and midwives are intertwined like Siamese twins - whatever happens to midwives affects women and whatever happens to women affects midwives. Midwives need to be strong and loving and sensitive to the needs of women; only then can women feel secure in the momentous experiences that surround the birth of a child(...) For midwives to be able to love, cherish and care for women throughout pregnancy, labour and the puerperium, midwives need to be loved, cherished and cared for themselves. (...)

It becomes increasingly obvious that many people become nurses and midwives because they want to be involved in other people's lives. Furthermore the one overriding quality that most women want of their attendants during pregnancy, labour and the puerperium is that they be emotionally involved with them - interested in them as people and not just as slabs of pregnant human flesh to be 'treated'.

(Flint, 1986, pp. 1 - 2).

The language utilised within this book is very emotive. Is this the image that midwifery portrays and is this what women expect? Do women feel that they have a friendly relationship with their midwife because their midwife exhibits some emotion towards them?

Whilst the women eventually described their midwife as friendly and they described their relationship as that of trust, they did not discuss trusting their midwife when they employed them. There may however have been an implicit trust in midwifery that reinforced women's desires to utilise such services but again this was not addressed by the women. Trusting their individual midwife seemed to develop as the midwife and the woman spent time together. It is therefore an outcome of this relationship, however it is not measurable. The relationship between the women and the midwife, appeared to differ with each woman and midwife combination.

Caitlin describes how she believes her trust of her midwife developed

*A lot of it may be just the (...) chatting over tea, that was the building of trust. Which to me is the most important thing, because you get to know the midwife and you kind of get that basis of trust. (...) Then you get on <to> the little things, you know, let's, let's check out your heart pressure and feel the baby and all that kind of stuff. (...) Also things are discussed which are really important.*

Caitlin, i2, 150 - 156

Jessica too, describes how the midwife knew what she wanted because they had spent time together and discussed many issues.

*She knew what I wanted (...) and she knew that, so without having to ask me and verify everything again. (...) Because we'd spent so much time together, talking about so many things that I think that she just knew what I wanted.*

Jessica, i2, 289 - 296

Whilst some of the women discussed the longer periods of time that their midwives took over appointments, Tessa, also discussed a different scenario. When asked in her interview to describe what she talked about when the midwife was there, she stated:

*What did I talk about? Just asked her how she thought I was doing. (...) She thought I was doing really well. I felt really well. So the visits only usually lasted about 15 minutes, if that.*

Tessa, i1, 55 - 59

Tessa was satisfied with the amount of time and the input into her maternity care that she received from her midwife. She, describes her relationship with her midwife as being “*like old mates* ” (i1, 310) and that she felt that she could talk to her and ask her questions. Quality of time, individualised care and open interactive communication, may be more relevant to women than quantity of time given by the midwife.

The women discussed developing trust and confidence and they saw it as being an important part of their midwifery relationship. Some of the women described their feelings of friendship for their midwife:

*A good deal of it was to do with the environment created by having a midwife there who actually felt more like a friend than a health professional.*

Joy, i1, 308 - 311

*It was like I'd known her all my life(...) She's been friendly, you know, she's my midwife but she's also my friend.*

Whitney, i2, 195 - 199

Whilst the women in the study viewed the friendship of the midwife as being of relevance and importance, one must look at the idea of friendship within the context of a professional relationship. As a health professional is it acceptable to be the woman's friend? Where are the ethical boundaries of this relationship drawn? Should we expect some sort of distance to remain between the woman and the midwife? Or is the development of a relationship that incorporates friendship as one of its components part of being "with woman"?

Oakley (1993, p. 77) discusses the importance of love and caring for childbearing women.

Love - caring - is as important as science - technical knowledge, monitoring and intervention - in the maternity services today. Rather than being a soft option, it is a

fundamental necessity. For those who wish to concern themselves with scientific proof, this can be demonstrated from published studies examining the effects of social support as distinct from clinical care. Consequently, the goals of satisfying mothers and producing healthy babies, which are so often deemed by obstetricians to be at odds with one another, are in reality the same goal.

The women in this study affirm the last statement as for them the most important issue was a healthy baby.

Other researchers have also looked at the midwife-woman relationship from the woman's perspective. Fleming (1995, p. 145) looked at the limits of the midwifery relationship. In her study the women stated the limits or the boundaries of their relationship with their midwife. Only one woman interviewed by Fleming thought it important to discuss her expectations of the relationship during the interview process and trust was the major issue that was presented there. Trust was an issue that has been described by the women in this study. All held a positive opinion of their midwifery relationship.

In the present study when asked why her relationship with her midwife was excellent, Tessa says

*She was like, I don't know an old friend kind of thing. We just hit it off and I didn't mind talking, telling her anything.*

Tessa, i2, 122 - 125

It appears that this friendliness is just a consequence of the midwifery relationship, of spending time with and being available to women. Boundaries did appear to be present in the midwife-woman relationship. Many of the women at the time of interview had not seen their midwife since they had their baby. Hence this “friendship” was present during the pregnancy and birth experience, but it appeared not to be an ongoing social relationship.

Hannah describes how she felt when the midwife completed her care.

*I mean it was quite an emotional time when she actually left, when that, that 6 week time was up I felt, cos you create such a bond. I was actually quite upset. (...) I mean she's been back to see us a couple of times since, but it was, yeah, it's quite a strong bond that you have with them (...) and, you know, then they're not there, and it's yeah, it's quite sad really.*

Hannah, i2, 360 - 370.

Whilst Hannah felt some sadness at the end of the midwifery relationship, she still felt that the midwife had maintained a professional relationship with her.

Joy discusses the importance that she placed on her midwife's professional qualifications and experience.

*I had lots of confidence in the midwife that I had. She was certainly very confident in her experience and level of competence and qualifications. (...) She was also very*

*encouraging about me being in control and I think that helped as well.*

Joy, i1, 223 - 227

Yet she also describes how her birthing experience had been facilitated and here talks of her midwife as being more of a friend.

*The experience was far more relaxed (...), almost more of a celebration than a medical event. (...) That may have been because of (...) the stage that I'm at in my life, that may have something to do with it. But I think a good deal of it was to do with the environment created by having a midwife there who actually felt more like a friend than a health professional.*

Joy, i1, 304 -311

In the present study, women were asked in the second interview to describe their relationship with their midwife. The midwife always seemed to be viewed positively. Through spending time women and midwives have developed a trust that was needed. As a consequence of this trust the women felt that they could rely on the midwife's judgement and they depended on their midwife when they were in situations that they didn't fully understand or when they needed help. The relationship was seen as being empowering by one woman.

*I felt they were very supportive and they guided us through the birth. They didn't dictate, they didn't control, they didn't overpower me or anything like that. I think that's one of the*

*most important things is that you keep the control and you feel empowered.*

Caitlin, i2, 346 - 350

Fleming (1995, p. 176), also discusses the issue of trust. In her study she states:

However, with regard to the overall midwife/client relationship a sense of trust was seen to be developing as the partnership strengthened during the periods of the clients' pregnancies. This sense of trust was what allowed issues of power to generally become less important as the relationship became more one of reciprocity.

Berg, Lundgren, Hermansson and Wahlberg (1996) used phenomenology to explore the women's experience of midwifery. They found that the important issues for the women were individuality, a trusting relationship with the midwife and that they were supported and guided on their own terms.

Berg et al describe how women were able to have a trusting relationship with their midwife. They described the following as being conducive to trust: "The midwife's character, professional knowledge and proficiency as well as the women's feeling of security". (Berg, Lundgren, Hermansson and Wahlberg, 1996, p. 13). Berg et al suggest that to achieve a trusting relationship "the need for good communication and proficiency was revealed". (p. 14). One could see that in the Berg et al study communication would have been vital as women had not met their midwives prior

to the birth of their babies. Communication between the woman and the midwife was also important in the context of the current study.

The idea of power was an issue that was only raised in the current study by one woman. Yet, through analysis of the transcripts the women in the present study, appeared at times to hold the power in their midwifery relationship.

*Basically, it got to the point where we wanted labour to start because of the high blood pressure, which I'd had for two weeks, and it was starting to get into the realms of you know, <my midwife> would sit there and say "well at this point I actually should be recommending you to an obstetrician". But I would go "oh what"! you know and she'd go "calm down, calm down, we'll just see what it's like tomorrow".*

Caitlin, i1, 663 - 669.

In the previous quotation, Caitlin is controlling the path of her pregnancy. Despite her midwife advising her that she should be recommending her to an obstetrician, Caitlin's words and actions change the midwife's proposed plan. This is not an example of shared decision making as discussed by Guilliland and Pairman (1994). Caitlin however, was the only woman to address the notion of power within her midwifery relationship.

*The relationship of trust had been established, the birth plan had been gone over, we had discussed all the things I wanted and didn't want (...) and the kind of environment I wanted and because I trusted her, it wasn't really a basis of she was*

*making decisions on my behalf, a kind of power thing. <It>  
was working together more, it wasn't really a power thing.*

Caitlin, i2, 43 - 50

It could be argued therefore that Caitlin trusted her midwife to act if need be. She protested against going to an obstetrician and her midwife acted according to Caitlin's wishes. As Caitlin trusted her midwife she must have believed that she and her baby were safe at that time.

Midwives sometimes used their power in an attempt to persuade women to have a home birth. Both of the women that addressed this issue felt that they remained in control and that the midwife respected their decisions not to have a homebirth.

*The midwife was keen for me to have a home birth, but in the end I didn't want a home birth and she was quite happy about that.*

Hannah, i2, 48 - 50

*As much as they <the midwives> had, (...) both felt that if it happened at home that would be fine, we were not quite as confident about that and there were reasons why it was important. We sort of felt that we wanted to be in the hospital.*

Joy, i1, 142 - 146.

Here the women made these decisions and they were satisfied with their birth experiences. The idea of “power” is an issue that has created much discussion and debate within midwifery circles. Midwives, it would seem attempt to rid themselves of power in this relationship through the education and empowerment of women. Fleming (1995, p. 170) states

Lesley here, like the other midwives in this study, is well aware of the responsibilities that accompany positions of power and in general found the issue of power to be problematic. To assist in the dissemination of this power, the midwives made every effort to pass on information to their clients.

Guilliland and Pairman (1994, p. 7) state that “Within the <midwifery> partnership both partners have equal status. Knowledge and power are shared between the partners and must achieve a balance which is negotiated and mutually satisfactory”. Whilst, the women in the current study produced examples of their midwives providing them with knowledge, they did not discuss the concept of ‘sharing power’ per se.

Joy was the only woman to address how she perceived that her midwife could perhaps control and manipulate women who were not perhaps as assertive as she may have been.

*I think that the particular midwife I had could be probably quite a bully and probably quite (...) particular about what she wanted. But that wasn't an issue for us, because I think*

*that we were both mature and experienced and (...) clear about what we wanted, and that was probably quite consistent with how she wanted it to be. (...) But I do think that there, there could be an issue where somebody that's younger and less experienced. (...) Yeah, may need to be able to express more firmly what their views were.*

Joy, i2, 277 - 286

Joy has described how she was able to have control over her birth experience because of her own knowledge and past experiences. Sarah too, felt that it was important to be in control of events.

*I said to <my husband> "I can't take anymore". I mean he was massaging my back and by this stage <my sister-in-law> had come back and she was massaging my back and I was sort of on the bed with them massaging my back. I was so uncomfortable I just said "Look, you know we've got to go to the hospital." And I rang <my midwife> up and she said "O.K I'll meet you there."*

Sarah, i1, 691 - 699.

Being in control is a concept discussed by Green, Coupland, and Kitzinger (1990). In their study they looked at women's expectations of birth, their experiences of birth and the way that control over their birth experience had affected the woman's postnatal psychological well-being. Information and control were issues that were prominent in their study and those women who felt informed were more likely to

have fulfilling experiences. Within the context of the Green et al (1990) study it was the feeling of being in control of events rather than the interventions that women experienced that led the women to have a positive outcome. In the Green et al (1990) study women had not received continuity of midwifery caregiver; they had received their maternity care from a number of different caregivers and had no prior knowledge of their labour and delivery midwives. The women believed the relationship that they had with the midwifery staff allowed them to keep in control.

Their <the women's> answers suggested that feeling in control of what staff did to them related much more broadly to the sort of relationship that they felt they had with the staff - whether they thought they had some potential influence over events or whether things were simply done to them.

(Green, Coupland & Kitzinger, 1990, p. 22)

Kirkham (1989), when observing the information exchange between midwives and women, describes that

the actions of all the midwives I observed appeared logical within their setting. The flow of information was very much dependent upon the power structure of the setting. In the vast majority of cases, the women I observed during labour 'waited on' the power holders - the men. (...) On a few occasions (...) I observed midwives, 'waiting on' the actual process of birth (...) The midwives who waited on the process of birth had gained knowledge and confidence which they conveyed to the women in their care. They learnt from those

they cared for, were trusted by them, and worked in partnership with them as respected equals.

(Kirkham, 1989, pp. 133 - 134).

Trust is important in any midwife - woman interaction. The important issue that separates the current study from those by Kirkham (1989); Berg et al (1996); Halldorsdottir & Karlsdottir (1996) and Green et al (1990), is that women in the current study had the opportunity if they wanted to, to select different health professionals. The women in the cited studies had no choice in their caregivers. As was described by these researchers, some of the women in these studies had bad experiences. Yet some women were able to develop a sense of trust with their midwives. As stated in these and the current study trusting the midwife was important to women, yet receiving midwifery from the “right” midwife was crucial for this trust to develop. In the current study the following quotation highlights how important having the right midwife was to Jessica:

*I felt that she was a friend, really which was very important to me because it's probably, (...) well it's been the most important thing I've done in my life really.(...) You need to have someone there that you trust and believe in their judgement.(...) Mostly I say that because of how it went in the end, I was just so glad that I had her because she handled the situation when it went bad .(...) You know I just couldn't fault her and I think that if I'd had the first midwife that wouldn't have happened she would have made her own judgement and said no we can hold on, we'll be all right.*

Jessica, i2, 157 - 171.

From the experience of the women in this study, it would appear that trust was something that was crucial for a successful working relationship with their midwife. Trust was not mentioned at the beginning of the relationship but it was an issue that was discussed with the researcher during the interviews which all took place after the completion of the woman's midwifery care. Hence as a consequence of spending time with women, a relationship between midwives and women develops. This relationship is described by the women in this study, as being friendly, not a power relationship and based on a foundation of trust. Women stated that they were able to be in control of their experience.

Within the context of this midwifery relationship and with regard to issues such as power and control women also spoke of their perception of differences between midwifery and medical management of pregnancy. Hannah describes how she views the different type of relationship that she had between her midwife with this pregnancy, and her doctor whom she had utilised in her first pregnancy:

*I wanted to go with a midwife this time and I also thought that a midwife was going to be easier in terms of they came to the house. With another toddler, having to go to the doctor, 10 minute visit and you are in and you are out. You don't really build a relationship with them. You know, they are not going to ask how your day was, or your night (laughing), but quickly hurry up, you are ok, you know and out you go. Whereas I felt with a midwife, it would be more relationship building and it is.*

Hannah, i1, 490 - 501

Caitlin also described how she perceived traditional obstetric care.

*You have to trust that you can do it <experience labour> as well, and have the people around you who you trust, and who you know, to a certain extent, that they are going to do what you want. So there has to be this basis of trust. And I think (...) that's a real big difference to my concept of what (...) obstetric care is. So I mean to me, that would be, when I think of traditional methods, I think of racing to a doctor for 15 minutes who weighs you and prods you and asks you 3 questions and you're out the door. That's to me what traditional <is>. (...) Yeah, well, I'm not into that. I'm not into going into waiting rooms of sick people, and to be given 15 minutes. I mean the shortest midwifery appointment I had was an hour.*

Caitlin, i2, 127 - 147.

These quotations point to differences between midwifery and obstetric practices. Bryar (1995) described the differences that she perceived within these two models of practice. Two important aspects of Bryar's discussion were that in the medical model, the doctors assumed the control of the woman's pregnancy and birth. This was compared to the midwifery model where the woman and her family were the major decision makers. Bryar also described how within the medical model, the idea of providing information was not a priority of this relationship. Often women's access to information was restricted. In the midwifery model information was shared between woman and midwife.

In this next quotation, Christine compares the two birth experiences that she had. With her first birth, she used the hospital maternity team of unknown doctors and unknown midwives. With her second experience she had an independent midwife whom she knew:

*The first time I had no midwife (...) I had the hospital care.*

*(...) I had absolutely no choices in anything. (...) And, yeah, I didn't like it.*

OK, What about the second time, how was that different?

*Yeah, it was a lot different. I had a choice of anything I wanted.*

And that is important?

*Yeah, and a personal midwife (...) instead of just some strange doctor walking into the room and saying do this, do that.*

Christine, i2, 92 - 108

Having choices and knowing her health professional, were definitely important to Christine. In the second scenario when she knew her midwife she was able to feel more in control of her experience.

Whilst receiving maternity care from midwives women spend time and develop a relationship that is described as being friendly and trusting with this health professional. As a consequence of this professional relationship issues such as power and control over the experience are addressed. For the women in this study the emphasis that they placed on such issues was a very individual thing. Yet

running through their pregnancy and birth experience was a relationship that they developed with their midwife. This temporary friendship was the basis of their trust in this health professional. Women needed to trust their midwives' knowledge so that they could indeed act to ensure their baby's well-being.

The issues that surrounds the idea of trust between the woman and her midwife are discussed in the following section. Imperative in this idea was the belief that the women looked to their midwife for her professional judgement and opinion. That is they trusted their midwife's knowledge.

### **6.3 Trusting the Midwife's Knowledge**

Women developed a sense of trust in their midwife whom they described as their friend. As a consequence of this trust, the women had developed expectations of their midwife; they looked to their midwife for her knowledge and her professional expertise.

Women, who participated in this study, acted in ways that ensured the health of their baby. They undertook screening tests and they looked to their midwife for confirmation of well-being at all stages of the midwifery relationship. They utilised midwifery for professional advice and services. They trusted their lives and their baby's life to their midwife.

*I would do anything she said basically,(...) because I had complete faith in her.*

Hannah, i2, 25 - 27

As stated previously when Jessica's birth experience made a large deviation from normality and her baby needed assistance Jessica was pleased that the midwife had taken over and made decisions for her at this crucial time because

*<My midwife> knew that I was not going to risk losing <my baby> at all.*

Jessica, i2, 271 - 272.

Midwifery guidance was not always associated with a crisis. Indeed during the course of the midwifery relationship midwives offered women tests to ensure their own well-being and that of their baby. The midwives' rationale for such action was discussed with the women. Sarah tells of her concern because of persistent glucose in her urine:

*Primarily in my mind most of the time was the health of my child and so naturally if I had gestational diabetes it was going to affect my baby so it was better that I found out than just to struggle along. I mean, I wasn't throwing heaps of sugar in my urine but there was traces of sugar and it was important for me to know. (...) <My midwife> said she doesn't generally do the glucose tolerance on all women but she does have a guideline that she will do the test on women who have a history of diabetes in their family.*

Sarah, i1, 304 - 317.

Caitlin too had a concern about Anti D, an immunoglobulin used in preventing Rhesus iso-immunisation, "most likely to occur if blood from a Rh positive foetus

leaks across the placental barrier and enters a <Rh negative> woman's bloodstream." (Bennett and Brown, 1993, p. 543). As a consequence of this sensitisation Haemolytic Disease of the Newborn, "destruction of some of the babies red blood cells associated with anaemia and jaundice" (Bennett and Brown, 1993, p. 547), may occur in future Rhesus positive pregnancies.

It was therefore important to Caitlin that the information that she received from her midwife and other friends, who also had medical backgrounds, was accurate. It was also important that she was given time to make the important decision about Anti D. To facilitate this, informed decision making midwives discussed these issues with women, over successive appointments. Caitlin, and the other women in this study, were not expected to make instant decisions.

*One day <my midwife> turned up and said "We have a small problem which I should make you aware of, or it doesn't have to be a problem, but it's something that you need to know about and that you need to make an informed decision about". And I said "OK". And she said "Basically the Anti D stuff that you normally get when you are RH negative has run out in New Zealand and we're now using the American stuff"...*

Caitlin, i1, 341 - 347

When discussing how pleased she was to have had time to think of the answers and conduct research into this specific problem and hearing of the possible consequences, Caitlin states:

*If I'd had that lack of time to make a decision I might have said no (to the Anti D injection) too, and I'm really really glad that I actually had a lot of time and was able to do a bit of research. I mean I didn't have that much time, I think I was about 34 weeks, but I mean I had weeks as opposed to days.*

Caitlin, i1, 452 - 457

Part of keeping the woman in control of her birth experience therefore, is allowing her the time, and providing her with information, to make her own informed decisions. All health practitioners have a legal obligation to provide consumers of health services with knowledge in order for them to make informed decisions about their maternity care (The Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations, 1996 ).

These regulations state that “Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent.” (Health and Disability Commissioner Regulations, 1996, p. 3). Informed consent and informed decision making are important aspects of midwifery care, however much has been written about women’s lack of control and professionals lack of providing information within the midwifery-obstetric scenario. (Johnstone, 1995; Kaufmann, 1983; Shapiro, et al, 1983; Smith, Slack, Shaw and Marteau,1994; and Uhrich, 1996).

Caitlin, described herself as having an intellectual pregnancy. She took much time and went to great lengths to learn as much as she could about pregnancy and birth.

Her rationale for this action was due to her wanting to be informed in case she was transferred from her home to the hospital because of complications that meant a homebirth was no longer a safe option:

*I knew what (...) all the things that could possibly happen, could happen (...) and how I would want to react in those situations. Instead of somebody just throwing information at you and saying "Oh yeah, this is da, da, da, (...), and we'd like your informed consent and pang!". You know, and you're supposed to make a decision on the spot, and if you don't know anything about it, I don't think that's good enough. (...) Informed consent to me is you know something about it and you don't get bla'ed with information and then here, OK is that all right? That's not to me, informed consent, you may as well, you know, save your breath.*

Caitlin, i2, 207 - 220

Sarah describes informed consent as a great goal but in her labour situation, she needed help and was pleased that her midwives made decisions for her.

*I think when you've been in labour that long you're that tired and you've just had the epidural so you do feel a little bit better, but you're sort of thinking hell, everything's not gone the way I planned it. The last thing you want is, informed consent's great, it's a wonderful thing, but the last thing you want is somebody coming in and say well these are your options, what do you want. (...) I think the good thing about*

*<my midwives> is that they let you guide them most of the way, but they know there's a point where they've got to step in and they take control of the situation, and I was quite happy that they did that.*

Sarah, i2, 50 - 62

The quotes by Sarah and Caitlin address the issue of obtaining informed consent from women who are in labour. Whilst Caitlin had participated in much learning and felt informed prior to going into labour, Sarah felt that at that time she was incapable of making informed decisions. She looked to her midwives to make these decisions for her. This was not seen as being disempowering by Sarah, as she said she had guided the midwives most of the way through her labour, but that they had provided her with their professional assistance when she needed it. These quotations do, however highlight the importance of providing women with information before they go into labour. Women have the opportunity to address issues that may be relevant and discuss these with their midwives if they want to.

Bluff and Holloway (1994) discuss a study of women's perceptions of midwifery care during labour and childbirth. This study highlights the importance of solid clinical advice and practice. The main theme in this study was that women expressed a belief in the expertise of their midwife. This again was a study where women had not met their midwife antenatally. Bluff and Holloway (1994) state

Trust in the knowledge and skill of the midwife influenced the decision of two clients to have epidural analgesia when initially they had been reluctant to receive such a form of

pain relief. The women believed that the training received and the experience gained by the midwives enabled them to make predictions and suggestions and the professional judgement was seen as accurate. The suggestions made by the midwife which were effective appeared to create the impression of competence which promotes credibility, thus instilling confidence and reinforcing that 'they know best'.

(p. 159)

This 'they know best' attitude signifies the woman's need for the midwife's professional judgement. Whilst this quotation is from women who had unknown midwifery caregivers, the "they know best" idea was reinforced by the women in this study. Yet it was not seen as being a negative aspect of midwifery practice. It appeared to be more of an acknowledgement of the midwife's professional skill and judgement.

One relevant issue here is the use of alternative therapies in midwifery practice. Some women in this study were keen to go to midwives because of midwives use of alternative remedies. Homeopathy was one particular therapy referred to in the interviews. Sometimes the women introduced this topic, at other times it was introduced by the midwives. Yet the question remains as to the appropriateness of providing and supporting the use of alternative remedies when midwives are not formally trained in these therapies.

In the following quotation Joy describes how she advised her midwife about her use of such remedies.

*I've grown to understand, particularly homeopathy, and quite a few natural remedies. So (...) it was interesting because I'd mentioned it to my midwife early on that you know, I'd be using Arnica and I used Hypericum afterwards and that sort of thing and she encouraged that but she didn't actually suggest it.*

Joy, i2, 75 - 80

Joy had undertaken much reading and felt comfortable with homeopathy. Here the midwife supported the use of these remedies during the pregnancy. Anne's midwives had offered her and she had taken many remedies during her pregnancy. Her belief was that

*They <the midwives> were very much drug free people, homeopathy that's fine it's all natural.*

Anne, i1, 124 - 125

Caitlin also used homeopathy and relied on her midwife to facilitate its use during her labour

*I think by that stage I'd had quite a few remedies cos at the beginning <my midwife> would say "I'm going to give you this remedy now".*

Caitlin, i1, 851- 853

Whilst Caitlin relied on the midwife to provide her with these remedies she was the only woman to utilise the services of a homeopath who was trained in the prescribing of homeopathy and knew its safety and applicability to maternity care. Yet many practices are not researched and sometimes may have disastrous consequences if not used properly (Calvert, 1998).

Women receive information from all manner of sources when they are pregnant. It is important that women receive time and are given the opportunity to investigate issues further, if they want to, before they are expected to make decisions. Some women spoke of the inappropriateness of the midwife requesting that they make decisions or give their informed consent for procedures when they were in labour. In this situation, for one woman, it was her midwife that she looked to for guidance. The women looked to their midwives for knowledge during their pregnancy and birth experience. The midwife's opinion was valued by the women.

### **6.3.1 Receiving Midwifery Expertise**

Women need information on which to base their decisions. As their maternity care provider, women look to their midwife for advice and professional guidance. They are looking to this midwife with whom they have developed a trusting relationship, for her expertise. Hannah, describes how her midwife assisted her with her desire to breastfeed by giving her literature and advice.

*I wanted to feed, wanted to breastfeed and I was a bit apprehensive about the sore nipples and things but <my midwife> had given me a really good book on breastfeeding*

*and I also fed differently this time. I fed on one side continuously at one feed and then the other side at the next feed and I think that gave one side a rest and I didn't have any sore nipples at all.*

What made you decide to do that?

*<My midwife's> advice.*

Hannah, i1, 350 - 360

In this study, the women wanted to hear the midwife's opinion. Women described their midwife as providing them with an opinion on topics that were relevant to their pregnancy and birth experience. Sarah describes how her midwife stated what she would do in a certain situation and thereby introduced an element of persuasion into the context of the decision that Sarah had to make. Sarah viewed this advice not as persuasion but just as a consequence of both parties holding similar views and opinions.

*I mean <my midwife> did have opinions of her own and she would say "Like if it was me this is what I would be doing but you know you make your own choices" and we think very much alike anyway which is handy.(...) But it was nice to read the sort of things that are written about, for say, Vitamin K.*

Sarah, i1, 1188 - 1194

Caitlin describes how her midwife provided her opinion, but was not coercive.

*She also managed to convey like her feelings, leaning, stance about things without saying this is what I would do or this is what's right.*

Caitlin, i1, 214 - 216

Sometimes the opinions that were offered by the midwives were often in an advisory capacity. Whitney's baby had been unsettled and the hospital midwife had advised her to complement the baby's breastfeeds with formula:

*So <my midwife> sort of told me that it's all right, but when she settles down then take her off the bottle and that's exactly what I did.*

Whitney, i1, 162 - 164

Shayne had concerns about scanning, and looked to her midwife for advice. As stated previously Shayne believed that she knew little about pregnancy and birth and therefore looked to her midwife to address these information needs.

*I asked if scans were OK because I'd heard that they weren't and she said they were fine.*

Shayne, i1, 88 - 89

The midwife's opinion and her professional knowledge are requested and respected without question in these instances. This is reiterated by Leap (1996a) who looked at the idea of midwives persuading women to give birth at home. Leap's (1996a) own belief is that

As long as our outcomes are excellent, as long as the feedback that we get from women - those who give birth at home and hospital - assures us that their experience of birth was positive in terms of their control of the experience, then arguably we can own our bias as a positive tool. (p.538)

Indeed under the circumstances described by Leap, the midwives could own their bias and use it very effectively. However, it is important to state that Leap also includes within her argument the idea that women want midwifery expertise. That is, women want a midwife who is up-to-date with current knowledge and skills.

What most women want from midwives however is our expertise. They want to access information from us and they want us to provide them and their babies with a 'safety net', an overview of what is appropriate based on our knowledge and experience.

(Leap, 1996a, p. 538)

Jessica discusses why she decided to contact her midwife, for professional advice, when having erratic, irregular contractions:

*First time it happened it was like, I think we did ring her, (...) and she said (...) have your waters broken? Has this happened? We were like no! and how far apart are they? Oh 2 hours you know! (...) But they lasted for half an hour or something, it was kind of like that. So yeah, she just said "Oh*

*look, don't worry about it, call me if such and such happens.(...) So we felt comfortable in that.*

Jessica, i1, 189 - 201.

Midwifery knowledge is also discussed by Fleming (1995). Fleming looks at different types of knowledge acquisition and midwives' attempts to disseminate knowledge to the women that they are working with. In Fleming's study, it was very important for the midwives to share their knowledge with the women. They saw this as disseminating their power to their clients. "As Sarah pointed out it is not merely the acquisition, recognition and dissemination of midwifery knowledge which is important, but that the knowledge of the midwife is seen to be in tune with the woman." (Fleming, 1995, p. 161). Fleming's study has relevance for the current study as in the Fleming study, the researcher went to the women and to the midwives thereby gaining a deeper understanding of the midwife-woman relationship by looking at both sides of the pregnancy and birth relationship.

Guilliland and Pairman (1995) discuss the idea of "individual negotiation". In their Partnership model of midwifery practice, they believe that; "Individual negotiation is the ongoing process by which the woman and the midwife work through issues of choice, consent, decision making, power sharing and advocacy, mutual rights and responsibilities as these arise within the partnership" (p. 45). In the Partnership model, both the midwife and the woman bring to the partnership their own individual expertise. However within the New Zealand context of practice, the only audit or quality control that exists to evaluate the currency and accuracy of the expertise that the midwife brings to the partnership is that of the midwifery

standards review. This is a peer and consumer review process that midwives undertake of their own volition. However midwives are only requested to bring their information resources to their standards review interview and there is no guarantee that such resources will be evaluated (Wellington Midwifery Standards Review Committee, 1997).

The current study describes some of the elements of individual negotiation as described by Guilliland and Pairman (1995). In the current study women often wanted midwives to make decisions for them, they followed instructions and were guided by the health care professionals that they had chosen for their labour and birth experience. The concept of equality or inequality between women and midwife was not discussed by the women. Women, when they handed over their decision making responsibility and followed instructions, did so spontaneously. The women accepted the advice and expertise at times without question as their primary focus was to act to ensure the health of their baby. Women trusted their midwives with their own and their child's safety. Whilst all women were provided with information and were encouraged to some degree to be autonomous in their decision making, they ultimately looked to the midwife for help, assistance and professional guidance throughout their relationship. Guilliland and Pairman (1995, p.45) state that "Whilst there may be episodes which necessitate the midwife acting on behalf of or speaking for the woman, this is done in a co-operative model. The midwife's role is one of empowerment towards self-determination rather than advocacy." The following quote describes such an incident:

*They, <the midwives>, were getting to the stage (...) where they were sort of gunna (...) let me know that what I was*

*doing was silly. You know, because I was putting the baby at risk (...) and myself, I wasn't doing too good either. They could see I'd reached my limit and that was the time when they actually started suggesting, not forcefully or anything. But just the heavy hints that I should be looking at intervention, you know, with the epidural.*

Sarah, i2, 14 - 25.

Sarah in fact requested an epidural of her own volition. She was pleased that the midwives had acknowledged their concern and raised the topic of epidural pain relief. Other women looked to the midwife to make decisions for them, these related to issues that pertained to the management of their pregnancy. Christine believes that her midwives made the decisions that she wanted them to make. She had an expectation that her midwife would make decisions for her with regard to going to the hospital and the timing and type of blood tests required during her pregnancy.

*An example would be to go to the hospital when my waters broke. (...) Mmm, just little things like the blood tests.*

Christine, i2, 34 - 42.

Whitney saw the need for the midwife to make decisions for her because:

*It's good (...) to have somebody who knows more, <has> more experience and knows more about it <pregnancy and birth> than I do.*

Whitney, i2, 55 - 57.

Hence women demand midwifery expertise. They look to their midwife to make decisions that facilitate the path of their pregnancy and birth experience because the midwives have a professional knowledge and technical skill that the women require. This idea was also described and discussed by Fleming (1996, p.8) who described this as the midwife supplementing the woman's needs. "The theme of supplementing was generated by clients who felt that as pregnancy or labour or being a mother progressed they needed midwives to do things for them that they were unable to do for themselves." These issues could include making the decision on the timing of blood tests and providing guidelines for when to go to hospital in labour.

The quotes cited from Sarah, Christine and Whitney in the present study and from Fleming (1996) suggest that the midwife is also an active participant in decision making. Whilst this may arise as a consequence of the woman actively deciding to hand the decision making responsibility over to her midwife, often it may be due to the women actually seeking midwifery assistance. Whilst the midwifery relationship in this study is with the woman, the midwife also acts for the baby. Such decision making is often of the midwife's own volition. Guilliland and Pairman ( 1994, p. 7) state that

In the midwifery model the woman is at the centre of care rather than the baby. It is not that the baby is unimportant or does not have needs, but that the midwifery relationship is with the woman who has the primary relationship with the baby and is responsible for decision making.

The words of the women and the actions taken by the midwives in this study present a contrasting picture to that described above. The quotation by Jessica, whereby the midwife acted and arranged an immediate consultation with an obstetrician because of perceived fetal distress provides an example of the midwife acting because of a perceived threat to the baby's safety.

*When she went out of the room to sort out the admission and the anaesthetists and everything, I was glad that she just went out and did all that and then came back and said "We're going to admit you"... after she'd gone and sorted it out, taken two minutes to do it all because otherwise if it was "Now do you want to have a Caesar or do you want to sit here for another hour or so", in pain and not know whether your baby's going to live or die! I'd... I felt that we knew one another well enough that I could give her some, of my responsibility.*

Jessica, i2, 274 - 284

Papps and Olssen (1997) discuss the idea of women being responsible for their baby's well-being. They use such argument to describe how members of the medical profession has used the idea of "safety" in order to control childbirth. Papps and Olssen (1997, p.153) state that "During the twentieth century, women have increasingly been given the message that the health and safety of their unborn child was theirs. (...) The issue of safety became paramount to the pregnant woman who wanted the best for her baby". In this argument perceived safety is associated with medical and technological involvement in pregnancy and birth.

One practice that is routinely performed because of the perceived effect on fetal safety is that of intrapartum fetal monitoring. Fetal monitoring is utilised throughout labour to assess the baby's well-being. Whilst there is some debate about the most appropriate way to monitor (Enkin, Keirse, Renfrew and Nielson, 1995; Rosser, 1996), all the midwives involved with women in this study participated in this practice in various forms. Some midwives had discussed this issue with their clients, other midwives had not. Some women however did not see the necessity to discuss monitoring.

Hannah knew what to expect having given birth before, but did not believe that discussion about fetal monitoring was an issue because *"You're doing all this for the well-being of your child"* (Hannah, i2, 152 - 153). However when discussing scanning, another issue of contention because of unknown risks to the foetus, she stated that

*I believe that if they're still doing it and babies aren't being harmed, well, what's the problem? (...). I'm the sort of person. (...) I'm not going to get uptight about it".*

Hannah, i2, 253 - 259.

Here Hannah is accepting fetal monitoring without question. She is happy to undergo tests and follow routine practices because they are deemed safe by society and generally accepted as part of the labour and birth routine. Hannah believes discussion in this instance is unnecessary.

Sarah's midwife also did not discuss fetal monitoring, though she did utilise it. Sarah, found the use of fetal monitoring reassuring.

*I thought it was great. I just thought it was absolutely wonderful to be plugged up to this monitor so I could see, cos I always used to get a big kick out of hearing the baby's heartbeat (...) at my monthly visits. (...) To be actually plugged up to a monitor where I could see the heart beat and everything printing out. I got a great kick out of that, I thought that was wonderful.*

Sarah, i2, 160 - 170

Anne's midwives had provided her with their guidelines for practice regarding monitoring. When asked if her midwives had discussed this issue with her before labour she stated:

*Very slightly, (...) The midwife likes to monitor maybe once every hour. (...) Just to be on the safe side. (...) And because it was so quick we kind of only did it like the once.*

Anne, i2, 49 - 55

Again Anne found listening to the heartbeat to be a positive experience. *"It's quite reassuring to hear a heartbeat."* (i2, 62 - 63)

The Nursing Council of New Zealand (1995) and the International Confederation of Midwives (1993) state that the midwife has a responsibility to provide women with safe birthing practices in all environments and cultures. Part of safe birthing practice

is therefore providing the women with accurate information on which to base their decisions. However, as has been described above, women follow routine practices, like electronic fetal monitoring. They do this, when they receive the bare minimum information about the practice of monitoring and the possible effects, because they trust their midwife's expertise and the women are reassured by such technology.

A study by Smith, Slack, Shaw and Marteau (1994) looked at barriers to providing information to women. Their study was specifically about prenatal screening and it highlighted how a lack of knowledge about tests and procedures in both medical and midwifery professionals was not conducive to providing women with information. Not providing women with information was compounded when the midwives had a large amount of clinical experience. Health professionals having minimal knowledge has important implications for the current study on the way that decisions were made between midwives and women. When addressing the question of quality control with regard to information, one must enquire as to how women know they are being given all the correct information. Whilst women in this study did undertake reading and did make enquiries of their own volition, there were many examples of women receiving explanation only from their midwife. Anne tells us of her midwife's unscientific explanation about her inability to stop pushing during crowning of the baby's head.

*The cord was wrapped around his head <several times>, so  
<my midwife> explained to me that it's my body's way of  
knowing there was something wrong and that's why I didn't  
stop pushing.*

Anne, i1, 172 - 176

Whitney describes her midwife's factual explanation to her about the positive aspects of breastfeeding.

*My midwife told me, that it's really important that I breastfeed because breastfeed milk is healthier. (...) I mean she didn't tell me that I don't have to put her on formula or anything, but she said "It's a lot easier, it's (...) safer, (...) <less> money and all that sort of thing". Yeah she said (...) "It's good, it makes your baby grow healthy."*

Whitney, i2, 134 - 143

It is important to remember that these quotations are the words of the women and not those of the midwife. Whilst these quotes do not necessarily highlight a lack of midwifery knowledge, the issue here is the quality of the information provided by each midwife. Smith et al discuss a lack of knowledge by the health professional as an issue of importance and address this by stating

One reason for sub optimal knowledge of a relatively new test is that there is no formal procedure for educating staff about clinical developments. Recognising this problem, the Royal College of Obstetricians and Gynaecologists has recommended that one member of staff be designated such a role in each clinic. It is not known how many clinics are following this recommendation.

(Smith, Slack, Shaw & Marteau, 1994, p.77).

Continuing education of midwives has definite value for ensuring consistency and quality assurance for practice. However midwives in the region where this study was undertaken are faced with a desperate lack of clinical refresher courses and quality assurance measures for information.

Attempts have been made to improve the quality and amount of information that is given to pregnant women in the United Kingdom. An initiative entitled the 'Informed Choice Initiative' has attempted to provide women with easy to read, accurate information in order for pregnant women to make informed choices about their care (Rosser, 1996). There appears to be no such initiative in New Zealand. Whilst the Ministry of Health and certain consumer groups (Post and Ante-Natal Distress Support Group (Wellington) Inc.) all publish information, its availability to women is often at the discretion of the lead care provider. The information may not be based on evidence.

#### **6.4 Summary**

In this chapter I have presented a discussion on the midwifery relationship and how it is an integral part of the woman's pregnancy and birth experience. Women saw their midwife as being a 'friend' and a relationship of trust develops as the woman and her midwife spend time together.

Women need information about aspects of pregnancy and birth. They rely upon their health professional to satisfy this need by providing them with information and assistance. There is an expectation that the service they receive, will be focused on

their needs and there is an underlying assumption that the services and information that they receive are safe, relevant and accurate. Women have described the times when they wanted the midwife to make decisions for them. In these cases, it is the midwife's professional judgement and knowledge that are most important to the women. Having developed a trusting relationship with their midwife they trust her to ensure their safety. However it is important that midwifery care and information provided to women are current and accurate. Questions about the quality of information must be addressed by practitioners. As midwives it is imperative that the services provided for women are factual, current and evidence based.

## **CHAPTER SEVEN**

### **MAKING DECISIONS: FOCUSING ON MY BABY'S WELL-BEING**

#### **7.1 Introduction**

In Chapters Four to Six, the description of the way that decisions were made between the midwife and the woman has been presented. Women have been described as acting in ways that promote their own and their baby's well-being. Women have described the control that they had over their pregnancy and birth experience and the relationship that developed with their midwife. This chapter therefore amalgamates the data that has been presented and presents an overall description of the process that evolved. Unless specifically stated the term woman in this chapter is used to describe the women in this study. Included in this chapter is final discussion on elements of this study, the limitations of the study and the recommendations for midwifery practice, education and future research.

#### **7.2 Making Decisions: Focusing on my baby's well-being**

Women in this study described their actions and choices, after they received confirmation of their pregnancy. When they sought out medical confirmation, enlisted the services of a maternity caregiver and engaged in some learning about pregnancy and birth, women were described as acknowledging their pregnancy. Women in this study all chose to utilise the services of an independent midwife for their maternity care. The emphasis that was placed on the activities that led the

woman to acknowledge her pregnancy and the time and effort engaged in reading and preparing for the baby's birth by each woman was different.

After women made this initial acknowledgement, there was an acceptance of the pregnancy and a need to know that their baby was healthy. Women discussed how they had utilised ultrasound scanning and had undergone other screening tests that allowed them to assess their baby's physical well-being. These tests gave them some reassurance that their baby appeared healthy. The women also looked to their midwife for additional reassurance. Routine checks and midwifery visits all added to the woman's feeling of well-being. Women were prepared to follow instructions given to them by their midwife and other health professionals, as they believed that each test or instruction that was undertaken, was done with the goal of ensuring the baby's well-being. Yet women believe that they had some control over their experience. They planned for their baby's birth and they made decisions that affected themselves and their baby. The women demonstrated that they were in control, when they too acted in ways to ensure their baby's well-being.

As the women spent time with their midwife, they developed a relationship with her. This relationship was described by the women as one of trust. When women enlisted their midwifery caregiver, trust in the individual midwife did not appear to be a major reason for their choice. Indeed only two women mentioned discussing their midwife's knowledge and experience prior to selection. For the majority of women, the reasons for utilising midwifery was because of the need for a health professional to attend them during their pregnancy and birth experience. Women accessed midwifery through personal recommendation often made by friends, or

because their health practice offered a midwifery service. Hence, the midwifery relationship that grew, did so because of the woman and the midwife spending time together and the midwife making herself available to the woman. Women described their relationship with their midwife as being friendly. Whilst this certainly was an important element in their professional relationship, it was the woman's trust in her midwife and her midwifery knowledge that were vital. Women had many questions that needed to be answered during their pregnancy and birth experience, some were general others more specific to their own circumstances and they looked to their midwife for answers. Whilst the women may have discussed these issues with friends and family, in most cases they looked to their midwife for final clarification.

There seemed to be an undisputed faith in the midwife and the women seemed to almost always implicitly accept what the midwife had to say as being the truth. To empower women to make decisions and to be in control of their experience, midwives have to ensure that the advice and instruction that the women receive is factual and appropriate. Hence the women looked to the midwife for her professional opinion and followed her routine management, her guidelines and her recommendations because the women had developed faith in their midwife.

Central to this pregnancy and birth experience, the reason for faith in the midwife and the decisions that women made during their pregnancy and birth was the woman's baby. Women in this study have said that their focus was on the health of their child. Hence, women would undergo screening tests, they would follow instructions because they believed that these instructions or tests would assess their child's well-being. Women decided to follow their midwife's instructions because

they trusted her knowledge. Whilst women did plan and make decisions about their pregnancy and birth their focus in the planning was on their baby. Hence, having developed a relationship of trust with their midwife the women expected that their chosen professional maternity caregiver, would help them achieve their ultimate goal - a healthy baby.

### **7.3 Discussion**

This study is about how decisions that affect a woman's childbirth experience were made between a woman and her midwife. It is derived from the words of the participating women who were of differing ages, mixed cultures and different socio-economic backgrounds. It is most important to acknowledge that it is the woman's background and her desire to learn and control her experience that often shape the way that decisions were made.

The overwhelming issue that was evident from talking to the women in this study was their desire to do what they believed was best for their unborn child. Women wanted to protect their baby and act in ways that ensured their baby's well-being. Their rationale for undergoing procedures and participating in screening tests, perhaps without question, was because they had a need to know that their baby was healthy.

Midwives, by determining the routine of the pregnancy and facilitating women's birth choices, showed that they were keen to participate in the women's birth experience. The women talked about the midwife providing them with information,

skill and professional opinion. It is a positive acknowledgement of their midwives that women in this study believed that they were in control of their pregnancy and birth experience. Yet women also provided examples of midwives instructing them or controlling their experience. Whilst this may be a concern for midwifery practitioners (Leap, 1996a), it is important to state that the women in this study did not feel disempowered when the midwife instructed them or made decisions for them. Women saw this as being their midwife's role. Many of the decisions were seen as being part of the pregnancy routine of scheduling visits and undergoing screening tests. Sometimes decisions such as consultation with an obstetrician whilst in labour were made for women and in these circumstances it was the facilitation of the "healthy" birth experience, not the "normal" birth experience that mattered most to the women. Hence, women looked to their midwife for support at times when they may not have been able to decide for themselves.

Being woman-centred is one of the attributes of midwives working in New Zealand and internationally. (Guilliland & Pairman, 1995; Leap, 1996a, 1996b; Page, 1991). To make the woman the centre or focus of her pregnancy and birth experience is an idea that is believed to enhance the woman's confidence and feelings of empowerment (Leap, 1996b).

Women in this study spoke at length of their experience and within these narratives were many examples and eventualities where the woman was the centre of care, where she made decisions and acted in ways so as to have control over her birthing experience. Yet at times these women actively looked to their health professional, their midwife, to facilitate their needs. Some of the women stated that at this time

the decision could have been made by their midwife and that would have been acceptable to them. Other women described a general inertia or lack of interest in the process of pregnancy and birth. These latter women wanted a health professional to tell them what to do and when. It was their decision to follow the predetermined path and routine of the midwife. To have made these women actively participate in the decision making process may have been disempowering and not, in these cases, woman-centred.

An important element of this study was the different expectation of every woman. Each woman in this study appeared to have different needs that pertained to their pregnancy and birth experience. They were individuals and it was imperative that the midwives acknowledged this individuality. What became apparent during this study was that not all women wanted an exhaustive list of references on which to base their decisions. Indeed some felt that they made few decisions and one woman, when given all the research and general opinion on topics, followed her previously predetermined decisions despite the evidence provided to her.

Midwives must acknowledge that women actually look to their health professional for guidance; only in doing this can practitioners ensure that the care that is provided is centred around the woman. Midwives must not make generalisations about women. The goal therefore must be to provide woman centred care which by implication should be individualised care.

## **7.4 Credibility of Results**

Sandelowski (1986, p. 35) presents strategies for assessing credibility of qualitative research results. Inherent within this is “obtaining validation from the subjects themselves.” In this study the women all received copies of their transcripts. All discussed these with me and only minor changes were made, e.g. punctuation. Most women were concerned about their constant reported use of terms like um and ah. Apart from this there was little of issue about the transcripts.

When the final description was derived, I contacted five of the women in this study. They listened to the description of the way that decisions were made and agreed with it.

## **7.5 Fit and Relevance**

As previously described one of the goals of qualitative research is to produce results that fit and are relevant to the participants in the study and others who may read this study.

Sandelowski (1986, p. 32) defines the characteristics of fit as being

The findings of the study whether in the form of description, explanation, or theory, “fit” the data from which they are derived. The findings are well-grounded in the life experiences studied and reflect their typical and atypical elements.

The data chapters of this thesis present the description that has been formulated by the researcher, but within this are the words of the women who participated in this study. Without these quotations the description that eventuated would not have been so rich.

Sandelowski also describes how it is important for others to view the findings in terms of their own experience and how this can add to validity. I undertook discussion with women who had chosen alternative forms of maternity care and their appreciation of the study's findings adds to the validity of the findings.

## **7.6 Transferability of results**

Transferability of results refers to their ability to be transferred from the sample under study to the general population. The aim of this study was to provide a description of the way that decisions were made in the midwife-woman relationship. It was not to provide a description of the way that decisions were made across all borders and through all types of relationship. By using theoretical sampling a diverse sample in terms of age, culture and maternity experience was obtained. The description however that was derived was the experience of the women in this study. Whilst there may be aspects of this study that are relevant to other groups of women and those of other cultures or in other countries it is not the expectation that replicating this study in these other environments would produce identical findings.

## **7.7 Implications for Midwifery**

Throughout this study there were certain issues that developed as the study progressed. The undisputed trust that women seemed to place in their midwife has many ramifications for practitioners. It appeared that whatever the circumstances and whoever was concerned, women looked to their midwife for guidance and assistance. They did this partly because this was their chosen health professional and partly because of the trust that they had developed in their midwife.

Trust was an aspect of the midwife-woman relationship that played a part in the way that decisions were made. Women expected that their midwife would act to ensure their own and their babies' safety. This resulted in women, however educated and articulate, following the midwife's plan when the need arose. There was an inherent trust in the midwife's judgement.

Women expect and trust midwives to provide them with a safe service. Yet there are no formal updating and continuing education requirements for midwifery practice. There are no guaranteed audits of information provided for women and there appears to be no general consensus on information that should be provided to women about aspects of their pregnancy and childbirth. The informed choice initiative is one way that information can be passed on to consumers. However, that is an initiative from the United Kingdom and there seem to be no moves within New Zealand to utilise this information. There is an inordinate amount of research about midwifery, maternity and obstetric practices. However, there appear to be no

measures or research being undertaken to assess how much of this evidence is being incorporated into practice.

Another issue was related to the amount of information that each woman needs in order to feel in control of her birthing experience. As has been stated woman-centred individualised care is crucial for midwifery practice. The woman's need for information is indeed a very personal thing. It was an issue that was relevant to the women in this study and the reality was that information needs varied greatly between individuals. If midwives are practising in a woman-centred way then this individual assessment of information needs will become an important element of practice.

Informed choice is another important aspect of this study that has implications for midwifery. Practitioners have a legal obligation to provide women with information so that they women can make informed choices. However the words of the women in this study provide us with examples of midwives providing opinions and perhaps influencing women's choices. As was evident from the interviews different practitioners with different philosophies all have their perceived "best way of doing things". Until practice is truly evidence based personal practitioner bias will always influence the individual woman's choice and women need to be made aware of this.

A further issue that arose from this thesis relates to a statement from NZCOMi (1993) that the midwife respects the decision made by the woman even if contrary to the midwife's beliefs. This is an interesting statement and there are examples of such issues in this study (Anne; Caitlin). However as stated in this study, women

planned for their birth experience. Their plans were followed by their midwife. However, when the women needed assistance or felt that they were out of their depth, they turned to their midwife for help. In these situations, the midwife may have made decisions but the women did not perceive the woman as attempting to control or overpower them.

One must look at the statement from NZCOMi in the light of evidence based practice. If midwives are researching the evidence and providing women with correct information on which to base their decisions would there ever be a situation in which opinions differed? If empowering women is central to practice then it must be that women are given all the information and not left to struggle with the consequences of their own incorrectly formulated decisions. Whilst it is the woman and the midwife who work together throughout the pregnancy and birth, ultimately the health of the baby is paramount. Women have stated that they followed procedures and underwent tests so as to ensure that their baby was healthy and they do not want to jeopardise this. Hence in light of the statement by NZCOMi the question of advocacy for the baby must be addressed. As women in this study have stated although their birth experience was not as natural as they had expected, they had healthy babies and ultimately that was all that mattered to them.

These findings present a different picture to that of Guilliland and Pairman (1995) that places the woman as the decision maker within the partnership model. In the current study, women did want to make decisions and the evidence is there to support the fact that they did. However, there are also descriptions of women who turned to a health professional for help and guidance during their birthing

experience. The women demonstrated that they respected their midwife's professional judgement and women actively chose to relinquish their role as decision makers in particular circumstances.

The actuality of women relinquishing their decision making control must be addressed by midwives. For midwives to facilitate the decision making and guide a woman to a healthy pregnancy outcome is a necessity at certain times. However, it is the process of taking over and thereby ensuring that the woman remains in control of her pregnancy and birth experience that is important for midwifery.

Women valued the time that the midwife spent with them and they saw that as creating the environment in which trust could begin. Yet in today's society when money and finance appear to control much of health care, and greater efficiencies are expected from practitioners can midwives justify spending hours with women when they, in fact, receive remuneration for only a small amount of their time? A campaign by NZCOMi in 1997 addressed the idea that women are worth more than seven minutes, the time allocated by doctors for antenatal care. Whilst this may be true for the establishment of a relationship, perhaps one needs to address the needs of the midwife. By spending a large amount of time with a woman midwives are being exploited by women and health care purchasers. This needs to be addressed by the midwifery profession as eventually burnout may lead to a decrease in the number of midwives who are willing to provide continuity of care. As has been discussed previously the focus should actually be on quality of time spent with the woman as opposed to quantity.

Within this study there were examples of the women not being made aware of the choices that they had in relation to their pregnancy and childbirth experience. Only 50% of the women in this study actively sought midwives as their lead maternity carer and often unless they knew a midwife, the woman had difficulties accessing a health professional. The midwifery profession must address this lack of public awareness of the work of midwives and their role as a lead maternity carer.

The proposed model of independent midwifery practice within New Zealand is described as being a partnership with women where decision making is shared. When women state that they want midwives to make decisions for them, then the time has come to address the exact nature of the New Zealand midwife-woman relationship. An exact definition of the partnership that encompasses all practices of midwifery may be needed. Inherent within this definition the question of the type of relationship that women want must be answered. Do women want a relationship where all decision making is deemed to be shared and what exactly does sharing decisions involve? These questions must be answered by practitioners.

### **7.8 Implications for Midwifery Education**

Continuing education of all practitioners needs to be expanded and developed within New Zealand. There are no professional requirements to attend formal refresher courses or even study days. There also is no formalised programme of continuing education that practitioners must attend. As it stands at the moment once a midwife has qualified she need never read any midwifery literature or attend any type of course again. Yet without this how can midwives state that they provide

evidence based midwifery?. The ongoing education requirements of practitioners needs to be addressed by the educational institutions and NZCOMi and steps taken to ensure quality of midwifery services. The proposal by the Nursing Council of New Zealand that competency based practising certificates be introduced is one way of ensuring that all practising midwives are engaged in ongoing education. That is not to say that every midwife must obtain a higher degree, but that there is education available to her to enable her to expand and develop her clinical practice.

### **7.9 Limitations of this Study**

- This study presents a description of the way that decisions were made between 10 women and their midwives. As this is a qualitative study it does not provide a description that can be generalised to the entire population. However I discussed this description with five of the women in this study (no other participants could be contacted at this time), and also with some other women who also had recently given birth. The response from all women was that the categories and issues raised in this study were common to all their experiences; the core variable and the description of the way that decisions were made had relevance to all of these women. Relevance of the theory is one of the attributes of a grounded theory (Glaser, 1978, p. 5). This relevance was reassuring to the researcher.
- This study only provides a rich description of the way that decisions were made as told by the women. Whilst this was the aim of the study as outlined in the

research proposal, ultimately a theory should be derived. Due to university course time constraints such a theory did not eventuate from this study.

- It was not believed that saturation was obtained. The reason for this was again due to course requirements and university completion dates. Hence although it appeared to the researcher, that recurring themes were becoming evident, it could not be stated conclusively that saturation had occurred. Had more time been available for further interviews, this may have been achieved.

#### 7.10 Recommendations for Future Research

- To gain an understanding of the way that the midwifery relationship breaks down it is imperative that research is undertaken that looks at **women who are not satisfied** with the midwifery service that they received. This, however, as stated previously is quite torrid ground and one could question the appropriateness of a midwife carrying out this research when the outcome has not been satisfactory. Yet for a researcher associated with another discipline to undertake research of this nature the emphasis and the understanding that would be obtained would alter. The recommendation is that a midwife carry out this research but that strict ethical guidelines be formulated to protect the mother, the midwife and the researcher.
- A study is necessary that looks at **the way that the midwife believes she makes decisions**. This could be compared to the experience of the woman.

Alternatively a combined study that has both the midwife and woman's experience of decision making would add depth and clarity to this research.

- A study looking at **the decision making experiences of women utilising all options of maternity care**, that is midwife only, shared care, hospital midwifery care, could provide an overview of the different perceptions that women have and the opportunities that they are given to control their experiences.
- The time is right to evaluate the research (Fleming, 1995) and the model (Guilliland & Pairman, 1995) that have been developed to address **the nature of the midwife - woman relationship**. As time progresses and as midwives are faced with fiscal constraints to practice, it is imperative to see if the focus and emphasis on the midwifery relationship has changed. There is also need to address **the women's expectations of midwives as a professional group**. This research needs to take a broad perspective and cover many different groups of women.
- This study highlighted that women were not receiving choices about their options for lead maternity caregiver. Policy makers need to be aware of this lack of information provision. Research is needed to **verify if women are still unaware of their options** and indeed to **see if they are receiving accurate unbiased information upon which to make their choices**. It would be necessary to discuss with women how they made their choice to utilise certain

caregivers to see if they indeed had been given any option and had any control over their pregnancy and birth experience.

### **7.11 Conclusion**

Grounded theory methodology has been used in this study to explore the way that decisions were made between the woman and her midwife. Women believed that they were in control of their pregnancy and birth experience and that their midwife was a friend, who provided them with the information that they needed to make informed choices. When given this information, women believed that they were the principal decision maker in their pregnancy and birth experience. Women felt they trusted their midwife to ensure the outcome of a healthy baby that they strove for.

Midwives must focus on empowering women to make the decisions that they want to during their pregnancy and birth. It must be acknowledged that many women do not want to be the main decision maker all the time. In times of need or when needing guidance women see decision making as being the role of the midwife. It must be highlighted therefore that seeing the woman as an individual and giving her the freedom to choose how much input and decision making responsibility she wants is far more empowering than embarking on a massive education campaign that leaves the woman feeling lost and out of control. Midwives have a responsibility to acknowledge women's differences, their wants and desires. By promoting woman-centred, individualised midwifery it can be stated that practice is in tune with what women want. By acting to ensure the health of the women and her baby, the midwife's focus will be the same as that of the woman.

## **APPENDIX A**

### **DEFINITION OF A MIDWIFE**

## **Definition of a Midwife**

A person, who having been regularly admitted to a midwifery educational programme duly recognised in the jurisdiction in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and or legally licensed to practise midwifery.

The sphere of practice: She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.

She has an important task in counselling and education - not only for patients, but also within the family and community. The work should involve ante-natal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care.

She may practise in hospitals, clinics, health units, domiciliary conditions or any other service (World Health Organisation, 1966).

## **APPENDIX B**

### **MIDWIVES INFORMATION SHEET**

## INFORMATION SHEET FOR MIDWIVES

Dear Colleague

As part of my Masters in Philosophy (Midwifery) degree, I am undertaking a research project. My topic is decision making in the midwife/woman relationship. My aim is to provide a rich description of the way in which decisions are made in the midwife/ woman relationship from the woman's perspective. I hope to interview women who have chosen midwife only care. In the interviews the women will be asked to talk about their most recent pregnancy and birth experience and it is hoped to explore in depth how decisions were made.

I am writing to request your assistance in recruiting participants. Selection criteria for participants are

- The woman had a midwife as her maternity care provider. Women who temporarily transfer for an aspect of care can still be included.
- That the woman is fluent in English.
- That neither I nor any midwife that I work with had any input into the woman's care.

I plan to start interviewing women after the six week check when their midwifery care is complete. However, I am happy to meet potential participants at any time to provide them with information and to obtain their consent.

I am therefore asking you to think about possible participants for this study and for you to ask the women to read the information sheet. The women are to get in touch with me directly. Your participation ends after you give them the information sheet.

It is important to state that I am looking at **how** decisions were made, not what care the woman received. This is not an analysis of midwifery care. It is also not a chance for the women to receive a second opinion about their care.

If however the woman has a complaint or grievance then I will refer her to the appropriate sources.

Thank you for taking the time to read this information sheet and for helping me to recruit participants for this study.



**SUE CALVERT**

**APPENDIX C****PARTICIPANT INFORMATION SHEET**



# RESEARCH ON DECISION MAKING IN THE MIDWIFERY RELATIONSHIP.

MASSEY  
UNIVERSITY

Private Bag 11222  
Palmerston North  
New Zealand  
Telephone +64-6-356 9099  
Facsimile +64-6-350 5668

FACULTY OF  
SOCIAL SCIENCES

## INFORMATION SHEET

18.10.96

My name is Sue Calvert. I am currently undertaking a research project as part of my Master of Philosophy degree, in midwifery. I am also a practising midwife. My supervisor is Dr Cheryl Benn, a midwife and senior lecturer in the Department of Nursing and Midwifery at Massey University

DEPARTMENT OF  
NURSING AND  
MIDWIFERY

The purpose of this study is to increase midwives' understanding of the decision making process during the childbirth experience

Midwifery philosophy of practice in New Zealand is based on the woman and her midwife working together in a partnership. Within this partnership there are certain ideas and suggestions that have been put forward depicting how decisions are made within the midwife/woman relationship. What this study hopes to do is look at the way that decisions about your care were made between yourself and your midwife. The focus is therefore your perception of the decision making process. I will not be looking at what decisions were made but **how**.

It is important for you to know that

- I will not be looking at what decisions were made about your care, but how they were made.
- I will not be analysing individual midwifery practice
- This will not be an opportunity for you to receive a second opinion about the care that you received.
- My role is that of researcher and not midwife.

Participation in this study will involve at least two interviews with you. These will be approximately 60 minutes each and they will be held at a time and place convenient to you. These interviews will occur after your midwifery care has been completed. During the interview you will be asked questions about your pregnancy and birth experience and how decisions were made. If you agree, these interviews will be taped. My supervisor and I will be the only people to have access to the taped interviews. The tapes will not be identifiable, as you will be given, or may select a pseudonym (a false name). The transcripts from the taped interviews and any direct quotes in the final report will use your pseudonym. I will transcribe the tapes which will be securely stored in my home. At the end of the study you have the option of having these interview tapes destroyed, archived or returned to you if you wish. During the interview I will also make written notes about your behaviour, for example, any anxiety displayed by the twisting of a handkerchief.

You are invited to participate in this study. However, there is no compulsion for you to do so. Participation is only dependent on English being your first language.

You have the right to

- Refuse to participate
- Withdraw from the study at any time. Withdrawal will not affect any midwifery care that you may receive in the future.
- Refuse to answer questions at any time.
- Ask questions about the study at any time and to expect an answer from the researcher
- Refuse to have the interviews taped
- Have the tape recorder turned off at any stage of the interview
- Provide information on the understanding that your name will not be used.
- Hear the tapes and see the transcriptions and notes made by the researcher, amend the text or remove quotations.

All information received is confidential and anonymity will be maintained by assigning you a pseudonym.

A summary of the research findings will be made available to you should you wish at the end of the study.

All information given during this study is confidential. It will be used to develop a thesis for examination. From this, articles for publication may be written and highlights or aspects of this study may be presented at midwifery conferences.

There are no perceived benefits that the researcher can see for you participating in this study for your current pregnancy. However in the future you may find that your decision making process changes through reflection on your past experience. The only risk that women may find in recounting their maternity history arises if an aspect of your care caused you distress. If this is the case then you are reminded that you can request that the tape be turned off at any stage. If it is obvious that there are still some unresolved issues surrounding your care then the researcher can refer you to the people who can help you.

Please take time to consider participation in this study. If you wish to participate in the study please contact me at your earliest convenience to discuss this further:

Sue Calvert

Phone 04 - 2331060 (home)

025 - 477771 ( work)

Alternatively you may wish to contact my supervisor Dr Cheryl Benn if you have any questions about this research. She can be contacted at

Massey University  
Department of Nursing and Midwifery  
Private Bag  
Palmerston North.

Alternatively she may be contacted by phone : 06 3504320 or 06 3570960.

If you have any concerns about this study you may contact  
The Chairperson,  
Central RHA, Wellington Ethics Committee,  
Wellington Hospital,  
Private Bag 7902  
Wellington.  
Phone 04 3855999 ext. 5185 or fax 04 3855840.

Thank you for taking the time to read this information sheet.

Yours faithfully

A handwritten signature in black ink, appearing to read 'Sue Calvert', written in a cursive style.

Sue Calvert.

**APPENDIX D**

**CONSENT FORM**

## DECISION MAKING IN THE MIDWIFERY RELATIONSHIP

### CONSENT FORM

Researcher: Sue Calvert, midwife, ph 025 - 477771

Venue of study: Wellington Region

The purpose of this study is to increase midwives' understanding of the decision making process during the childbirth experience.

Participating women will be involves in a minimum of two interviews. It is envisaged that they will take approximately sixty minutes each. They will be held at a time and place convenient to the woman.

Confidentiality will be maintained by the assignment of pseudonyms to each woman. All tapes will be transcribed by the researcher and all tapes and transcriptions will be kept in a safe place. Each participant has the right to refuse to have the interview taped.

---

**Statement to be signed in the presence of the researcher and where possible to be witnessed.**

I have read the information sheet and the consent form. I have had the opportunity for discussion with Sue Calvert

I know that I have the right to withdraw from the study at any time and I understand that this withdrawal will not adversely affect my future maternity care. I have the right to decline to answer any particular questions.

I understand that prior to the interview the researcher will reiterate project information and my rights as a participant. I will be given the opportunity to, once again, give my verbal consent prior to each interview beginning.

I understand that this study has been approved by the Central Regional Health Authority, Wellington Ethics Committee and if I have any concerns about the study, I may contact the Ethics Committee, Wellington Hospital. Telephone 3855999 ext. 5185.

**I agree to take part in this study.**

**Signed** ..... (participant) / / (date)

..... (witness) / / (date)

**Witness name** .....(print name)

**Statement by investigator**

**I have discussed with** ..... **the aims and procedures involved in this study.**

**Signed** .....(researcher) / / (date)

**APPENDIX E**

**STATEMENT OF NON-DISCLOSURE OF  
INFORMATION**

**EQUALITY IN THE MIDWIFE/WOMAN RELATIONSHIP  
THEORETICAL GOAL OR PRACTICE REALITY**

**NON DISCLOSURE OF INFORMATION  
TYPIST/TRANSCRIBER**

I, \_\_\_\_\_ agree not to disclose the name, or any information that would lead to the identification of, the participant in the research study being undertaken by Susan Calvert. The audiotapes, transcripts and computer disks will not be made available to anyone but the researcher or her supervisor and will be kept securely while in my possession. I will not retain any copies of the audiotapes, computer disks, or transcriptions.

Signed: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

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