Choices of care in the third stage of labour.

A Foucauldian discourse analysis.

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The Road goes ever on and on

Down from the door where it began.

Now far ahead the Road has gone,

And I must follow, if I can,

Pursuing it with weary feet,

Until it joins some larger way,

Where many paths and errands meet.

And wither then? I cannot say.

The Fellowship of the Ring.
J.R.R Tolkien.

ABSTRACT

For the majority of women, the culmination of pregnancy and birth is the arrival of the baby. The third stage of labour, or the birth of the *whenua*, is the completion of labour and the end of the pregnancy. This time of birth is largely disregarded but can be decisive in the postnatal health of the women.

This study examines the third stage of labour focussing on the choices made by women regarding their care with particular reference to the information used by women and midwives to assist choice. The project places the birth of the *whenua* within the labour continuum, and within the context of the participant's life experience.

The philosophy of Michel Foucault suggests that power and knowledge within discourse gives rise to truths and provides authority for statements and actions within the discourse. This project utilises Foucault's definition of discourse and is used to discern the varying discourses, and to locate possible dominant and emergent discourses, within the specific data collected and presented in the thesis.

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I would like to thank the person who inspired me to begin my academic journey. My sister-in-law Susan was a bright, witty, erudite woman, a marvellous raconteuse with an incisive wit. She died not long after my visit to the UK in 1997 and her gift to me is an indescribable determination to value every day. Trite as it may seem, across the years I can still feel the influence of meeting with her in her dying.

Thank you to my supervisor Cheryl Benn who patiently would not let me give up, even when I said I wanted to, who has encouraged and kept we from the rambling and woolly thoughts that I love to indulge in. Without her my doubts would have overwhelmed me.

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INTERTEXT

A little recitation entitled…..

I would love to say that I am a poet. What I will say is that I write some kind of poetry and my efforts have accompanied my thesis writing and have, at times of difficulty and doubt, eclipsed it. I have written since I was an angst-ridden teenager and am heartily glad to say that none of those ovular works remain. I was encouraged to offer my poetry in this thesis by my supervisor and by reading Elizabeth Smythe's work. The poems form an intertext, a commentary on my thesis journey. These reflections on my educational journey are every bit as important as the conclusions reached. I have been frustrated, despondent, alarmed and amazed: I have never been bored. My postgraduate education has been a journey to a different place, a place with multitudinous numbers of doors and rooms. The more doors I open, the more doors and the more rooms appear to sight. Academic writing is very much a discipline to me, with little room to *believe* or *feel*. In poetry, as in midwifery, what is believed and felt is very important and I consider that we ignore them at our peril, even in the measured world of the university degree. In my poetry the writing, the meaning and emotion are all very much mine and the only reference my own experience.

For Susan

Hey there

Remember that teenager that was attached

to the guy you married?

Not very pretty and well perhaps maybe just about

fit to talk to who thought

you were definitely the wrong

person for the job and

I do not see

what he sees in you?

Remember seriously

bad taste jokes

food, animals

('Cos you were a veggie and I just couldn't resist.....)

Remember—

That one about—no don't...

laughing so hard I thought that I would

die, stop breathing, no don't

stop talking...

Words polished, faceted

like diamonds

edged so sharp even

deep cuts were clean.

Remember days driving

listening watching learning

how your world revolved

as you honed away

the pain of not having or having too much.

Finally seeing

what he saw in you.

Hey there

I remember that autumn day

centred within me—

tucked under my heart like

a love note beneath my pillow—

a spun-glass meeting

the approach of an ending

the start of my beginning.

Kate Alice, 2004

Hey, Mum; Hey, Susan—EFD.

Contents.

INTRODUCTION

Journey's end?

For five years I have endured the rigours of the Masters programme: I have been challenged, excited and exhausted. During the same five years, I have also been pregnant, given birth, fed a child, taken on a new job, moved towns and houses. So much has changed in my personal life that it is obvious that the person I am now is different from the one at the beginning of the programme. The changes that I have made in the last five years are part of a complex process and my studies became an integral part of my decision-making rather than simply extra baggage. I found that as I gained more knowledge, a vast vista of undiscovered country was revealed to me and I was astonished, alarmed and exhilarated at how little I knew and how much more I wanted, I *needed* to learn. At the outset, I thought that when I came to write my thesis it would be a culmination of the years of hard, if somewhat sporadic, work. This is not the case.

Where do I come from?

For this study, I do not view the participants or data from a detached or scientific viewpoint: my own personal and clinical experiences as a midwife, mother and immigrant to New Zealand form the background of the project, the setting in which the information is placed.

Midwifery came into my life at an early age following holidays with Auntie Edith, who was a community midwife in the English countryside of rural Devon. She had an Austin A40, a small Mini-like car, with big knobbly tyres on the rear wheels to get up farm tracks to labouring women. Edith lived in the centre of a small village where everyone knew who the midwife was. She seemed never to be off duty, her house always full of women, women and their babies, babies in arms and babies in stomachs. In addition, Edith looked like a midwife—or at least, how a ten-year-old *thought* that a midwife should look—tall, solid, comforting and nothing seemed beyond her organisational abilities. I thought she was amazing.

My own entry into midwifery was through a British clinical training of the early 1980s. I went into nursing first, partly due to the scarcity of available direct entry midwifery courses, and partly because my mother and I felt that I would have more choices of employment if I nursed first. In the event, there were very few choices of any sort when I qualified: it was 1982 and Margaret Thatcher had been in power for three years and her disdain of nationalised industries, including the health service, was making itself felt. I gained a position at a midwifery school so after six months as a staff nurse on a frantically busy paediatric ICU, I went joyfully to my midwifery training.

I was based at a small suburban hospital that had about 3500 births per annum. The training was rigorous and intensely clinical; situations were black or

white, with a right or a wrong answer for everything and women were simply expected to do as they were told. Terrifying Sisters[1], maiden women who had no other life but midwifery ran the clinical areas. The students came and went and, if midwifery wasn't in our souls by nature, they were not going to nurture it there. The women we cared for were mostly immigrants from Bangladesh and Pakistan with little English but they were generous and stoical people surrounded by loving families. In clinic, they nodded and smiled as information was given to them via the interpreter, then came in and pushed out their breech twins while we fumbled with their clothing. Naturally, we did not know about the twins as few women had an ultrasound scan and when the second twin was diagnosed—"Nurse, don't give the synto, there's another one here"—and went into the transverse, Sister would deftly do an external version to a longitudinal lie. "Doesn't really matter which way up, Nurse, as long as the long axis of the baby is longitudinal to the long axis of the uterus" and she would dextrously birth the baby as the registrar came panting in from his bed, his hair all on end like a young thrush's behind. If Sister were feeling generous she would let the registrar stitch the episiotomy that we always performed.

It was a truly wondrous time and although I envy modern students their grounding in research, their thorough education in bioscience and

[1] 'Sister' is the title used for the senior midwife on the unit. Responsible for the ward running, they would also take a clinical load and be responsible in part for the teaching of students. Beneath them in the hierarchy were the Staff Midwives. In most hospitals in the UK, the Sister's rank was denoted by her starched cap and frilled collar and/or cuffs, as well as her general air of authority.

pharmacology, I regret the passing of those formidable women with their extensive practice knowledge and desire to teach anybody, from the Consultant down, about midwifery. We did all of these things so as "not to bother the doctor, Nurse, he's already been up for a forceps" and did we learn!

I came to New Zealand in 1992 to visit a friend and returned in 1993 to a job. I was full of confidence and very vocal about the wonders of the clinical training in the UK. I went into self-employed continuity practice in 1994 and became much quieter. Practising woman-centred midwifery is a win-win situation for me, satisfying the needs of the pregnant woman and upholding the philosophy of normality at the heart of midwifery. It is practice not for an institution, a hospital, 'Sister' or 'Doctor' but for the pregnant woman. The midwife's autonomy and the woman's right to excellent care are legal entities, challenging yet supportive. During my practice I did a homebirth apprenticeship, fell in love with waterbirth and, offered both shared and midwifery-only care.

CHAPTER ONE

This chapter indicates the focus of the thesis, the third stage of labour, and describes the journey and subsequent questions that caused the researcher to concentrate on the concluding part of labour. The chapter briefly introduces the philosophy of Foucault, which forms the theoretical background for the analysis of the data collected in the project.

Why the whenua and why whenua?

This thesis examines the lattermost part of labour, called the third stage, which is from the birth of the baby and includes the control of bleeding immediately following the birth. The *Tangata Whenua*[1] of Aotearoa/New Zealand recognises the value of the placenta by calling it the *whenua*. I have chosen to include the Maori word for the placenta for several reasons: firstly to disassociate this project as far as possible from latent medical connotations inherent in the word *placenta;* secondly, afterbirth does not accord the *whenua* its full status and relegates it to a disposable container and thirdly to acknowledge my respect for the word *whenua,* with its roots in the land, the growing place for the individual. There will be occasions when I use all of the terms above, the foremost being to avoid cumbersome repetition. When reviewing medical investigations into the birth of the *whenua*, the term placenta

[1] Maori are the *Tangata whenua,* the original people, and the indigenous people of Aotearoa/New Zealand. Aotearoa is the Maori name for New Zealand and where there is a Maori and English name for a place or object, I use both, joined with a forward slash.

will be used. For convenience, the phrase 'the third stage' will indicate the period of time from the birth of the baby until the woman is deemed by her caregiver to be recovered enough from the birth to be left alone. In addition, I have attempted to indicate that the different phrases connote the differing values placed upon the organ.

My abiding fascination with the afterbirth began in the 1980s and was sealed shortly after my arrival in New Zealand. As a freshly promoted 'Sister' on the Birth Suite in 1988, I carried on in the routine 'anterior-shoulder-Syntometrine-in' approach to third stage. On this busy unit it was also usual for midwives to work without a second midwife, giving the ecbolic at a convenient time after the birth of the baby. One night while alone at a birth, cord unclamped and still attached to the baby resting peacefully on his mother, the labouring woman indicated that she wanted to push again. With very little maternal effort the *whenua* birthed neatly onto the bed with minimal blood loss. As I was not confident enough to totally omit the ecbolic and, as active management was the policy, the time of drug administration was vague in my records but I was interested. A more radical colleague further stimulated my interest by introducing me to Sally Inch (1985). I started to offer women the choice of having a drug-free third stage, if it seemed appropriate to the birthing context. My more conventional colleagues were horrified, predicting haemorrhage and disaster. This did not occur and I was reminded that hospital policy was to actively manage the third stage of labour. In discussion with the clinical

manager of the Birth Suite I cited Common Law—giving an injection without consent constituted assault. Further outrage of 'Allowing the father to cut the cord, Sister! He is not sterile!' and I could see my philosophy did not find favour.

In 1993 as a newly emigrated midwife in Wanganui I attended a birth with a colleague and was helping her clear her trolley in the sluice. I asked her how the afterbirth was disposed of in New Zealand. To my absolute amazement—and I will now admit to a slight repulsion—she informed me that the woman wished to take the *whenua* home with her. I was dumbfounded. Working in the UK the placenta was collected, frozen and sold to cosmetic companies, without any reference to the woman who had grown it. *Ask* the woman what she wanted to do with the organ? Even more amazing, take the afterbirth *home*? Return it to the family *marae*[2]? This was my introduction to the concept that the *whenua* belonged to the woman, was hers to dispose of as she wished and could have spiritual meaning to her and her family/*whanau*[3]. Yet this was congruent with the nascent philosophy that I had embarked upon by offering physiological care in the UK.

The *whenua* is an amazing organ, grown for and with each baby. It is the same genetic make-up as the child, breathing, feeding, protecting and

[2]A *Marae* is the meeting point of whanau or iwi, the focal point of a settlement, the central area of a village and its buildings. In spiritual terms, it is the home of the member of the iwi or whanau.

[3] In Maori terms, the *whanau* is the family and it will include the extended family and can encompass people who one considers to be family.

supporting the baby until—and some would say beyond—birth. The *whenua* is not merely the container of the precious child-cargo, not even a 'tree of life' but is becoming for me a sort of mute twin, a companion, a lover. The *whenua* gives itself away for the baby yet even when abandoned holds all kinds of secrets. It is both a source of information for researchers and the most fascinating cells in the body, stem cells, can be obtained and stored by drawing blood from the cord and placental vessels (Apperley, 1994; Almici, Carlo-Stella, Wagner & Rizzoli, 1995; Weber-Nordt, Schott, Finke, Henscheler, Schulz & Mertelsmann, 1996).

This study, therefore, grows out of both my personal history and my reverence for the *whenua*. In my practice I continue to offer women physiological care in birthing the *whenua*, basing the decision around the woman's request and my own clinical judgement of the situation. I have read the studies comparing physiological care and active management in the third stage and am well aware of the reported raised risk of postpartum haemorrhage following expectant care (Rogers, Wood, McCandlish, Ayers & Truesdale, 1998). My clinical experience of being with labouring women causes my approach to be to *expect* to give *expectant* care for the release of the *whenua* rather than routinely providing active management. Up until the birth of the baby midwives do not expect to intervene—why should intervention be anticipated in the birth of the *whenua*? In my homebirth practice I carry ecbolics but explain that if the birth of the baby occurs without assistance, then the *whenua* should

do likewise. I have no objection to using ecbolics as treatment for a given circumstance but I do not use any item routinely in a labour: each labour and each woman is different and will require or desire a different combination of actions.

I am aware that the previous statement may seem over-obvious yet it was the application of a standard set of actions and prophylactic pharmaceuticals to a part of birth that stimulated my interest. My research question is based upon this curiosity—it appeared that midwives, in the third stage of labour, based their decisions on routine expected actions rather than looking at the labour as a whole. Once the great event of the baby's birth has been achieved, the *whenua* appears to be an afterthought, yet the pregnancy is not over until the *whenua* is born. It appears that in the last minutes or hours of the birthing, the labour ceases to be a continuum and becomes pervaded by medical dialogues—the length of time to birth the *whenua*, the possibility of haemorrhage, the risk of blood transfusion. I do not deny that such events could occur: I would argue that they should be placed in the context of the individual labour, the life choices of the woman and supported by the knowledges[4] of the midwife.

[4] *Knowledges* indicates that the midwife's practice is based upon more than skills acquired to be legally recognised as a midwife. It is a suggestion of the breadth of knowledge used in caring for the pregnant woman. It can include scientific knowledge, intuition, experience, love and prayer and is individual to each woman/midwife interaction.

To some extent, therefore, my question extends to the whole labour. There are discrete events that mark the physical changes a woman's body journeys through in labour, culminating in the birth of the baby. Midwives have become comfortable with 'staging' labour into distinct entities, each with its own definition and timing. Does this indicate, therefore, that we as midwives have:

- become so familiar or comfortable with the risk dialogue pertaining to the birth of the *whenua* or third stage, that active management becomes accepted and obvious as part of a normal labour?
- conceded to a devaluing of the third stage and see it as simply 'clearing up' after the birth of the baby?
- transformed the philosophy of birth as a normal life event into so much rhetoric that care during the third stage is simply a return to the comfort zone—routine, medicalised childbirth?

The Midwives' handbook for practice (NZCOM, 2002) claims that midwifery, especially in the setting of continuity of care, 'enhances and protects the normal *processes* of childbirth' (p. 3, my emphasis). Personal observation leads me to question at least some of this.

Considering that midwives may covertly or unknowingly espouse the medical viewpoint made me re-read the literature being produced by midwives pertaining to the third stage. I am aware that no studies the size of the Bristol or Hinchingbrooke trials could be undertaken: it could be said that in order to look at physiological third stage in context, the whole labour should be physiological

and as Banks (2001) points out, rarely is a truly physiological labour possible outside the home situation. Bearing this in mind, I re-read the midwifery literature.

Radical feminism of the 1960s and 1970s has a phrase that came to mind while reading the literature on the third stage—speaking the language of the oppressors. Political correctness can be considered a joke for our stand-up comedians yet it is, I believe, due in part to the consciousness raising of that period that we strive to make our language non-offensive to our interlocutors. Applying this concept to the midwifery studies pertaining to the birth of the *whenua* I found that the works used medicalised language which, in my view, did not entirely support the philosophy of birth as a normal process. This cannot devalue the work that midwives have done on the third stage but raises questions about where, in which *discourse*, the research midwives located themselves.

Foucauldian discourse analysis.

I tried diligently to avoid this methodology for two years. Foucault is a hard taskmaster, tantalising the student with glimpses of a larger world but his price is to tax the understanding. His literature is densely packed with words and ideas, for I believe that to consider Foucault for a methodology is also to embrace a philosophy. Perversely, this challenge appealed to me and I found that as I studied Foucault, many of my assumptions were undermined and

some completely undone. For example, I had believed in the grandeur and separateness of language, an artefact somehow outside and above the objects it described. Language was a tool we possessed to describe an object and comment upon our feelings regarding that object. Foucauldian discourse analysis *is* concerned with the linguistic content of language but focuses upon groupings of statements that describe, and thus define, an issue. Discourses are constructive, they create 'the objects of which they speak' (Carabine, 2001, p.268). I found this a radical and fascinating notion, especially as Foucault argues that truth is not absolute but rather is constructed, is contextually or historically based. Foucault's contention swept away my notions of common sense, of a greater abstract truth outside the individual and the power of language for me took on a new form—the person speaking had the power not only to describe but also to define the truth. In addition, that speaker might not be me.

That language plays a part in both describing and defining utterly fascinates me: the notion that truth is contextual I find at once liberating and alarming. In these circumstances language can never be, as I once thought it to be, neutral, separate and objective. Language constantly reveals your background, your beliefs, your philosophy and your allegiances. It both creates and undermines. It will create normality; how and even where, the physical actions of normality will be enacted. I explore the last statement in more detail in Chapter 3, but the concept of discourses prescribing place may be simply

illustrated. Joan Donley, in her book 'Save the Midwife' (1986) considers the discourse of westernised birth in New Zealand. Birth was a family event that occurred in the home with the woman's familiar caregivers. The physician attending the birth may bring with him the infections of the charnel house (p.43), but gradually the concept of birth being safer in a hospital when controlled by medicine began to emerge and gain credence. Midwives became disparaged as 'dirty and dangerous' (p.44) and, indeed, there was a plan to discontinue midwifery training (p. 46). Women became 'clinical material' for House surgeons and medical students, and women were able to ' "enjoy" the benefits of doctor/hospital-orientated rather than midwife/domiciliary maternity care' (p.47). Hospitals, which had formally been places for treating the sick, became places to treat pregnancy and maternity hospitals were built on this premise. Pregnancy, by association therefore, was transformed into a pathological condition, a condition that required treatment to return to the normal, non-pregnant state. Access to medical knowledge was through the hospital and the hospital contained equipment that medical knowledge deemed to be necessary for a 'safe' birth.

Foucauldian theory explores why some discourses gain authority and in so doing, which discourses become ignored or invalidated. Dominant or powerful discourses also engender resistance to their definitions, possibly by the information subjugated by that dominant discourse, so when a definition is

created, a counter definition can arise. It should be stressed, however, that Foucault disavows causality or continuity, asking instead

> How is it that at certain moments and in certain orders of knowledge, there are these sudden take-offs, these hastenings of evolution, these transformations which fail to correspond to the calm, continuist image that is normally accredited? (Foucault, 1972).

A dominant discourse will be reflected over multiple areas. For example, components of scientific, legal and technological discourse appear in medical discourse: medicine shares the language of neutrality, objectivity and repeatability with science and the concept of evidence, that which can be reliably proved, with law. Discourses interlink and suppositions within a discourse refer to another for validation: thus dominant discourses internally ratify each other. For a discourse to attain validity, therefore, to have its hypotheses take the status of truth, its endorsement must be evident not only within itself but in other overlapping discourses. As the dictates of a discourse gain the status of truth, they are able to effect the actions of people within the discourse. When examining how a discourse gains recognition in a particular time or place, and how it is reflected in other discourses of the time, most famously in his examination of madness and criminality, Foucault describes his technique as *archaeology*. Foucault states:

> This term (archaeology) does not imply the search for a beginning; it does not relate analysis to geological excavation. It designates the

> general theme of a description that questions the already-said at the level of its existence: of the enunciative function that operates within it, and the general archive system to which it belongs (1972, p.148).

Foucauldian philosophy, therefore, moves from what can be said—knowledge—to what should be said—limits of knowledge—to how and where such knowledge can be applied—power. The examination of the interplay of power and knowledge in its context is termed archaeology. Foucault's philosophy of knowledge and power is explored in more detail in Chapter three.

It would appear from the outset of this project that there is a presumption about what constitutes normality within childbirth. This is made by the literature, the participants in the study and myself. Yet if either or both midwifery and medical discourses base their reason for action or care upon what they consider normal in birthing the *whenua*, who was *describing* this normality? From a Foucauldian viewpoint, those describing normality would also be defining it. In this study I identify the discourse(s) within the care options pertaining to the third stage of labour, and note if any evince particular authority on the behaviour of the participants, by examining how women and midwives regard care options surrounding the birth of the *whenua*, both in their approach to practice and the information given to the pregnant women. Moreover, I was aware that practice is not only guided by consideration of available information: institutions produce guidelines on clinically recommended best practice for midwives working within

the hospital facility. The guidelines explicating 'best practice' cannot, in Foucauldian terms be neutral but must be regarded as constituting part of a discourse. In researching for this project, I requested that managers from maternity units around the country share their guidelines regarding care in the third stage of labour. While all stressed the woman's choice, most indicated that active management for the third stage is the preferred care option (Appendix A).

During my project I intend to examine the differing discourses within the care options for the birth of the whenua and these are presented in chapter 5. This may raise the question of whether midwifery reflects a philosophy of normality and woman centred care or whether this is but rhetoric to disguise being firmly allied to the medical discourse. It may also be that this analysis reveals that both discourses, medical and midwifery, are encompassed by a dominant discourse that is greater than both.

Summary.

This project considers the third stage of labour in order to discern the various discourses within the care choices available to pregnant women regarding their care for the birth of the whenua. The thesis uses the philosophy of Foucault in the definition of discourse, and ascertains whether any discourse pertains to a dominant discourse. It also suggests that midwifery and medicine, both of which seek to define what is normal in childbirth, may be separate or overlapping discourses and may themselves be contained within a larger

discourse.

Foreign lands

Awaking one morning I found myself

approaching a new land.

I had prepared for travel

read the guides talked to fellow pilgrims

but facts were jumbled and the view obscure so

the silent frosted dawn, the wolf hour

caught me alone, afraid.

Then came a friend who

paced out the unknown steps

made sense in the timeless timetables

marked the mapless paths with me.

My solo navigation found its polestar.

Finally

I knew I arrived

disorientated by strange familiarities—

what was this destination?

Landmarks that mutated utterly foreign

irrevocably changed, beyond knowledge yet somehow known.

Finally

I saw not what but who.

K Alice

17/06/03

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter reviews the literature available on the birth of the *whenua* from both medical and midwifery sources, with specific reference to two large randomised controlled trials, the Bristol trial (1988) and the Hinchingbrooke trial (1998). The focus of the medical literature is comparison between methods of care in the third stage, active and physiological, and the particular outcome measure is the incidence of postpartum haemorrhage.

Examination of midwifery literature includes studies that explicate the physiology of the release of the *whenua*. Given that the texts on pregnancy physiology now examine the physiology of the third stage and blood loss in detail (Blackburn, 2003; Coad, 2001; Stables, 1999), some of these studies (Inch, 1983, 1985, 1988) are dated but are included to illustrate the history of midwifery study into this area, and to indicate questioning of the routine management of the third stage of labour. Midwifery studies (Long, 2003; Featherstone 1999) also identify a third type of care, adaptive or piecemeal cares, which include aspects of both active and physiological care. One midwifery study (Pritchard, O'Boyle & Hodgen, 1992) examines third stage care within the setting of home birth.

Definitions

The third stage of labour is defined by medical (Beisher & Mackay, 1994) and midwifery texts (Myles, 1968; Gaskin, 1977;Sweet, 1997) as being from the birth of the baby to the release of the *whenua.* Some authorities (Beisher & Mackay, 1994; Sweet, 1997) add the control of bleeding and haemorrhage.

Postpartum haemorrhage has claimed and continues to claim the lives of parturient women around the world, with rates being especially high in third world countries (WHO, 1996). Care during and management of the third stage of labour is an area of women's health care that has generated significant interest, especially in the last ten to fifteen years. The history of uterotonics (Baskett, 2000; den Hertog, de Groot & van Dongen, 2001) identifies the discovery of three types of compounds designed to cause contraction of the muscle fibres of the uterus: ergot alkaloids; oxytocics and prostaglandins. The WHO standard recommends the use of 10iu of oxytocin to be used to facilitate the third stage and to decrease the incidence of postpartum haemorrhage (WHO, 1989).

The available literature on the third stage is divided into four main topic areas:

- Medical papers including randomised controlled trials
- Midwifery research and its concomitant links to midwifery philosophy and care of the woman;

- Blood loss following birth, definition of haemorrhage and the normal blood values of the woman during pregnancy or immediately postpartum.
- The efficacy of various pharmaceutical agents either prophylatically or as treatment in regard to the third stage.

This review examines medical and midwifery literature pertaining to the birth of the *whenua*.

The birth of the *whenua* is closely linked to postpartum blood loss. Mayes' Midwifery (Sweet, 1997) defines postpartum haemorrhage as excessive bleeding from the genital tract at any time following the birth of the baby to end of the puerperium: primary postpartum haemorrhage is excessive bleeding within twenty-four hours of the birth. The amount that is designated as excessive is open to question. Some sources (Levy & Moore, 1985) suggest that 500mls is excessive, given that the calculation of blood after a birth is open to interpretative estimation. More recent texts on the physiology of childbirth, however, emphasise that physiological adaptation of the female body during pregnancy prepares the woman for postpartum blood loss. Blackburn (2003) suggests that the loss of 500mls at a normal birth and 1000mls at Caesarean section are 10% and 15-30% respectively of the woman's total blood volume at the time (p.266). Earlier, Blackburn and Loper (1992) noted that 'the decrease in blood and plasma volume during the immediate postpartum period corresponds to the amount of blood loss with delivery' (p.170). Coad (2001, p. 234) and Stables (1999, p. 201) both point out that there is physiological

haemodilution in pregnancy which should minimise the effect of haemoglobin lost in bleeding at the time of birth. Since the adaptation to blood loss post birth, therefore, is dependent upon individual physiology, the definition of *excessive blood loss* should be based upon that amount which 'adversely affects the woman' (Sweet, 1997, p.704).

The possibility of morbidity or mortality caused by excessive loss or haemorrhage prompted recommendations of medical management of the third stage of labour with the use of prophylactic uterotonic drugs (Cochrane Database of Systemic Reviews, 2002). The amount of possible blood loss *without* morbidity is hard to quantify (Watson, 1990; Gyte, 1992). Much of the literature studying blood loss post birth is based largely upon a disease/injury approach that defines blood loss as detrimental to health. As pregnancy and repeated monthly blood loss are woman-specific, there is a small amount of work that suggests that female biology is uniquely adapted to lose a certain, individualised amount of blood without undue harm or disease (World Health Organisation, 1999).

For convenience, I have divided the literature under consideration into two main sections: that written from a medical viewpoint, mainly randomised controlled trials, and midwifery studies, which do not involve large numbers of participants and examine the third stage in contexts other than hospital births. I have not included information obtained from searching the Internet. Internet

searches can harvest a great deal of information, calling up recognised sites (www.bmj.com; www.nzcom.co.nz; www.entrezpubmed.com; www.midirs.co.uk) or, conversely, sites whose provenance is uncertain. Readers of recognised sites, such as those noted above, are able to refer from the site to verifiable sources such as peer reviewed journals. In addition, Internet sites are transitory and can carry unsupported opinion. The Internet as a source of information for midwives has been studied (Stewart, 2001) but is not considered in this project.

Active and physiological cares for the third stage of labour.

All the trials reviewed in this section depended upon recognised definitions of active and physiological care. The definition of active care is, relative to physiological care, well defined. Active management is a series of associated actions designed to facilitate the birth of the *whenua*. It consists of early clamping and cutting of the umbilical cord; administration of a prophylactic uterotonic and the use of controlled cord traction combined with uterine support to extract the afterbirth from the upper vagina. The timing of the uterotonic may vary but is given either as the child is born, at the appearance of the anterior shoulder or immediately after birth. All the literature in this review defined active management of the third stage of labour similarly (Inch, 1985; Prendiville et al, 1988; Begley, 1989; Thiliaganathan, et al., 1993; Elbourne et al, 1998; Featherstone, 1999; Long, 2003). In their study, Levy & Moore (1985) noted that in performing active management, some practitioners awaited signs of separation while others commenced controlled cord traction immediately (p.48).

Physiological care is not so easily defined as it is characterised by observation and not specific actions. The cord is left intact either until the birth of the baby or until pulsation has ceased. No uterotonic is administered and maternal effort and gravity birth the *whenua*. Variations to this may include clamping and cutting of the cord for purposes of resuscitation or necessity but should this occur the maternal end of the cord is released to prevent back pressure in the placental bed (Inch, 1985).

Piecemeal or adaptive processes as noted by Featherstone (1999), and Long (2003) describe practices in which a combination of components from both active and physiological care are used. Featherstone suggests that certain combinations of practices can place the women at risk of postpartum haemorrhage or retention of part of the *whenua* (p. 220). Long also considers that particular adaptive practices can be detrimental to the baby and specifically refers to the dangers of over transfusion of the baby (p.367).

Medical and midwifery 'models'.

I do not intend to explore medical or midwifery 'model(s)' in the course of this project, nor will I assume a model that is understood by both reader and writer. In New Zealand midwives use the *Partnership Model* outlined by Guilliland and Pairman (1995) as one of the NZCOM foundation documents. As a basis for care this model presents the concept that woman and midwife both bring knowledge to the relationship formed for the duration of that particular

childbearing experience, and that each has an equal share in bringing the pregnancy to a fruitful conclusion. In addition, the *Midwives handbook for practice* (2002) states:

> The midwife promotes and supports the normal childbirth process, identifies complications in mother and baby, accesses appropriate medical assistance...(p.4)
>
> Midwives accept the right of each woman to control her pregnancy and birthing experience (p.5).

Midwifery in New Zealand posits a relationship in which normal childbirth can flourish with midwife and woman contributing to the outcome. Nevertheless, the woman is 'responsible for the decisions that affect herself, her baby and her family/*whanau* (NZCOM standards for practice, p. 5).

The midwifery approach, therefore, suggests that the relationship each woman makes with her midwife is unique and to that relationship she will bring feelings, actions and information that are specific to that pregnancy. Similarly, the midwife brings particular knowledges gained from other labours and births, to be reworked anew in the light of *this* pregnancy, *this* woman, *this* birth.

In relation to the medical standpoint, Thomas (2000) cites Hillier (1991) whose suggestion is that medicine, and by association the medical profession, tend to 'expand their claims' and thus 'more and more of human life and its

social processes become defined by medicine' (p.175). Thomas suggests that, as 'social processes' take on the health and illness dichotomy, so there is medical encroachment into areas of life previously unnoticed or deemed to be social or personal concerns.

Childbirth has been moved out of the realm of the family and under the auspices of medicine. Thomas cites Oakley (1980), noting that pregnancy and childbirth have been 'redefined as a potentially pathological process, requiring increasing levels of medical intervention and control' (p.175). Thomas suggests that the ritual of admitting a woman to a hospital, even following a normal, healthy pregnancy and concluding in a normal birth, reinforce a societal norm that pregnancy is a potential pathology for which hospital care and expertise is required.

Davis-Floyd (1992) described the modern attitude to childbirth in hospitals as 'technocratic' even if individuals—midwives and medical staff—wish to practice more wholistic birthing (p.159). Davis-Floyd feels that even if practitioners wish to offer more individualised and natural birthing, the institutional philosophy will not facilitate this. She states that birth in hospital can turn out to be 'a tug of war between the two conceptual models of birthing' (p.159). Davis-Floyd is aware that she is presenting the extreme forms of the two philosophies ('technocratic' and 'natural') but her contention is that the institution itself plays a part in upholding the technocratic model. Davis-Floyd

suggests that in the technocratic model, it is the institution and its players—medical and midwifery staff, the father to be—which deliver the baby, rather than the pregnant woman (p. 165). The institution does not serve the mother, as Davis-Floyd feels it should (p.157), but the technicians. In removing birth from the home to the institution Davis-Floyd suggests that the institution rather than the family becomes the 'significant social unit' (p.161).

Davis-Floyd posits that birth in an institution is technocratic, that is, regarding the body as a machine and birth as production (p.160-1). Moreover medicine, particularly when placed within such institutions, is perceived to ally itself to scientific methods which supposes all problems can be subject to a reductive, precise and measurable approach. It is thus implied that a question subjected to scientific enquiry will always be able to receive an answer. In practice, science and its methods can never illuminate some questions because human beings are separate, unpredictable and unreliable. Both medical and midwifery use scientific knowledge but Thomas (2000) cites Dubos and surmises that a basic philosophical approach separates medicine and midwifery. Medicine espouses the belief that health is 'freedom from clinically ascertainable disease' (p.174) and midwifery to 'discover...the natural laws which will ensure a healthy mind in a healthy body' (p.174). I conjecture that such a philosophy would not integrate well into the scientific matrix.

In this project, there is a basic assumption that midwifery and medicine are guided by differing philosophies. One profession is not considered superior to the other although there is recognition that one may be held in greater esteem than the other depending on the situation and on the practitioner. Furthermore, there is awareness that at times there may be considerable integration between the two professions.

Medical research into the third stage of labour.

Three major medical trials conducted in the last twenty years relate to policies and protocols pertaining to care during the third stage of labour. In 1988 Walter Prendiville and his colleagues published the results of a randomised controlled trial called the Bristol third stage trial. Thilaganathan, Cutner, Latimer and Beard published their study of third stage management in 1993 (the Brighton trial) and finally Elbourne and her colleagues published the Hinchingbrooke randomised controlled trial in 1998. All trials compared the efficacy of active versus physiological management of the third stage of labour and had a profound effect on the care offered to women, particularly within the hospital setting. The 1989 Dublin trial, by Cecily Begley, is also included in this section.

The Bristol third stage trial (1988).

In 1988 Prendiville, Harding, Elbourne and Stirrat published the results of a randomised, controlled trial that compared active and physiological

management of the third stage of labour. Its principal objective was to record the incidence of postpartum haemorrhage amongst the participants, postpartum haemorrhage being defined for this trial as being blood loss greater than 500mls (p.1296). At the time of conducting the trial, active management of the third stage was 'virtually universal in those units known to have a policy for the third stage of labour.' (p.1295) The researchers reported that routine active management had been challenged by Dunn (1985), who considered the impact upon fetal adaptation to extra-uterine life of early cord separation required by active management and Inch (1985), who suggested that routine active management interfered with the physiological processes and thus led to a 'cascade of intervention'. (p. 1295). In the 1988 trial, Prendiville and his colleagues sought to address these contentions and to determine whether the policy of routine active management of the third stage of labour was justified. It must be emphasised that the Bristol study acknowledged that the application of prophylactic uterotonics to the birth of the *whenua* had been introduced without clinical trials.

The use of uterotonics[1], especially ergometrine and its compounds, is not without side effects to the woman. There have been debates over the use of

[1] The history of the use of uterotonics notes (Baskett, 2000; Hertog, de Groot and van Dongen, 2001) that the discovery of ergot alkaloids produced by fungus on damp and mouldy rye led to the substance being called *pulvis ad partum*—the powder of birth. The power of these Woman Tc contractions, however, could overwhelm the mother and child when used in labour and the ergot compound was subsequently called *pulvis ad mortem*—the powder of death. Administering ergot prior to birth was abandoned but its efficacy in preventing bleeding after the birth continued to be recognised (Baskett, 2000, p.490).

ergometrine, Syntometrine and Syntocinon for the third stage of labour (Mitchell, & Elbourne, 1993; McDonald, Prendiville & Blair, 1993; McDonald, Prendiville & Elbourne, 2000; McDonald, Abbott & Higgins, 2004) and any advice regarding the birth of the *whenua* should include information about the possible consequences of a uterotonic. Possible side effects of Syntometrine include nausea, vomiting, uterine hypertonicity leading to afterpains, headache, and dizziness. Ergometrine and its compound Syntometrine can also be associated with hypertension and should not administered to women with raised blood pressure in pregnancy. Occasionally, the ergometrine component of the drug has been known to cause cardiac arrhythmia and cardiac arrest (New Ethicals Catalogue, 2003).

Syntocinon has fewer side effects, being without an ergot component but can still cause nausea and vomiting and over-administration of the drug for haemorrhage can cause water toxicity and hyponatraemia (New Ethicals Catalogue, 2003). Some obstetricians feel that the above side effects are a small price to pay compared to the risk of mortality and morbidity from postpartum haemorrhage (Dwyer, 1994). In relation to possible side effects following the administration of a uterotonic, a questionnaire distributed to participants of the Bristol trial (1989) concluded that both women and midwives in the study were supportive of the continuation of prophylactic uterotonics.

The Bristol trial was conducted in a maternity hospital having approximately 4500-5000 births per year and ran from January 1986 to January 1987 (Prendiville, Harding, Elbourne & Stirrat). All women birthing in the hospital were eligible to join the trial: 1695 women were recruited and randomly allocated into two groups to receive either active or physiological care in the third stage. Exclusion criteria included women who declined entry to the trial, those with multiple births, cardiac disease, antepartum haemorrhage and intrauterine death.

The trial was modified in May 1986 when it was discovered that there were significantly more postpartum haemorrhages than expected in the group receiving expectant care. Three criteria were added to exclude women from the trial who could be at risk of postpartum haemorrhage prior to birth: having received a tocolytic within two hours of the birth; receiving anticoagulant therapy and any condition 'that would necessitate a particular management of the third stage' (p.1297).

The trial coordinators concluded that the policy of routine active management in the trial was justified, citing results that postpartum haemorrhage was significantly reduced in the women receiving active management (5.9% in the active group and 17.9% in the physiological group) (p. 1295). The length of third stage was reduced in the group receiving active management; the median length being five minutes (p. 1298) as opposed to

fifteen minutes median length in the physiological care group (p.1298). The authors also noted that the incidence of postpartum haemorrhage of over *1000mls* and those women requiring a blood transfusion was greater for women in the physiological group. The weight of the evidence was against expectant care.

The Bristol trial was significant support for continuing the policy of routine active management of the third stage of labour. Obstetrics and midwifery in the 1980s provided active and interventionist care for women in labour with the notion of 'masterful' inactivity over-ridden by the concept of precisely managed labours. Indeed, the authors of the Bristol trial cite Romney and White (1984), who argued for a trial reviewing care in the third stage 'before the best exponents of non-active management have retired from the service' (p.1295). Thus the ability of the midwives to care for a woman birthing her *whenua* without drugs in the trial unit was lacking and the authors (Prendiville et al) note: "active management was the norm at this hospital...and few of the midwives were experienced in carrying out physiological management" (p.1299).

Although the authors of the Bristol trial concluded that active management was beneficial in reducing postpartum haemorrhage in women birthing normally, it had several variables that could be said to affect the validity of the trial.

- While the amount of blood constituting a postpartum haemorrhage was defined (p.1296), the type of postpartum haemorrhage, primary or secondary, was not considered;
- All women expected to birth vaginally were eligible for entry to the trial (p.1296), including women who had interventions to the first and second stages of their labours. Women who had had induction and augmentation of their labours, those using epidural anaesthesia, women having assisted births and, until the trial protocol was altered in 1986, women who had received tocolytics would have been eligible for physiological care. A higher than expected number of postpartum haemorrhages in the physiological group caused this to be reviewed and thereafter women who had received tocolytics two hours prior to birth (p.1297) were excluded and allowance was made for 'any condition that would necessitate a particular management of third stage' (p.1297);
- As identified above, the midwifery practitioners were not fully skilled in providing physiological care to women in the third stage. In 1986 the midwife researcher, Joanna Harding, wrote for the UK Association of Radical Midwives Newsletter about the setting up of the trial. Ms Harding was the midwife who undertook to train midwives in physiological care for the birth of the *whenua* for the Bristol trial. This training was six weeks prior to commencing the trial. In her paper she noted 'Inevitably a trial such as this one involves extra work for the midwives, and prejudices have to be overcome by both medical and midwifery staff' (p. 8);

- Despite assistance with physiological care and guidelines from the researchers, 403 women out of the group of 849 allocated to the physiological group had physiological care as described by the researchers ('no prophylactic oxytocic given, cord not clamped until after placenta delivered and no cord traction given') (p.1297). The remaining women had a prophylactic oxytocic given (n=168), cord clamped before placental delivery (n=437) and/or cord traction (n=336). Examining the figures crudely in this fashion does not indicate which women in the physiological group required the application of such measures due to non-physiological problems in the first or second stages of their labours. Nonetheless, under half of the women in this group received full physiological care. In the women receiving active management, 840 out of 846 received the active care as allocated ('prophylactic oxytocic given, cord clamped before placenta delivered and cord traction given') (p.1297).

The Bristol trial was the first large trial to compare active and physiological care in the third stage of labour. It reflected the prevailing culture of a highly interventionist medical model, as evidenced by the lack of midwifery staff confident in expectant care in third stage. Active management of the whole labour process was commonplace with active management of the third stage of labour the recommended practice. Thus it can be said that practitioners did not have the appropriate skill base for an accurate comparison between models of

care in the third stage to be made. The Hinchingbrooke trial in 1998 sought to address this criticism.

The Brighton trial.

This trial is less reported than either the Bristol trial (1985) or the Hinchingbrooke trial. Women in low risk groups were randomised to receive either active or physiological care. High risk categories included women who were grand multiparas; had had an antepartum haemorrhage; previous Caesarean section; previous postpartum haemorrhage; pregnancy induced hypertension and premature rupture of membranes. This trial concluded that active management reduced the length of the third stage (p.21) but may not reduce blood loss for women who were at low risk for postpartum haemorrhage (p.21).

The Dublin trial.

Published by Cecily Begley in 1989, this trial is included in the medical research section for, while a midwife was the researcher, it was nonetheless conducted along medical lines. Set in a maternity hospital in Dublin, the study population was limited to women in the public system only as the researcher was not able to secure full compliance with the study criteria from consultants giving private obstetric care to women (p.6). As with the Bristol trial, active management of the third stage was the norm for midwifery staff and had been for the preceding fifteen years (p.5). The guide to physiological care for the trial

(p.6) was therefore carefully worded to assist midwives to comply with the trial but indicates that the researcher was not fully confident with the ability of the midwives to overcome the practices of the previous decade. It is also noteworthy that the midwives are described as being 'in charge of the deliveries' (p.6). In addition, unlike any other trial, the uterotonic used was 0.5mg Ergometrine given intravenously. Begley notes that this was the drug used routinely in this setting and 'no change of management was envisaged in the near future' (p.5).

Begley found that while active management decreased primary postpartum haemorrhage, none of the women in the physiological group who had a postpartum haemorrhage suffered any further adverse consequences (p.14). In addition, women who had had active management showed a higher incidence of complications within the first weeks postpartum, in particular, bleeding within the first five days that required treatment with antibiotics or oral ergometrine (n=11 in the active group versus n=4 in the physiological group) and attending out-patients or requiring re-admission for bleeding (n=16 and n=5, respectively) (p.13). Begley speculates that the more aggressive management of third stage, causing the uterus to contract in a non-physiological way combined with cord traction caused 'the retention of small particles of placenta or membranes' (p. 15). Begley goes on to conclude that routine active management in low-risk women 'is not necessary...and has many adverse effects' (p.15).

The Dublin trial makes fascinating reading both as research and as an indication of how routine medical care was accepted without question. It is also salutary to remember that active management of the entire labour had been pioneered at the National Maternity Hospital in Dublin. To stage this trial at all represented a significant challenge to established medical practice.

The Hinchingbrooke trial.

The Hinchingbrooke trial (Rogers, Wood, McCandlish, Ayers, Truesdale & Elbourne), published in 1998, again made a comparison of active and expectant care in the third stage of labour. The hypotheses tested were 'that active management lowers the rate of *primary postpartum haemorrhage* and longer term consequences compared with expectant management' (p. 693, my italics). In the trial setting, 'both managements are commonly practised' (p. 693), and primary postpartum haemorrhage was defined as a 'maternal blood loss of 500ml or more within 24h of delivery' (p.693). Secondary to these hypotheses was the supposition that upright posture in women birthing the *whenua* physiologically accounted for part of the higher estimations of blood loss. Women in the trial were randomly allocated into one of four groups, to receive active or physiological care for the third stage of labour and additionally to the supine or upright groups.

The Hinchingbrooke trial was thoroughly planned and sensitively executed, and there were a greater number of midwives conversant with

physiological care in the third stage. The outcome measured was the incidence of primary postpartum haemorrhage and the effect of position on blood loss. Elbourne and her colleagues concluded from the trial that to prevent one postpartum haemorrhage, ten women would require prophylactic oxytocics and forty-eight women would require prophylactic treatment to prevent one blood transfusion. This information is valuable in light of the researchers' belief that the information in the trial would be used not only by the midwifery and medical professions but the parents themselves.

One of major criticisms of the Bristol trial was its lack of consultation and applicability to the end users of the project—the birthing mothers. In the Hinchingbrooke trial, however, the researchers state:

> The conclusions of the study may be used to enable individual women, together with their caregivers, to weigh up the relative importance of the various outcomes...Some women, for example, may rate a small personal risk of PPH of little importance compared with intervention in an otherwise straightforward labour (Elbourne et al, 1998, p.698).

The Hinchingbrooke study and the third stage of labour are thus placed within the context of the entire labour and the individual woman's choices and values. The study goes on to say 'Midwives need to be competent and confident in both approaches [i.e., active and physiological approaches] (p.698). Given the results of the trial, however, active management is recommended as

the policy in hospital settings, and this is reflected in the guidelines located in Appendix A. The trial pays respect to the woman's decision regarding her care but the policy position, the default position for birthing women, is that of active management.

As recruitment for the Hinchingbrooke trial was in progress (1993), ongoing were parliamentary investigations into maternity care in the United Kingdom. The report of the Expert Maternity group, known as the Camberlege report (1993), indicated that women were not satisfied with being merely the recipients of care and/or decisions but wished to be part of the process determining their care in pregnancy and birth. The Bristol trial did not consult with the women but the Hinchingbrooke trial evinced a far more consultative approach to the trial participants.

Midwifery is concerned with physiological pregnancy and birth, as midwives must seek medical assistance if problems are detected in the pregnancy and labour[2]. The scope of the midwife's practice is normality and recognition of deviations from the norm. Midwifery examination of the third stage of labour will therefore be concerned with preserving normality and being alert for movement away from physiological occurrences.

[2] Sweet (1997) notes that 'the definition of a midwife was jointly developed by the International Confederation of Midwives (ICM) and the Internatonal Federation of Gynaecologists and Obstetricians (FIGO). It was adopted by these bodies in 1972 and 1973 respectively and was later adopted by the World Health Organisation (WHO)' (p. 3). NZCOM bases its definition of a midwife on this work.

Midwifery research into the third stage of labour.

No midwifery papers have been written or research conducted on the scale of the Bristol trial (1985), the study conducted by Thilaganathan et al (1993) or the Hinchingbrooke trial (1998). These trials were large, randomised controlled trials conducted over considerable periods of time with their focus being the hospital environment. Midwives argue that uncomplicated labours should be in the home or home-like environment in order to support physiological care (Banks, 2000, p.145).

Sally Inch's ovular work in the 1980s was fundamental to challenging the almost universal active management practised in maternity units at that time. In her 1984 study, Inch called active management of the third stage 'another cascade of intervention' (p. 114). Inch described the physiological sequence of events that enabled the unhampered uterus to expel the afterbirth, a sequence which, for many practitioners, she felt was unknown or at least disregarded. Inch pointed out that the process of contraction and retraction had been taking place throughout the labour and did not cease after the baby's birth (p. 114). The uterus continued to contract in order to expel the afterbirth and control blood loss. Inch did not deny the usefulness of oxytocic preparations in treating mothers with excessive blood loss but states: '*because a drug is valuable in certain situations does not mean that its routine prophylactic use is justified*' (p. 118, emphasis in original). Inch asks for the demonstration of the benefits of the

routine disruption of normality where the birth is normal and without identified risk (p.120).

Inch's work (1983, 1985, 1988) placed great emphasis on the physiology of the third stage as part of the labour continuum and the need to treat individual women and their labours according to their specific needs. The medical randomised controlled trials cited earlier (1985, 1993, 1998) however constructed and applied, treated all women in the trial groups identically.

In 1982 Nancy Stewart, Chairperson for the UK Association for Improvements in Maternity Services, wrote for the Midwives' Chronicle regarding her experience of birth with and without an ecbolic for the third stage of labour. Having requested a drug-free birth, Stewart was surprised to receive an injection to 'help the uterus contract and stop any bleeding' (p.293). Such was the routine of active management that this drug, given after a physiological labour, was almost not 'counted'. Stewart states:

> The third stage of labour is probably the most neglected in parents' concerns. After all, the baby is born, so it is easy to stop our attention and leave it to the experts to tidy up the scene (p.293).

Stewart supports the use of oxytocics in cases of problems but feels that in normal labours ecbolic use may induce difficulties where none existed. She goes on to point out that in situations where the 'natural processes of birth' are

respected, then ecbolic use is rarely needed (p.294). Stewart's observations uphold the principle of normality until proved otherwise, with treatment for problems as required rather than universal prophylaxis.

Levy and Moore (1985) studied the actions of midwives caring for women in third stage of labour. This was not a large study with only thirty-three midwives being surveyed regarding their actions in the third stage. The women in the study (data from 489 women) all received Syntometrine as an ecbolic to facilitate the birth of the placenta (p.48). Midwives were asked to 'conduct the third stage as she felt was right for the particular woman' (p. 48). The midwives were questioned about their decisions whether or not to await signs of separation prior to commencing controlled cord traction. The study concluded that the midwives had varied practices around waiting for signs of separation.

The study illustrates a mix of medical policy and midwifery knowledge. The use of an uterotonic was not questioned and the language used in the article reflects the medical model (patient, deliveries, conducting the third stage). The trial also supports the midwifery model in that midwives' skills in assessing the nature of the labour and the third stage are taken into account. The opinions of the women in the study, or their possible contributions, are not evident.

This uneasy balance is found in other midwifery papers considering the third stage. Featherstone (1999) studied active and physiological care in the third stage, as well as 'adaptive practice' (Inch, 1985, as cited by Featherstone). As with Levy and Moore (1985), the midwifery focus on supporting physiological processes emerges in that 'adaptive practice'(s) attempt to combine the recommended actions of active management with the physiology of normal birth (p.49). Featherstone conducted an exploratory study among delivery suite midwives, using a questionnaire as her research tool. Her question was 'Are there different interpretations by midwives of what constitutes physiological management of the third stage of labour?' (p.218). In all, Featherstone found a total of nine varieties of practice for assisting the birth of the placenta, having surveyed eighty-six midwives. These vary from the most expectant care to fully active management. Featherstone points out that 'there is considerable uncertainty among the midwives surveyed regarding the safe management of *physiological* third stage' (p.220, my emphasis).

The work of Featherstone and Levy and Moore evidences the friction between birth as pathology until completed and belief in the birth process as a natural, if testing life, event. Both studies are concerned with providing the women with an appropriate conclusion to their labour (Levy & Moore, p.47; Featherstone, p. 221) and both tend towards the language of medicalised trials in their writing. I would surmise that the midwives in both trials were well informed on the possible risks of excessive bleeding during and after the birth of

the *whenua,* aware of the physiology of the third stage and aware of the policies within their birthing units. In addition, Featherstone pays some attention to the 'women's informed choice' (p.216 & p.221). It would appear that at the birth of the *whenua* the midwife is at the meeting point of medical recommendations for practice, the physiology of the birthing, the woman's desire for her birthing, and the midwife's own knowledge and philosophy of practice.

Midwifery research into the third stage of labour walks a line between the supposed objectivity of the randomised, controlled trial and the experiential nature of midwifery where being with a woman throughout her pregnancy and labour informs individual practice. It is possible to fully understand the physiology of the third stage (Inch, 1983, 1985, 1988), to 'manage without drugs' (Stroud & Cochrane, 1990). Midwives practising in the setting of a study or trial, however, cannot but be aware of the hospital guidelines and policies that dictate, to some extent, the care of women in labour. Knowledge of institutional recommendations can cause the practitioner to provide care that is out of context of the individual labour but within the context of the setting where the birth is occurring. The work of Smythe et al in 1990, just prior to Aotearoa/New Zealand midwives regaining their autonomy, illustrated the variety of beliefs and practices of midwives, most of whom practised in the hospital setting, towards the provision of care in the third stage. Smythe's paper, a descriptive exploratory survey, demonstrated that while the respondents to the study sought to provide a high standard of care for the

woman, at least part of their practice related to either enforcing or challenging the medical model, thus according it a particular status.

Pritchard, O'Boyle and Hodgen (1992) considered physiological care during the third stage within the home birth setting in New Zealand. This work centres on women experiencing a physiological labour and is the only study that is entirely located in the home setting. This was a retrospective study conducted by postal survey of midwives practicing in the homebirth setting.

It is usual for women birthing at home to be attended by midwives they know, whose philosophy seeks to 'minimise both physical and psychological interference in the natural processes at work in the birth of the placenta' (The Pritchard study is not paginated: third page of study). The researchers were concerned that physiological care is a safe practice, and their study indicates that this is so, but who is defining 'safe'? It would appear that, again, the authority of definition is outside the midwives and refers to the concept of routine, standardised care to prevent blood loss.

Pritchard et al refer to 'modified physiological care' used by midwives if the situation required it. This was done in such a way that disruption of the physiological process was minimised, largely for the comfort of the woman (p.14 Pritchard et al of study). The majority of women received full physiological care, that being described as

> The cord is not clamped or cut until after birth of the placenta and membranes. No ecbolic is given, the fundus is not massaged, no traction is applied to the cord and the placenta is expelled by maternal effort (p.2 Pritchard et al of study).

If other treatments, excluding a uterotonic, are used, this is termed 'modified physiological care' (p.2 of Pritchard et al study).

Long's (2003) paper on optimal practice in the third stage of labour discussed modified third stage care, terming it 'adaptive' care. Considering how midwives defined 'active', 'natural' or 'adaptive' third stage care' (p. 366), she conjectured that the understanding of active third stage care would be well understood but that there would be varied comprehension of the latter two terms. Long's language is woman-centred (p.369) and looks at effects both on the mother and baby from the various practices. Long argues that expectant care is less taught because it is less practised—a negative feedback circle. As fewer midwives are able to demonstrate physiological care, normal will become active management or one of the adaptive practices or a piecemeal approach, whereby cares from both active and physiological practice are combined; for example, no uterotonic is given but controlled cord traction is applied (Featherstone, 1999).

Long's paper is a discussion of care in the third stage but demonstrates that far from being an either/or situation—*either* active management *or*

physiological care—adaptive or piecemeal care occupies a space that requires consideration. In particular Long reviews situations in which expectant care gives way to active management. As in the work of Pritchard et al, adaptive care may be appropriate in situations where the baby requires assistance (p.369) and trials to date give no indication about the optimum time to undertake such interventions when providing physiological third stage care. In addition, Long warns that, given the variety of adaptive or piecemeal cares, 'making generalised sweeping statements about them would be unwise' (p.367).

The authors of midwifery literature, therefore, do not construct studies that oppose the conclusions that active management reduces the amount of blood loss or incidence of postpartum haemorrhage. It would not be possible to perform a study that randomised women who have chosen to have an entirely physiological birth into receiving care that is dictated from without their own personal labour continuum. As Pritchard et al (1992) state:

> To allocate women to specific management prevents the active involvement of birthing women in the choice and mode of application of the physiological method. This makes a randomised controlled trial impossible in the homebirth setting (p. 5 of study).

In addition, it is futile to attempt to prove such a study as the Hinchingbrooke trial as 'wrong': rather one must question its applicability for midwifery and to all women in labour, whatever their circumstances. In this light,

the reflections of midwives in the midwifery trials, their anecdotal and experiential knowledge should not be discounted. Knowledges such as:

- To birth the body of the baby slowly, enabling the uterus to descend in a more controlled manner, will facilitate physiological contraction of the myometrium, aid separation of the *whenua* and thus prevent postpartum haemorrhage (Donald as cited in Ward, 1983; Myles, 1968);
- The concept that the non-physiological muscle contraction created by a uterotonic, particularly ergometrine, may result in less bleeding in the third stage of labour but a greater loss once the effects of the drugs cease (Begley, 1989; Pritchard et al, 1992; Smythe et al, 1992; Banks, personal communication, 2003);
- That the female body is superbly prepared for birth and blood loss at birth (Blackburn, 2003; Coad, 2001; Stables, 1999). There is no indication of how much blood loss in the third stage is too *little* (Gyte, 1992);
- The time taken to birth the *whenua.* Medical studies are overwhelmingly concerned with time (Prendiville et al, 1995; Thilaganathan et al, 1993; Elbourne et al, 1998). This is, of course, hospital, institution and medical time and not that of the woman. Midwifery studies (Smythe et al, 1992; Pritchard et al, 1992; Featherstone, 1999) do not ignore the clock but rather accommodate it to the woman, her birth and her well-being.

Elbourne et al (1998) emphasise that it is vital for caregivers to be able to provide physiological care for women who request it and to remain skilled in

both active and physiological cares. Sadly, as interventions disrupt the first and second stages of labour, the likelihood of active management of the third stage increases. In addition, midwives practising within the hospital are aware of the recommended care being to give a uterotonic agent (Appendix A). The misplaced desire to support physiology with pharmaceuticals can lead to adaptive processes that may, conversely, endanger the woman (Featherstone, 1999) by increasing the risk of the cord avulsing, retention of placental tissue (p.219), or over-transfusion of the baby (p.218) .

Discussion.

In the course of this literature review I have illustrated the breadth of research into the third stage of labour, and some of the differing viewpoints of medical and midwifery research. It is apparent from the guidelines in Appendix A that maternity units around New Zealand recommend the use of prophylactic uterotonics for women in the third stage of labour. Equally evident within these guidelines is the continuing emphasis on treatment being guided by the informed choice of the woman receiving the care. The current study does not intend to challenge or repeat any of the projects detailed in this chapter but the studies illustrate the variety of information that is available to midwives on such a small and generally undervalued part of birth.

The birth of the *whenua* represents the end of the pregnancy but, paradoxically, as the danger to parturient woman appears to diminish it may be

beginning. The information given to parents cannot therefore be incomplete, nor can it permit the parents to think that the third stage can be left 'to the experts to tidy up the scene' (Stewart, 1982, p. 293): the birth of the child is a beginning, not an end. In addition, the mother/child dyad is now physically separate: care in the third stage is entirely for the woman but will benefit the child and its family/*whanau*. It may not, therefore, contradictory to the parents that the mother may choose to be drug free for the birth of the child and medicated for the release of the *whenua*. The compelling reasons to remain healthy—for the baby—and at this point the regarding of self as only related to the child takes on a new form. The drugs used to facilitate the release of the afterbirth do not directly affect the wellbeing of the newborn child but can safeguard (or not) the health of the mother. Although ergot compounds (ergometrine and Syntometrine) can influence breast feeding by effecting prolactin levels (Jordan, 2002, p.171), the overall gain of an uncompromised mother may be felt to outweigh this disadvantage.

Summary

The literature in this review has been divided up into randomised controlled trials examining the efficacy of active management versus physiological care. These trials have all accepted that active management contains the features of prophylactic uterotonics, early clamping and cutting of the cord and controlled cord traction. Application of active management to the third stage reduces the risk of postpartum haemorrhage (Prendiville et al, 1985;

Elbourne et al, 1998) and decreases the length of the third stage (Prendiville et al, 1985; Thiliaganathan et al, 1995; Elbourne et al, 1998). It does not appear to increase the risk of retained placenta (Elbourne et al, 1998).

The midwifery studies are not large trials and are largely retrospective using a questionnaire (Pritchard et al, 1992; Smythe et al, 1992; Featherstone, 1999). Midwifery studies also highlight the existence of cares that are a mixture of the elements of both active and physiological care and are labelled adaptive or piecemeal (Inch, 1985; Featherstone, 1999; Long, 2003). The majority of units in New Zealand have a policy of active management of the third stage (Appendix A) unless otherwise indicated by the woman. The possibility of observing the outcome of physiological births at home concluding in a physiological release of the *whenua* does not appear valid due to the small numbers available but there is a suggestion by Banks (2000) that only in this setting, without any intervention, can true physiological care be observed.

Midwifery studies do not question the use of active management in the third stage of labour for women at risk of postpartum haemorrhage; for example those requiring with assisted births or previous bleeding but do question whether routine application of active management is efficacious for all labours.

Wavescape.

Late night, early morning

silence creaking as the sleepers stir.

Fishing for words

no pull to the line.

I am out of my depth, and

like a swimmer seeing land

strike out wildly

but the illusion of shore

is just a trick of the tide.

All things considered

I wish I was safe berthed

dreaming sound

not here chasing flotsam thought

in this precise, bitter, self-battle.

Look closely—am I not

become bones stripped,

word-wired, jangling?

Down full fathom five

still no pearls found.

Dive deeper yet

hoping the prize is worth

the pressure.

Kate Alice

August 2003.

CHAPTER THREE

Foucauldian philosophy and its pertinence to midwifery enquiry.

> What, do you imagine that I would take so much trouble and so much pleasure in writing, do you think that I would keep so persistently to my task, if I were not preparing...a labyrinth into which I can venture, in which I can move my discourse, opening up underground passages, forcing it to go far from itself, finding overhangs that reduce and deform its itinerary, in which I can lose myself and appear at last to eyes I will never have to meet again (Foucault, 1972, p. 19).

Introduction.

In the above quote, Foucault states that he is writing to prepare 'a labyrinth into which I can venture' and this is illustrative of both his writing and his philosophy. His work is not deliberately convoluted but it is densely packed with words and ideas, which can be linked over a wide field. This broad and disparate spread of his ideas enables modern theorists, such as feminists (Sawicki, 1991), to apply his thoughts to varied disciplines. Foucault explored madness[1] (*Folie et déraison, 1961*), the medical gaze (*Naissance de la clinique, 1963*) and punishment (*Surveiller et punir, 1975*). I do not wish to suggest that

[1] The dates cited here are the dates of the original publications in French. Dates used in the project are those of the publication in translation.

wide usage of Foucault's philosophy and theorising implies that it is above criticism: in his day Foucault was both revered and reviled and his work still provokes controversy. Nevertheless, he is accepted as 'being one of, if not the, most influential thinkers of our time' (Danaher, Schirato & Webb, 2000, pp.1-2).

Foucault was born in 1926 in Poitiers in France. His father was a wealthy surgeon and his background is that of comfortable bourgeois conservatism. He began to study philosophy in 1942 and in 1943 passed his *baccalauréat*, whereupon his father wished him to go into medicine. Foucault, however, wished to go to the *École Normale Supérieure* (ENS) in Paris. This was an intellectual forcing house and Foucault's entry was by no means assured. Years of study for the exam to enter the ENS resulted in him being admitted to the school in 1946. (http://www.wikipedia.org/; http://www.stanford.edu/dept)

At the time of Foucault's education the scope of philosophical inquiries in France was broad and included existentialism and phenomenology. These are philosophies of experience, what it is to exist and make sense of oneself as a human being (McHoul & Grace, 1993, pp.8-9). As an existentialist, Jean-Paul Sartre (1905-80) argued that meaning was derived from existence, from the facility to act and make decisions and choices. Phenomenology explores how beings experience objects, how things seem to the consciousness. For the phenomenologist, it is not the object itself that has meaning but meaning is derived from our experience or perception of the object. Theorists pursuing

phenomenology were Heidegger (1889-1976), who studied being, the interaction of humans with life, and Husserl (1859-1938) who sought to understand the structures that enabled experience (Danaher, Schirato & Webb, 2000, pp. 5-6).

In some aspects Foucault's theorising is similar to that of phenomenology in that the phenomenologist searches for the conditions that allow a truth to be possible. Dreyfus and Rabinow (1982) also claim that Foucault's detachment is 'twice as radical' (p.50) in a phenomenological sense. They state: 'by remaining neutral with respect to the very notion of truth, opens up the possibility of a *pure description* of discursive events' (p.50, emphasis in original). For Foucault, therefore, even perception and experience must be stripped of its status as a referent to allow discourse to emerge as not 'a sign of something else', but something that emerge(s) in its own complexity' (Foucault, as cited in Dreyfus & Rabinow, p.50).

Discourse in Foucauldian terms is inescapably embedded in a particular social context and historically within a timeframe: its reference point, its 'horizon' (Dreyfus & Rabinow) is, however, itself and not the perceptions of those within the discourse. In order to indicate that discourse operates within a particular space and place within history, Foucault uses the term *archaeology* to describe the processes whereby a discourse may be positioned and examined in its cultural and historical setting. In *The archeology of knowledge* (1972), Foucault

described *archeology* by what it is *not*. He stated 'archeology tries to define not the thoughts, themes, preoccupations that are concealed or revealed in discourses; but those discourses themselves, those discourses (are) 'practices obeying certain rules' (p.155). He goes on to say that

> Archeology does not seek to rediscover the continuous, insensible transition that relates discourses, on a gentle slope, to what precedes them, surrounds them or follows them....its problem is to define discourses in their specificity; to show in what way the set of rules they put into operation is irreducible to any other (p.155).

It must be considered that although the word *archeology* has distinct links with historical enquiry; Foucault's use of it in this context is to explore how discourses operated at a given time. In the introduction to *The archeology of knowledge* Foucault reverses the concept of history as a collective memory evinced in documents: rather it is the conglomeration of items by a society as evidence of its visibility, of its discourses. *Archeology,* therefore, is the means by which items are 'grouped, made relevant, placed in relation to one another to form totalities' (p.8).

This project uses Foucault's work to identify discourses within data pertaining to the third stage and analyse it in terms of Foucault's concepts using discourse analysis. Various branches of discourse analysis examine linguistically the written or spoken language of a particular subject: discourse analysis can also 'be located in wider social structures' (Lupton as cited in

Powers, 1996, p. 207). Foucauldian discourse analysis, however, extends beyond textual and written communications and considers concepts, rituals, institutions and power relations intrinsic to discourse.

Foucauldian philosophy is challenging for the reader and has the tendency to undermine assumptions until the taken-for-granted truths of life are stripped naked. Despite that, however, Foucault never claimed to be building a meta-philosophy nor did he see himself as replacing the 'prime movers' of some philosophies. Most of all his philosophy appears to be a collection of tools, an aid to seeing past the indoctrination that may be called 'common sense'. In addition, it is important to understand that Foucault did not deny the physical existence of an object. Thus the table that I am writing on has a particular reality but my perception of it—an old desk, brought from England and used by my Grandfather to write his works—is mediated by my knowledge of its history. Moreover, for Foucault there is no sensation of some pre-existing condition of pure 'tableness' that lies metaphysically behind my desk. My table exists in a physical space and the values I place on this object—my knowledge of its history—is a lens through which I view it. No object, no thing, no situation, Foucault suggests, can be viewed without taking into account this lens of meaning. Similarly, Foucauldian discourse analysis offers the reader a lens, a means to recognise and examine the discourses around her, to undo what seems natural, a taken-for-granted truth that has always been so, and by placing it contextually reveal it as constructed and ephemeral. By locating his

theories historically, Foucault examined the ways in which individuals were *able* or permitted to experience.

This chapter, therefore, proposes to concisely explicate Foucauldian philosophy: it does not intend to be an in-depth examination of the work of Foucault but rather an examination of its application to this thesis topic and it pertinence as a means for midwifery enquiry. In particular, I consider Foucault's use of the term discourse; his linking of power and knowledge as power-knowledge, with particular reference to confession and surveillance; and his theory of the subject both forming and being formed by discourse.

Discourse.

The most intimate and dramatic moments of our lives are mediated through language. Discourse is inescapably linked with language but in Foucauldian terms discourse is not limited or contained by language: the concept of discourse is also enmeshed with other terms such as power-knowledge, confession and discipline. Language is thus a powerful tool but it cannot be neutral or separate: rather it both creates and is created by the user. Foucault, however, is not specifically concerned with particular conversations or language systems but with statements which are not only speech acts, but language as 'windows...which allows us to make sense of, and 'see' things' (Danaher, Schirato & Webb, p.31).

Foucault's concept of discourse, therefore, contains language in its linguistic forms but also moves towards discourse considered as *discipline*. In *The archaeology of knowledge* Foucault writes of discourse as

> Sometimes...the general domain of all statements, sometimes...an individualised group of statements and sometimes...a *regulated practice that accounts for a number of statements.* (Foucault, 1972, p.8, my emphasis).

McHoul and Grace (1993) express this succinctly:

> Foucault's idea of discourse shows the historically specific relations between disciplines (defined as bodies of knowledge) and disciplinary practices (forms of social control and social possibility). (p. 26).

Hall (2001) adds that Foucault was interested not only in what controlled the production of meaningful statements in a discourse but also the historical setting, the context in which these statements were regarded as authoritative. Hall goes onto describe Foucault as regarding discourse as 'a group of statements which provide a language for talking about...a particular topic at a particular time' (p.72).

The whole notion of discipline is very important in Foucauldian theory, as it encompasses not only the notion of discipline in the scholarly sense—that which is taught, the body of learning pertaining to a profession—but also that of containment, of rules and regulation, of government. This in its turn connects with Foucault's notion of *biopower*. In *Discipline and punish* (1995) Foucault

describes the attributes of discipline, and such criteria can be equally applied to mastery over a subject as a system over a person: 'disciplines characterise, classify, specialise; they distribute along a scale, around a norm, hierarchise individuals in relation to one another and, if necessary, disqualify and invalidate' (p.223). In this example, Foucault is speaking of the discipline of human beings, of the creation of tractable individuals in a society but it can arguably be applied to acquisition of an academic discipline.

Discipline in this way can be linked by Foucault's use of power-knowledge. Danaher, Schirato and Webb (2000) illustrate this point by describing how a person who wishes to learn enters an institution (a school or university) to acquire knowledge. The acquisition of various academic qualifications enables them to gain employment or recognition. At the same time as they gain this knowledge, they become visible to the institution so that their progress towards the desired knowledge may be monitored. Certain behaviours and attitudes may be expected of the student. Thus in acquiring the discipline—the particular knowledge—the required attitude is acquired.

Foucault, therefore, moves discourse away from linguistics, conversation and speech itself, although the linguistic implications of discourse remain implicit within his work, and examines how the discourse can direct what is able to be said, the forms in which a subject can be meaningfully discussed (Hall, 2001). In doing so, in theorising that discourse is able to dictate what is and is

not valid within a subject, Foucault also encompasses the concept of discourse as a discipline: certain items are valid and allowed to exist within the discourse, other items are disallowed and invalidated. Hence the discourse will generate the facility in its laws and practices to discipline those who try to admit disallowed items.

It is important to differentiate between Foucault's use of the word *discourse* and *discourse* as used by other methods of discourse analysis. I have not considered in detail the formalist aspects of discourse analysis and the following can be considered only as a brief overview to illustrate the contrast with the Foucauldian discourse analysis I intend to use for this project. It is possible to interchange 'discourse' with other meanings, many of which are linked with words, statements, written and spoken language. As noted above, Foucauldian discourse analysis suggests that language is only one aspect considered: in Foucauldian terms items which are *not* language, such as maps, diagrams and charts, can comprise part of a discourse.

Formal approaches to discourse analysis consider discourse as text and consider the social functions of language: formalist approaches are largely associated with linguistics. McHoul and Grace (1993) note that certain aspects of formal linguistic methods of discourse analysis can be mechanistic (p.28), attempting to discover governing rules that lie behind the text being examined. McHoul and Grace also point out that formalist methods can be critical in that it

is possible to examine texts for their positions within certain fields—class, gender and politics (p.28).

In the empirical methodology *discourse* is frequently taken to mean human conversation and its occurrences. The empirical approach searches for 'the common-sense knowledges which inform conversational rules and procedures' (McHoul & Grace, p.29). The link with Foucauldian discourse analysis occurs in that some empirical analyses indicate that language can be used to achieve particular objectives: the outcome of the exchange is the creation of a prisoner, a patient, a criminal. For example, attending a doctor's surgery at a given time and day implies the need for a health consultation between doctor and patient rather than simply a social exchange: the setting and the language used assist in the construction of the subject 'patient' and 'doctor'. The analysis centres on how such subjects are achieved: Foucault wishes to examine why the discourse appears, how this limits what can and cannot be and where the paths to challenging these definitions occur.

Both empirical and Foucauldian discourse analysis rely on examination of an archive, a body of collected data. For Foucault, however, an archive is not only the collection of the pieces but also the manner of collection, the organisation. Foucault examines what limits are placed upon that which can be collected, how it is judged worthy of collection. The collection of data is governed by rules that decide what it is appropriate to know in that particular

period: documentation or information will be retained or discarded in accordance with these rules. Thus empirical discourse analysis looks at the technical aspects of language—turn-taking or interruption, for example—whereas Foucauldian discourse analysis examines the limits of what can be said within a particular discourse at a particular time.

A further aspect of discourse for Foucault was the space in which a discourse is able to appear. Powers (1996) notes that for recipe writing to appear in its currently known format, a precondition required was the ability to read and write (p.209), and a standardised weights and measurement system (p.207). She points out that when a standardised or normalised form was produced, other practices were displaced and that various pressures were exerted to ensure adherence to the norm (p.208). The norm will, therefore, promote certain actions at the expense or exclusion of others. The promoted procedures, in the Powers' example of recipe writing, will gain authority until all recipes are written in a standardised fashion. Other pieces of writing capable of being used as recipes will be ignored and excluded, will lack social validity.

Discourse, therefore, does not stand alone. It is not only associated with its historical context, it is also situated within the 'larger, practical, social context' (Powers, p. 209). In seeking to analyse any discourse, one must also be aware of the surroundings, of what pre-existing conditions enabled this particular

discourse to emerge and gain authority. Thus a space or arena must be available for the discourse to become apparent.

In terms of this project, for example, a necessary space for active management of the third stage of labour was the acceptance of and availability of drugs that could be administered to the parturient woman; that the drugs were of a consistent quality and the means of administration was safe and effective. A further space could be said to be the place where the woman is giving birth, which furnishes the means to oversee and direct the manner and the timing of the administration of those drugs. The place in which the pregnant woman gives birth is part of the discourse in that it facilitates medical observation and subjects the woman to the discipline of the medical discourse. It could therefore be argued that to enter into the hospital environment is to move physically into a discourse.

Power

Foucault's concept of power is one of the central tenets of discourse analysis. Foucault's theorising of power is very different from how power has previously been conceived in that it moves away from power as a top-down, repressive force, which can be possessed, or not possessed, by persons towards the concept of power as a network in operation at all levels (Foucault, 1978, p.92).

The most pervasive view of power remains that of a repressive top-down force, the ability to exact punishment if the person does not act in a particular or prescribed way (Foucault, 1978, p.85). This form of power has as its basis the ability of power to be executed as law, and making it lawful to use power. The ultimate expression of such top-down power is the monarchy and Foucault posits that western monarchies 'were constructed as systems of law, they expressed themselves through theories of law, and they made their mechanisms of power work in the form of law' (1978, p.87). Although the monarchy no longer has the power to enact its wishes on the physical bodies of the people, Foucault suggests that we still 'have not cut off the head of the king' (1978, p.89) in that it is still accepted that 'power is enacted in the form of law' (p.88).

Foucault's model of power surmises a web of power 'that brings things and events into interrelations, even remote ones' (Grosz, 1994, p. 147). In this network of power, no one item, as in the pyramid concept, is ever far removed from another and the network is able to promulgate what is held to be truth. As noted above, the dominant discourse is evident throughout the discursive field, from the most authoritative tomes to the most commonplace gossip. Thus the subject is both constantly visible to the discourse and the discourse is continually available to the subject.

Sawicki (1991) surmised that if power ceases to be a possession it can become 'a relational model of power' (p.21). Further, Sawicki suggests, focussing on the power relations, one is able to comprehend how subjects are constructed and why the productive model of power is more sympathetic and durable than the notion of power as simply a repressive force. It is not possible to discuss Foucault's view of power without also explicating his construction of the subject. In its simplest terms, the subject is both created by and creates the discourse but this bald statement conceals the complex relationship between the subject and the discourse, and the multiplicity of associations between knowledge, power and the subject.

The subject recognises or makes sense of her/himself by reference to various discourses (Danaher, Schirato & Webb 2000, p.50). For example, I recognise myself as a midwife. I do this by referral to the knowledge that I utilise in my care of pregnant women. My status as a midwife and the knowledge required to attain this status is regulated by law to enable me to operate in various institutions. Such extrinsic recognition places a requirement upon my status as midwife to monitor and to be monitored in my practice. I need to satisfy myself and those external to me that I am a midwife and, if I am in error, allow the system to pass judgement upon me to discontinue my practice as a midwife. This process cannot negate my knowledge of women or midwifery but it can regulate my status as 'midwife'. Consequently I am linking being a midwife—having the knowledge to assist women in childbirth—with the ability to

practice my profession. As a midwife I utilise the mechanism of discourse—knowledge, discipline and surveillance—to gain the necessary authority to practice midwifery. I permit a discourse of midwifery to describe 'being a midwife' and ascribe the penalties when I do not act as prescribed.

This is not to suggest, however, that discourse is somehow static and fixed within a discipline. As stated above, discourses become dominant but are constantly challenged. The actions of the subjects constantly test and extend a discourse, new categories are erected and a discourse is challenged. Leap and Hunter (1993) describe midwifery as moving from 'handy woman to professional midwife', and the image of the drunken 'Sairy Gamp'[2] is still present in the modern mind.

The subject, therefore, is created by a discourse—a midwife, a homosexual, a criminal—and once the subject has identified her/himself, s/he then utilises, and maintains the created categories. The discourse creates what it is possible to know and we, as subjects, support this.

I am aware that such a view may appear to be dead-end and pessimistic, the ability to reference to greater and outside truths quashed. Truth, in Foucauldian terms, is created and sustained by the discourse and is historically

[2] Charles Dickens, *Martin Chuzzlewit*: 'Mrs Gamp being, in her highest walk of art, a monthly nurse, or, as her sign board boldly had it, 'Midwife' (p.374). 'The face of Mrs Gamp—the nose in particular—was somewhat red and swollen, and it was difficult to enjoy her society without becoming conscious of a smell of spirits' (p.378)

mediated: it is self generated and self-sustained. The head of the King has been removed (Danaher, Schirato & Webb 2000) and there is only vacuum left. Into this space Foucault surmises power not as a divine force but as a linked series, a network of relations. Power for Foucault is not repressive but productive in that it is able to create discourses and subjects: it will also create counter-discourse and resistance: 'Where there is power, there is resistance...this resistance is never in a position of exteriority in relation to power' (1978, p.95).

The mighty power of the one sovereign has gone but in its place are discourses that mutate as differing knowledges are produced. As noted above, there have been various views of midwives over the centuries but there is no one definitive interpretation of midwifery or midwives. Perhaps it could be said that, just as feminist theory posits 'feminisms', so will midwifery theory, as it develops, speculate on the variety of 'midwiferies'? The removal in Foucauldian terms of the sovereign head permits multiple discourses and disallows one standard definition. Discourses, however, can attain dominance and can thus define the madman, the criminal, the homosexual and the midwife but the seat of absolute power remains empty and the dominant discourse will be challenged.

If, therefore, the sovereign power or pyramidal type of power has been removed and there is a power 'web', how is compliance to the dictates of the

discourse assured? It would seem that the top-down power structure remains and to some extent this is true but this power is dependent upon acquiescence from within rather than power given as divine right. The Prime Minister or government of a country has the ability to make laws, which can then be enforced on the people of a state. If, however, the recognition of the government to enact laws is removed and a different power is erected, then laws can be removed or revoked. In addition, the enactment of any law on persons requires that we, the people of the state, are complicit with the state in their enforcement.

Foucault used the image of Bentham's Panopticon to demonstrate how persons are co-opted into self-surveillance. In contrast to systems that closed prisoners away from view, the Panopticon was based on the assumption of constant surveillance, with cells open to scrutiny built around a central watchtower. The prisoner, however, was unable to tell if s/he was or was not being watched and was required to act at all times as if under observation. The prisoner modifies his/her behaviour on the assumption of being observed, then constantly polices this observation: s/he colludes in the modification of his/her behaviour. Foucault states: ' Hence the major effect of the Panopticon: to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power' (1977, p.201).

The law regarding driving at speed demonstrates the need for complicity. In New Zealand speed on the open road for cars is restricted to 100 kph. The majority of cars purchased today are able to travel at twice this speed and are equipped to protect the driver in the event of impact. Nevertheless, it is reasonable to restrict the speed at which motorists travel as the ability to control a vehicle at speed varies from driver to driver. New Zealand, however, has 91,800[3] kilometres of road and 6,908[4] police officers to enforce the speed rulings.

To promote the concept of travelling at a 'safe' speed, therefore, requires that the motorist her/himself be involved in monitoring and controlling speed, thus acting as her/his own police officer. To promote this self-surveillance, the morality of travelling at any speed other than the official limit is brought into question. In advertisements it is suggested that motorists travelling in excess of 100kph are prepared not only to die but also to cause the death of those around them. The construction of a safe motorist then creates an 'unsafe motorist' who will ignore, not just safety, but the moral imperative created by this construction to consider the wellbeing of his fellow person. It does not require a system of penalty to enforce the requirement to drive at 100 kph or less, although one will exist: persons who wish to be considered as responsible members of our society will self-monitor their adherence to the law. Thus the system co-opts subjects into acting as agents in their own surveillance who will then, by

[3] Statistics New Zealand, 2000
[4] Sworn officers, Statistics New Zealand, 2000

extension, ensure that others also co-operate. The motorist becomes, therefore, not only governed by power, in this case the law restricting speed, but is also part of its application. Foucault states: ' they...should be caught up in a power situation of which *they are themselves the bearers'* (1977, p.201, my emphasis).

Surveillance, therefore, requires that subjects co-operate in their own monitoring, which they perceive as being to their benefit. In the above example, monitoring one's road speed, the perceived rewards are road safety and acting as a morally responsible person. The notion of self-surveillance and being voluntarily co-opted into self-surveillance is an area that I wish to explore in the current study. I would surmise that self-monitoring and regulation are specific attributes of a dominant discourse, a particular relationship to the power network. Thus to co-operate in self-regulation is to accept the interpretation of the dominant discourse. As in the above example of road speed, opponents of the 'speed equals fatality' may cite that their compliance is to avoid monetary penalty. Nevertheless, even this form of obedience accepts that the penalty for speeding—a money forfeit—is legitimate.

In terms of the current study, have midwifery practitioners accepted that there is an active management/physiological management dichotomy and, as with other dichotomies—mind/body, male/female—the left side of the equation somehow has, in some way, 'greater' legitimacy? Although physiological care in

the third stage may have credibility within midwifery are the policies and guidelines for the third stage of labour (Appendix A) evidence of a dominant discourse that coerces midwives into monitoring their practice against a standard which may not be coherent with a midwifery philosophy which regards birth as a normal life event (NZCOM, 2002, p. 3)? As Hacking (1981) notes, the evidence of a dominant discourse stretches across from the 'annals of public hygiene but also the broadsheets of the day' so it could be expected that those working with midwives and those using midwives will be aware of the 'standards' generated by the dominant discourse—in this case the policies of the third stage—and the subsequently expected compliance with the 'standards'.

Confession and biopower.

Why should systems seek to compel compliance in subjects? I have suggested that constant surveillance co-opts the subject into self-monitoring and also that subjects become vehicles for the expression of power: this constant surveillance also creates what Foucault calls *docile* bodies, a subject who is obedient to the system as a result of her/his own self-discipline. This is what McHoul and Grace denote as 'useful obedience' (p.68), a subject whom the state will find effective. If the sovereign power, the King, has been removed then a state is no longer represented by a single person, an embodied power, but by its collective citizens. Thus a subject is required to be *useful* to the state

and *useable* by the state: obedience needs to be 'written' in the body of the subject and is termed 'biopower' by Foucault.

Biopower is that which is acted out in the body of the subject. Self-regulation and discipline, as noted above, simultaneously render the subject compliant and useful: biopower will also render the subject visible and open to control. McHoul and Grace note that biopower is exercised not only on the individual body but also on collective bodies—the population as a whole (pp. 77-8). This impacts upon areas that are taken for granted, as being public requirements—public health and safety, a clean environment, access to services—but can also be seen as a means of monitoring and thus controlling large bodies of people. It is also into this category that I would place safety, particularly safety within our institutions. The definition of being safe, especially in birth, is a large area and the current study does not intend to discuss it. I would argue, however, that being safe and defining safety is not 'common sense' but is part of a discourse that is context dependent. Elizabeth Smythe (1998) enlarges upon this theme in her Doctoral thesis.

Ensuring physical safety plays a significant role in exacting compliance from subjects: in the example above of speed restriction, the safety of self and others was the reward for compliance to the law. In healthcare, the safety of clients in the system is of paramount importance. Nevertheless, the definition of such safety is the interpretation of the dominant discourse. If the subject wishes

to remain 'safe' it is implied, s/he must accept the construct of the discourse. While the above may be true, it is also evident that this is a means of control, a means of biopower, of rendering subjects visible, docile and useful.

Biopower, therefore, is exercised directly on the body of the subject both individually and collectively as a population. As with the concept of self-surveillance, the action of biopower is not disparate from the subject: the subject becomes an integral part in its operation. McHoul (1987) argues that the Panopticon moulds the 'outer person' by ensuring compliance but it is the confessional that 'presses us to make visible our inner selves' (p. 15). Foucault linked the confessional with the 'production of truth' (1979, p.58). Although Foucault based the concept of confession on religious practices, McHoul (1987) notes that the confessional is distinct from religious practice but still has the admonishment of truth telling upon it. Foucault states that 'Western man has become a confessing animal' (1979, p.59). Confession in modern life has a similar regard for secrecy in the form of privacy and has the ability to be used across a wide range of areas, from institutions to the family (McHoul & Grace, 1993, p.79). McHoul and Grace go on to note that confessions can 'take the form of interrogations, interviews, conversations, consultations' (p.80). They go on to point out that confessions 'always unfold within a power relation' (p.80). The person who confesses hands over information for the judgement of others—the priest, the judge, the doctor and the midwife—and thus for the possible control and manipulation of others.

In midwifery or medical terms I would suggest that confession is in the form of information offered by the client[5] during 'history taking', whereby information is obtained from the subject under the bounds of privacy. Such privacy is illusory as the information gained is used by multiple persons in the care of the client and thus renders the client visible to the hospital system. The subject is exhorted to be truthful in order to assist in her/his own treatment. In the course of the confession, I would suggest, the subject also learns what is expected of him/her. It is not unusual in a history taking for a subject to ask 'is that normal?' of the history taker, appealing for confirmation that a habit, action or symptom is acceptable. During the course of the history/confession the subject ascertains the particular normality required and how/if s/he deviates from the norm. If biopower, therefore, is the means of controlling the bodies of the subject, confession is the means by which subjects voluntarily make themselves visible *for* the actions of biopower.

It is pertinent that I touch briefly on normality, particularly with reference to what is deemed to be normal for New Zealand midwives. The sense of what is and is not normal pervades midwifery and medical literature. It is not possible to read without wondering what definitions of normality are being observed. Midwifery and medical researchers of the third stage of labour use 'normal' as their baseline: how is 'normality' or 'normal' constructed?

[5] I have used the word 'client' here to include any person using the health system, not only women using maternity services.

Normality.

In defining normality Foucault expounds the view that definitions of normality render the subject simultaneously productive and powerful: productive in that the person internalises the normality as a discipline and powerful in that the person co-operates with the discipline and becomes subject to and a vehicle for the power within the discipline.

Sawicki (1991) in her examination of reproductive technologies, noted that such knowledges establish 'bodily norms and techniques for observing, monitoring and controlling bodily movements, processes and capacities' (p. 83). Thus what is produced is what McHoul and Grace call 'useful obedience' (p. 68). They go on to cite Foucault: 'The human body was entering a machinery of power that explores it, breaks it down and rearranges it' (Foucault, 1977, cited by McHoul & Grace, 1993, p. 68). For example, when establishing normality in labour, by the demarcation of boundaries, a woman's body becomes visible to medical intervention when normality is not 'achieved'. The attraction of defining and normalising an event is that of ease, of prediction. In 1980, O'Driscoll and Meagher published their 'integrated system' of active management in labour, seeking to do away with the 'passive attitude to labour, where nothing could be done to resolve an admittedly unpleasant situation' (p.1). Women delivering at National Maternity Hospital in Dublin were given a guarantee that their 'unpleasant situation' would not exceed twelve hours once they were admitted in labour. If the woman did not achieve the norm of 1cm per hour cervical

dilatation when in labour, augmentation was used. The terms of production and predictability are placed on the body of the labouring woman.

To define normality, therefore, is also to place on it expectations of predictability, what one expects to happen and often, the time one expects it to occur within. If an event falls outside those definitions, it is deemed to be abnormal. For example, in Aotearoa/New Zealand in 2003 the principle of maternity care is enacted in law (Notice pursuant to section 88 of the New Zealand Public Health and Disability Act 2000). Contained within section 88 are guidelines for consulting with obstetric services which include a list of conditions where the practitioner is advised to consult with an obstetrician or medical specialist.[6] As a midwife in Aotearoa/New Zealand I work within section 88 and when a Lead Maternity Carer (LMC) I must follow the guidelines for referral. In doing so, however, am I accepting that normality in pregnancy is being defined by the absence of these medical conditions, a vacuum where normality should be? A more detailed definition of normality in an individual, therefore, amalgamates the concepts of a rightly functioning, mechanically organised, rigidly defined, predictable entity with the absence of anything that disorders the capacity of that individual to function in the desired manner.

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[6] The levels of referral go from one to three:

- Level 1: the Lead Maternity Carer may recommend to the woman (or the parents in the case of the baby) that a consultation with a specialist is warranted.....
- Level 2: the Lead Maternity Carer must recommend to the woman (or the parents in the case of the baby) that a consultation with a specialist is warranted.....
- Level 3: the Lead Maternity Carer must recommend to the woman (or the parents in the case of the baby) that the responsibility for her care be transferred to a specialist.....

(Section 88, p. 31, emphasis in the original).

Summary.

I am aware that in this chapter is a limited examination of specific parts of Foucault's philosophy, which I regard as important to this project. A Foucauldian approach is valid for midwifery enquiry in that it obliterates the facile assumptions, the 'taken-for-grantedness' that can so easily underpin research into care of the pregnant woman. It causes me to ask who is *the woman* for whom I claim to practice? How can I *empower* someone when power is fluid? Do I tacitly accept a dominant discourse, perhaps in this case medical and scientific knowledge, then monitor myself against standards that are outside the midwifery discourse? Do I encourage women to 'confess' so that I can judge their 'normality'? Midwifery and medical literature dealing with the birth of the *whenua* and the third stage is pervaded by the image of normality. It becomes increasingly clear as I journey deeper into this project that the objective detachment of scientific literature is fallacious: equally, the radical detachment of Foucauldian philosophy is equally hard to acquire when one is within the discourse. Thus I surmise that the purpose of Foucauldian philosophy is to identify the discourses present in order to challenge their natural and taken for granted status, to reveal them as a lens for viewing various human situations.

Curiosity certainly finished me.

The end of a long day

and I was just about ready

to relax back on cushioned comfort of my assumptions

let myself slide into a nice warm truth.

I vaunted my validity

believed that I had a way with words and

the candyfloss castles I wove certainly

had beauty, originality and

if I didn't move mountains

well, maybe a small hill or two

shivered.

Then

my castles met with acid.

Caustic, invisible—all

I saw was a pile of glistening baubles

on the ground and recognised

my assumptions,

torn tattered truths

contextual veracities—

no longer a fortress but terrifyingly

varied according to

space

place

time.

No more palaces to build

no shining structures

too often the ground shifts

foundations are insecure.

Yet

there is a fierce joy and

I still toss my shining trinkets

into the air

but

I am not so sure now

where they will land.

That day, that learning cost me dear. I exchanged my unquestioning certainty for an endless and varied terrain.

The price of life is constant vigilance, unquenchable curiosity.

One lifetime *will not, can not*

be enough.

Kate Alice 29/04/04

CHAPTER FOUR

Methodology and method.

'Though this be madness, yet there is method in't' (Hamlet, Act 2, Scene 2, l.207-8).

Introduction.

The journey towards the methodology for this study has been somewhat prolonged as the pursuit and study of Foucault's philosophy can appear to be 'all smoke and mirrors' (Anderson, 2004, personal communication). Discourse analysis appeals to me because it enables icons of apparent impeachable authority to be held up for examination and critique to reveal the overt and covert power relations in seemingly objective information and actions. Everything is open to challenge and re-interpretation, including Foucault's philosophies.

The focus of this study is to locate possible discourse(s) within the care options for birthing the *whenua*. I am aware that within Foucault's work, women and concerns specifically female are largely invisible. Sawicki (1991), however, argues that Foucault ' isolated the "hysterization" of women's bodies and the socialization of procreative behaviour' (p. 50, emphasis in original) as areas for analysis. It is my contention that Foucault's philosophy is particularly applicable to childbirth, as both topic and event inspire emotion and controversy. Debate

occurs not only between practitioners, midwifery and medical, but also amongst users of the service who seem to require the pleasure of nature and service of science without accepting the limitations of either. By examining the discourses that arise during what may be regarded as the least or end point of the pregnancy, the birth of the *whenua*, I hope to illuminate a small part of the discursive field that encompasses the pregnant woman and childbirth.

Foucault's philosophy as it guides this study is detailed in Chapter Three. This chapter comprises of a description of the methodology on which this study is based; difficulties encountered in utilising this methodology; design of the study; ethics approval; recruitment to the study, data collection and data analysis.

Methodology.

The methodology chosen for this project was a Foucauldian discourse analysis. As stated above, Foucault's philosophical appeal was one component in methodology selection. In addition, this is a qualitative study and does not intend to review clinical behaviour but to ascertain why and how a certain group of people chose one or other course of action. Foucault claims that disciplinary practices more sharply delineate the individual (Foucault, 1977, p. 139) thus his philosophy is pertinent when examining the specific choices made by a small group of people.

The methodology for this project is based upon Foucault's contention that discourses exist within any society, and within bodies of knowledge, and these discourses limit what may and may not be said about a subject. In relation to this project, it can be surmised that discourses are discernable within the information provided to pregnant women with regard to the third stage of labour.

A discourse is different from a theme in several important ways: firstly, as stated above, discourse limits what can and cannot be said of a given subject. In Chapter three I noted (p. 53) that discourse links together bodies of knowledge and disciplinary practices. Thus knowledge is linked to the ability to control what is said or thought about a subject: knowledge is linked to power and the production of truth. So closely linked are power and knowledge that Foucault denotes them as power-knowledge. What can be said, what is permissible to say, takes on the force of truth. Thus truth is not an objective and pure essence, somehow detached and separate from the discourse but is generated by power within the discourse itself. Foucault states:

> there are manifold relations of power which permeate, characterise and constitute the social body, and these relations of power cannot themselves be established, consolidated nor implemented without the production, accumulation, circulation and functioning of a discourse... Power never ceases its interrogation, its inquisition, its registration of truth; it institutionalises, professionalises and rewards its pursuit (1980, p. 93).

This is not to say that the discourse itself generates power but rather that power is not something that can be possessed or given away. Power is inherent in all the exchanges within a discourse and is based upon the possession of knowledge: interactions within the discourses generate power. It should be emphasised, as in Chapter Three, that power envisaged by Foucault is not the traditional top-down pyramidal concept but a web or mesh of power relations that affect all persons and to which all contribute. Such power not only has the ability to promote 'truths'; it will also dictate which documents and what information survives, what forms the *archive*. McHoul and Grace emphasise that the archive is not the physical documentation that forms the archive, but 'the conditions (the "set of rules") by which it is possible to "know" something at a specific historical point' (1993, p. 31, emphasis in original). It is salutary to remember at this point that power within the discourse is not restrictive: power is productive and Foucault states that power depends upon opposition and such resistance is not a 'great Refusal' (1978, p.96) but multiple 'points of resistance...everywhere in the power network' (1978, p.95). Power, therefore, has numerous and diverse applications and is concrete in its effects. It governs what it is possible to know and how information is applied.

As noted in Chapter Three (p. 53) power is linked through knowledge to discipline, and discipline is often enacted on the body to produce concrete results. In addition, power requires 'instruments for the formation and recording of knowledge...methods of observation, techniques of registration, procedures

for investigation, apparatuses of control' (Hacking, 1981 as quoted by McHoul & Grace, p.22).

A discourse also requires a surface of emergence, that is a social or cultural area through which the discourse appears. For this project, the birth of the *whenua* is contained within the larger context of the birth of the child. As Hacking (1981) notes, evidence of a discourse can be located in a wide range of places. It is possible within these various locations to identify both a dominant discourse and the points of resistance to that discourse.

Related to this is a '*terrain* of power' (McHoul & Grace, p. 22, emphasis in original) or a grid which links items within the discourse to each other; for example, the differing definitions of mothers within a medical discourse of pregnancy. If one surmises that a medical discourse holds pregnancy to be uneventful only in retrospect (Thomas, 2000), then one could conjecture that the link between a woman needing treatment for a medical disorder and a woman experiencing a normal pregnancy, as being 'patient' for the former and 'potential patient' for the latter. Within the terrain of power all pregnant women are viewed as pathological, as suffering from a condition, until proven otherwise.

Methodological Issues

Part of the challenge of this study was the realisation that I could not and did not intend to bring any fresh knowledge to care offered to women birthing the *whenua*. I do not examine the physiology of the event anew and am not able to stage a large clinical trial. This study, therefore, does not replicate a clinical trial or critique cares for the birth of the *whenua*. The aim is rather is discover whether any of the information within the data appears to have a particular prominence, to be in a position to influence the decisions of the participants. The focus of the study will be the birth of the *whenua* and the care choices pertaining to this: these choices are situated in the context of the birth.

Discourse analysis allows the researcher to examine the data in context, set within its historical surroundings. I consider that the small number of participants recruited limits this study, and those recruited do not illustrate a broad spectrum of either midwives or birthing women: consequently examination of the context will necessarily be restricted. Nevertheless, I posit that examination of the information offered by midwives and choices made by parents about care in the third stage of labour can be illustrative of the discourses surrounding childbirth. To this end, my focus is on data obtained from the participants, who were women and midwives.

As the study progressed I became aware of Hacking's (1981) advice to search for evidence of the discourse across a broad field. For this study,

however, the primary source of data to be analysed are the interviews of the women and midwife participants. I do not intend to analyse the literature reviewed, or that supplied by midwives to their clients, as I would anticipate a wide variety of sources, specific to the woman/midwife relationship and dependent upon the birthing history, if any, of the pregnant woman. I do, however, examine references to literature if they arise in the data, or if participants specifically direct or are directed to identified sources of published information.

Rigour.

Validity and reliability are concepts more fitted to quantitative research. The notion of rigour, however, may be considered in qualitative or 'naturalistic enquiry' (Guba & Lincoln, 1995) with regard to how a reader can have confidence that the outcome of the study is more than the researcher's opinion. Criticisms of qualitative enquiry as 'soft' research are based upon scientific tradition that demands that data analysis be bounded by four criteria for rigour: truth values; applicability; consistency and neutrality (Guba & Lincoln, 1995, p.103-4).

Truth and applicability: Guba and Lincoln note that in the scientific paradigm there is 'one reality, and information is...valid if it describes that reality' (p.105). This study utilises a Foucauldian viewpoint where there is no one specific truth or reality pertaining to care in the third stage of labour sought

in the data, and the analysis does not strive to be universal but specific to participants in their distinct setting. Truth value, in Foucauldian terms, is both located within and authorised by the discourse. By seeking the discourses in the data I am describing truth and authority as denoted by a specific discourse at a particular juncture revealed within a set of data. Thus its truth and its applicability is to a discrete group, the participants in the study, and may be indicative of a larger group, all mothers and midwives.

Consistency, as denoted by Guba and Lincoln (p. 104 and p.120) is linked to replication of results of a study if repeated in similar circumstances. I would argue that such replicability is not congruent with Foucauldian enquiry. Those considering data from a Foucauldian perspective would wish to detect similarities upholding dominant discourse(s) but would also examine gaps or inconsistencies indicating possible emergent or suppressed discourses. Given the concept that truth is specific to time and context, it is arguable that it is also dependent upon the study population examined when or if such anomalies arise. Davidson and Tolich (1999), state that qualitative research presents 'a precise...description of what people said or did in a particular research location' (p. 34). I posit, therefore, that consistency in my study is more aligned with accurate rendering of the data than replicability. The delineation of discourses therein, however, is open to critique and revision.

Neutrality: within the study I am quite clear that I position myself as mother and midwife and cannot thus claim my stance to be that of a neutral observer. As stated on page 94 of the thesis, I view this to be desirable from a professional standpoint and, as a researcher, my knowledge and experience in caring for pregnant women makes interaction with the participants and the data unavoidable. In addition, I reflected on a possible perceived disjunction in status between myself as a professional and participants who had birthed: it was possible that my presence as a researcher could distort data towards one or other discourse. I thus felt that I both collected and contributed to the study data.

Ethics approval.

Approval for this study was obtained from two Ethics committees prior to the commencement of data collection. The project was considered by the Ethics committee of Massey University, where I am enrolled in the Masters' programme, and the Regional Ethics committee of the area where data were collected. Approval was obtained from Massey without undue difficulty, the main assurance required being that adequate support was in place for Maori participants. The intended participants for the study were midwives from the region and mothers who had recently had a normal or assisted birth. Ethnicity data for the region indicated that approximately 4.8% of the mothers birthing in the tertiary hospital identified themselves as being of Maori descent (MOH, 2002). Of the midwives in New Zealand, 6% of qualified midwives identified

themselves as being of Maori descent (New Zealand College of Midwives, 2004). Given that this is a small study, therefore, provision for consultation was made with a cultural advisor should the need arise.

Following approval from Massey, the regional Ethics committee was approached and in this case the application proved to be more problematic. The Ethics committee in the region has more applications from researchers proposing to do quantitative research and the committee therefore required greater detail of the proposed methodology of Foucauldian discourse analysis before approval could be granted. In addition, the regional ethics committee required evidence that supervision was available to the researcher on cultural matters. Approval was obtained after lengthy discussions over the methodology for the project with one committee member. Approval for the study was obtained in March 2003, recruitment for the study began in April 2003 and data were intensively collected in June and July 2003.

Participant recruitment.

The intention was to recruit to the study six women who had recently had a vaginal birth and six midwives. Posters were placed in the post-natal area of the local hospital inviting mothers who had had a normal or assisted vaginal birth to contact the researcher (Appendix B). Similar posters for midwife recruitment were sent to all New Zealand College of Midwives' members in the region via the e-mail list: this list is available to all local members and the

regional chairperson was made aware that recruitment for the project was in progress (Appendix C). The posters invited interested persons to make contact for further details of the project. Taking part in the study would entail a home visit from the researcher and approximately one hour of their time. Women who had given birth were assured that declining to be in the study would in no way affect their future care. The practice of midwife participants was not under scrutiny but rather the area of interest was the information presented to parents to assist choice of care during the third stage of labour.

Midwife participants.

Recruiting midwife participants for the study was accomplished easily and quickly. All midwives were invited to take part; self-employed, and those employed by the local hospital as case-loading midwives or Core midwives. Following the posting of the advertisement for participants on the local New Zealand College of Midwives e-mail list, six midwives identified themselves as being willing to take part in the study. All of these midwives were in self-employed continuity practice in the area and their range of experience was extensive. The average practice duration for these participants was 15 years.

Core midwives have a wide range of experience but no midwives employed by the facility responded to the study. It may have been perceived that being involved with labouring women on an episodic rather than continuity

basis precluded inclusion. I was aware that Core midwives had a higher involvement with problematic labours, for which active care for the third stage would be requisite. Nevertheless, they will also care for women experiencing normal labours and have access to facility guidelines regarding the management of the third stage. It is unfortunate that such data is not included in this study.

Participants who were mothers

Mothers who had recently given birth were slower to respond to the advertisement. When planning this study, I was aware that the third stage of labour and its attendant problems were more likely to be of interest to midwives and medical practitioners. In pregnancy a woman is naturally focused upon the birth of the baby, not the actual completion of the labour. Continuity midwife colleagues were able to give more detail of the study to women in their care, resulting in a greater response to the call for study participants. Eventually, four women instead of the proposed six were recruited into the study.

Women who had had a surgical birth were excluded from the study, as the *whenua* is manually removed from the uterus during the operation. This included women who had expected a vaginal birth but had required an emergency Caesarean section and those who had had an elective Caesarean section. It was decided to include mothers who had assisted births, despite being aware that such assistance largely precluded physiological care for the

third stage, as other interventions such as artificial rupture of membranes did not prevent admission to the study. When recruiting for the project I hoped to have a cross-section of women including some who had birthed at home with no intervention. All the participants, however, had birthed in the hospital environment.

With both sets of participants, I positioned myself as midwife and mother, as well as the researcher for the project: no attempt was made to become an objective or disinterested observer. It was, however, made clear to the mothers in the study that specific questions regarding their births should be addressed to their Lead Maternity Caregiver (LMC), rather than me as the researcher: data gathering for the study was not intended as a debrief of the birth. All participants were assured that they could withdraw from the study at any point.

Once participants had identified themselves, they were sent an information sheet containing more details of the study; a consent form (Appendices D for mothers; E for midwives) and a stamped addressed envelope to return the consent form (Appendix F) to my home address. Once the consent form was in my possession, I contacted the participant to make a mutually suitable time to visit them. All data were collected in the participants' homes. Data were collected throughout June and July 2003.

Data collection.

Data were collected using semi-structured interviews, based on oral history taking methods. Oral history methods require that, unless the interviewee requests that the interview stop for some reason, the tape be kept running continuously, as far as possible (Ffyfe, 1999). The interviews were recorded using a Sony Walkman Professional WMD6C and a clip-on microphone. TDK 90 minute cassettes were used for recording and the resulting tapes maintained a good level of clarity throughout the interview. Participants at first felt self-conscious about the clip-on microphone, and on occasion required a reminder not to touch the microphone or its attached wire. Once they became more comfortable with the process the recordings progressed smoothly. One midwife participant remarked that it was pleasant to be invited simply to talk and be the focus of some-one's interest. Women who had birthed were usually quite at ease sharing their stories as the process of pregnancy and birth invites information sharing; for example, the woman's medical history, her birth plans.

The interviews were semi-structured: in the discussion prior to the interview participants were shown a series of question prompts (Appendix G for mothers, H for midwives) around which the interview was to be based. These were guidelines only to assist the participant and interviewer. The interview encouraged diversions from the main topic to be explored if both participant and researcher felt it to be pertinent to the discussion. The participants were made aware that although I had some questions that I wished to place in the

interview, the participants themselves would determine the sequence of addressing the questions. In keeping with the methodology, participant and researcher explored the background of the participant's decision regarding third stage care, placing it in the context of the birth and the life of the participant. All participants were informed that I would attempt to keep the tape running if possible but that they could ask to stop the tape or decline to answer a question at any point in the interview. The interviews for the women varied in length from one hour to twenty-five minutes, the average time being forty minutes. For the midwife participants the interview times were slightly longer, ranging from fifty to ninety minutes. The average interview time for the midwife participants was one hour.

Women who had given birth.

Women who had recently given birth were invited to speak about their birthing in order to place the birth of the *whenua* within the context of the whole birth experience. Women were also asked about how they reached a decision about third stage care or if they considered it at all given, as stated above, the mother's focus is on the birth of the baby not the *whenua*. Nevertheless, even in circumstances where a mother could not recall making a choice about her care, I wished to note the space or the 'gap' in her account.

Midwife participants.

In order to place the advice given to mothers within its context, midwife participants were asked to describe their professional lives and current practice. Some of the participants had written leaflets about the birth of the *whenua* for distribution to their clients. One of the leaflets, found in Appendix I, is included in the study with their author's permission but the author's name has been removed to protect her privacy. It was emphasised to the midwife participants that there was no suggestion of a 'right' or 'wrong' way to give care in the third stage but that the study was an exploration of the practices and backgrounds that midwives used to offer advice to women regarding their care. At the end of the interview, midwife participants were invited to share their memories of the best, most difficult or most amusing *whenua* release they could remember: the anecdotes related here indicated the depth of love, wisdom and experience these midwives brought to their practice.

Once all the interviews were complete, the tapes were transcribed ready for analysis. A person outside the study did the transcription and an undertaking as to non-disclosure of information (Appendix J) was signed by the transcriber. The transcribing took six months to complete. Once received the transcripts were checked for accuracy against the recorded interviews. Transcripts were not returned to the participants prior to data analysis due to time constraints imposed by examination. In the final preparation of the thesis, however, all transcripts were returned for verification and participants were requested to

contact the researcher if they wished to have any part of the text removed from the data analysis. At this time no requests for withdrawal have been received.

Data analysis.

Data analysed were the transcriptions of the taped interviews of the participants. My first intention had been to consider the data separately, women who had given birth and midwives, as the views of the women and midwives appeared disparate. Repeated reading of the data, however, indicated that the integration of the data was necessary for a more exact consideration of the discourses found therein.

The intent of the interviews and the data analysis was to examine the birth of the *whenua* and the care choices therein but it was necessary to place this narrow interest in its context. I was aware from reviewing the literature that the randomised, controlled trials sought measurable outcomes in the form of reduced postpartum haemorrhage, median time for the third stage (Prendiville et al, 1985; Elbourne et al, 1998) but such measurements did not illustrate how the participants, midwives and mothers, utilised such information during the medium of the individual labour. In the Literature Review, Chapter Two, (pp. 19-51) the studies are examined separately, and a differing philosophy for medical and midwifery approaches to the birth of the *whenua* is suggested (pp. 24-28). The analysis of the data does not assume a simple division of philosophy or a model but examines what is present and what discourse(s) can be identified

from examination of the data. In addition, the analysis searches for discourse(s) that appear to be held by the participants as self-evident or true, and to determine the status of each discourse identified.

As noted above, I positioned myself as midwife and mother in the data collection. Thus it was necessary to hold myself open to the possibility of locating a discourse in the data that I had difficulty or disagreed with. It must also be stressed that this is my interpretation of the data and thus the study findings are open to critique or reinterpretation.

Summary

This chapter has outlined the methodology for the study and its appropriateness for the subject under consideration. As with all research, qualitative and quantitative, there have been difficulties and some limitations to the project, particularly in regard to recruitment. As a qualitative study, this project aims to illuminate a small section of labour, the birth of the *whenua*, and place it in its larger context.

Initially, data from the midwife and mother participants was considered separately as the standpoints of the two groups of participants appeared disparate: closer examination found the discourses to be integrated so the findings in Chapter Five are taken from the data of both mothers and midwife participants.

Well maybe just a small one.

Drinks have characters

separate as people.

They don't call them spirits for nothing.

Whiskey hoots mon, Hogmanay aye, another wee dram

No, no a splash of water don't want to drown it taste the peat.

Brandy has portent, cigar and a fine rounded character

flat in the city and a country residence.

Swirled gold warm in womanly glass.

Rum is bluff, sun over the yard arm

luffed round the point, breezy weather.

Hail fellow, well met.

Gin—a slapper's tipple, late night

laugh loud and too much leg

I shouldn't really but maybe one more ooo you are awful.

I get on with Gin. Her familiarity grounds me

on nights when the analysis is too detailed

and I prefer reality to

blur, just a little.

Kate Alice

August 2003

CHAPTER FIVE

Findings

Introduction.

In this chapter data collected from the participants are analysed utilising a discourse analysis based on the philosophy of Foucault, as explored in Chapter Three. Not all discursive threads have been identified: the intention was to locate and analyse the main discourses and discern, if present, any dominant discourse(s).

The data obtained were from two groups: women who had recently given birth and practising midwives. The data were examined in transcript and the quotations from the data are from those transcriptions. Extracts from the participants' data are italicised: extracts of the interviewer's comments are in bold type.

Of the mothers who had given birth, two were first time mothers and two were having their second babies. The ethnicity of the women was not ascertained but all had had a vaginal birth within the previous year. The data from the participants who were mothers was difficult to analyse, as I had to be cautious that due to my own interest and position as a midwife, I did not assume particular discourses to be present. In addition, the data regarding the woman's

decision making in the third stage of labour was sparse, with the participants naturally more focussed on the birth of the baby. Participants who are mothers are denoted in the analysis by the first initial of their forenames to protect privacy.

All six midwife participants practised continuity midwifery, as self-employed practitioners: two participants had other work and so cared for a correspondingly smaller number of women. As noted in Chapter Four, although the invitation for participation in the project was open to all midwives in the region, no employed midwives responded. The data in this project pertains to midwives providing continuity of care and caring for a group of pregnant women and all of the midwife participants were LMC midwives. Midwife participants are identified as 'Midwife' and the first letter of their forenames to maintain their privacy. Two midwife participants had the same initial of their forenames: to prevent confusion in the analysis, one is denoted as 'Midwife M' and the other as 'Midwife MA'.

Discourses.

Three main discourses were apparent in the data, the most pervasive being that of a discourse of pregnancy. This discursive theme was perhaps the most obvious and yet the most elusive to analyse as it was taken for granted by both the participants and the researcher. Within this discourse is the concept of pregnancy as a time of risk, especially for first time mothers. A sub-discourse of

pregnancy as a time of risk is a sense by the midwife participants that they were being observed by persons outside their practice.

A second discourse was located around the concept of choice. Participants who were mothers made choices about caregivers, place of birth and cares for the third stage of labour. A sub-discourse of making decisions or having choices was the midwives use of clinical judgement, which would at times over-ride the choices made by the woman, if the midwife felt that the client's wellbeing was at stake. A further component within the sub-discourse of clinical judgement is what I have termed 'handing over'. Stewart (1982) stated: "it is easy to ...leave it to the experts to tidy up the scene (p.293); 'handing over' implies a relinquishing of decision making by the woman to clinical judgement of the midwife or physician.

A third discourse is related solely to the data of the midwife participants but impacts upon the care of the pregnant woman: this is a discourse of the education or training of the midwife participants. I have included this as a discourse because the acquisition of knowledge in Foucauldian terms implies entry into a discipline and 'the related disciplinary practices that control or create options and behaviours (McHoul & Grace, 1993, as cited by Gilmour, 2002, p.547).

The first part of this chapter considers the professional histories of the midwife participants to provide a setting for the information given to parents about care in the third stage of labour. I have described this as 'setting the scene'.

Setting the scene: professional lives.

I began data collection from the midwife participants by asking them to outline their professional lives as I wished to place the information about the birth of the *whenua* into context. For pregnant women, the birth of the *whenua* is situated within the individual pregnancy: for the midwife participants I was aware of the multiple influences that inform the practice of midwifery. As I noted in Chapter One (p.6), my own practice related to the birth of the *whenua* was guided by experience, knowledge obtained from studies and from colleagues. I was also aware that the midwives I interviewed were of a comparable age to myself and likely to have trained in similar medicalised environments of the 1970s and 80s. Prior to the interviews, therefore, I surmised that the participants' professional lives might evince discourses that would inform their stance about the birth of the whenua and thus affect the information given to mothers.

The midwife participants who had practised as registered nurses were more descriptive about their nurse training than those who had had limited

experience following qualification. Only one participant described her training in any detail and that was in relation to her obstetric module.

> *part of my training was to be an obstetric nurse so I think we spent six months doing obstetrics. Three months as a junior and three months as a senior. And when I finished my nurse training, a midwife was the last thing I wanted to be because it was pretty horrific down in the little maternity unit* (Midwife A).

Midwife J also did training that included six months as an obstetric nurse:

> *It was hospital based training so there was a lot of clinical experience…in that in three-and-a-half years I did six months obstetrics so I worked a lot.*

Midwife J goes on to say:

> *I had wanted to do my midwifery from when I was doing my nursing…(it) grew as I did my nursing…(and I) never bought into [the] medical model even before I knew what it was.*

Both these midwives identify that the care of pregnant women at the time of their training left much to be desired. Midwife A called the maternity unit 'pretty horrific'. Midwife J describes an antenatal clinic:

> *Sometimes it…reminded me of being on a farm really, you know...these sort of cubicles had like seventeen or eighteen little cubicles that people came in like a holding pen…and went out the other side.*

In addition to noting that care for pregnant women was not optimum, Midwife J speaks of a 'medical model' but it is unclear whether that concept is from subsequent reflection or that she was cognisant of a model or philosophy at the time of her training.

Midwife J goes on to say, of her family:

I have never thrived in institutions…my father brought all us kids up to be fiercely questioning.

Midwife J feels that as she progressed in her midwifery experience that she had 'an awful lot to unlearn'. Her data infers that she needed to 'unlearn' nursing when acquiring midwifery knowledge. Moreover, she suggests that she wished to practice in a different way. She states:

I think I saw a lot but I knew that even when I was doing it [her midwifery training] I knew that wasn't how I wanted to practice.

The above data identifies philosophies that were not coherent with the participants' way of thinking and describes, directly or indirectly, situations that they regard as unacceptable or constraining, both to themselves as trainees and to women in their care.

The two participants' material opens up a field within the data that is related to training and doing as one is told, not questioning those in authority. It depicts a discourse in Foucauldian terms as it implies or states a discipline in

that while acquiring knowledge, the participants are also molded into compliance.

Midwife M states of her midwifery training:

... [I] had the label as a good student because I just followed on, did everything I was supposed to do. I learned rapidly that if you wanted a good report[1] *you didn't question, you just went along with what was expected.*

Midwife S says:

I think the thing I remember about my training, both nursing and midwifery, was you would be told to do something and you would do it and you wouldn't question it.

These two participants indicate that they did not question what they had to do, or how they were to do it. Midwife S goes on to say:

You wouldn't think for a moment what the research said, what the latest evidence was, you just did it.

The data from these participants indicates that a component of the training of midwives was an enforced acceptance of the learning acquired therein. Midwifery trainees were encouraged to accept the situation and to act without question. Even Midwife J, who was encouraged by her family to 'always

[1] Where clinical training was done under the guidance of ward midwives, the senior midwife or sister would write a report that went to the student's tutor. This report would include clinical achievements and the attitude of the student. The reports were rarely questioned by tutor or student.

question people', is aware that to survive the training and to gain a midwifery qualification she needed to co-operate to some degree. She is, however, conscious that she did not want to practice in the manner she was taught (p.107).

The participants' data, therefore, demonstrates that the participants were confined to repeating what their training considered to be appropriate. This constraint included bodily discipline as illustrated by Midwife J who was told

> *It was unprofessional to be left-handed and I wasn't allowed to do anything with my left hand. So I had to do all my vaginal examinations and episiotomies and anything else that was happening with my right hand.*

The discipline of the training, therefore, extended into forcing Midwife J to use her non-dominant hand as to use the left hand was 'unprofessional'. Midwife J was not in a position to dispute this.

The data collected from the midwife participants moved quite rapidly from a description of where and when they had trained to being regulated as part of their education. This regulation involved not only the acceptance of certain knowledge(s) but in one case, the regulation of the body of the student. In addition, midwife participants may not have felt uncomfortable at the time of their training about the level of compliance expected of them, but mature reflection had enabled them to detect their adherence.

In contrast to the other participants, Midwife MA did not complete her midwifery education in the UK but went into midwifery after several years as a nurse.

Researcher: What made you decide to go and do midwifery?

I did get a wee bit bored and I was doing twelve hour shifts…I had been doing twelve hour shifts [as a nurse] for about four years.

Midwife MA's midwifery training was not a clinical training but was a degree course.

people were coming out with Masters in Nursing straight away so I thought what is the best way here education-wise. So I thought getting a double degree would probably be the best thing to do…

Researcher: So you got your Bachelor of Nursing and Bachelor of Midwifery?

Mmm…

Prior to gaining her academic qualification Midwife MA had been nursing for some years and on completing her midwifery degree she returned to her original place of work. She comments:

I actually really quite like midwifery and I liked the hours and I really liked the autonomy and that was something that was most definitely missing in nursing. Even though I was working in an intensive care area it is still very much missing.

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Midwife MA does not comment about any discipline that she encountered in her training or education but she pointed to a perception of difference between her experience of nursing and midwifery concerned with the nature of autonomy. Midwife MA's data is not explicit on what difference in autonomy she perceived but she does state it is noticeable when she returned to the work area after graduating as a midwife. She also indicated that knowledge about nursing and midwifery can be gained through academic application as well as clinical experience.

The data from the midwife participants pertaining to their midwifery education, particularly from those participants who experienced hospital training, clearly demonstrates induction into a discipline and that the discipline extended to modifying the body (p.109). The participants were encouraged not to question (p. 108) but to accept what was taught unequivocally. Such conditions imply that what is taught is 'truth'; it is produced by the discourse. In Foucauldian terms, discipline describes not only a body of knowledge—the discipline of midwifery, for example—but the creation of an individual through the mechanisms of discipline. Foucault expresses it as:

> It is not that the beautiful totality of the individual is amputated, repressed altered by our social order, it is rather that *the individual is carefully fabricated in it*, according to a whole technique of bodies and forces (Discipline and Punish, 1977, p. 217, my emphasis).

Despite the sensation in the data of being repressed by their training, I would argue that the participants are being willingly coerced into the discipline of midwifery in order to attain a midwifery qualification. Midwife A states:

> *Everybody got a scalp clip put on the baby's head even if they were in second stage…uterine catheters, the works. But I sort of figured pretty quickly that I was going to get a good training, it wasn't quite like I wanted but I thought well…all the time I was just thinking how I could do it differently (Midwife A, my emphasis).*

The data above illustrates that the midwife participants entered into a discourse of midwifery: they acquired knowledge and were expected to behave in a certain way, to be 'professional' (Midwife J, p. 109). In addition, discourses are

> permeated with power—power to inform and form, to dictate what is said and by whom and they are imbued with the power leading to acceptance of what comes to be seen as a truth (Gilmour, 2002, p.548).

Power in Foucauldian terms is productive: it produces knowledge (Foucault, 1977, p.27) and it also produces resistance: 'power relationships…depends on a multiplicity of points of resistance' (Foucault, 1979, p.95). Thus the midwife participants resist the discipline of midwifery:

> *it wasn't quite like I wanted [what] but I thought well…all the time I was just thinking how I could do it differently* (Midwife A).

I knew that wasn't how I wanted to practice (Midwife J).

I was always mousy-looking and also the clothes I wear are so conventional that people get tricked into thinking I was toeing the party line (Midwife J).

The discourse described in the midwife participants' opening data is one of being obliged to behave in a certain way in order to acquire knowledge. The data outlines the participants being unable to question but the participants describe overtly complying but covertly resisting the discourse by searching for different ways to practice (p. 112), or appearing compliant when not (Midwife J, above). Nevertheless, it may be that this resistance is the product of their mature reflection as earlier data implies that at the time, some of the participants did not question (p.108).

The discourse of midwifery training comes through strongly in the midwife participants' introductory data. Midwife MA stands out in that she did not feel constrained within a particular discipline during her midwifery education. She, however, has been registered as a midwife for a shorter time, and achieved her registration through an academic institution.

The data of the midwives' professional lives introduced the discourse that pervaded the data of the both the midwife participants and the participants who were mothers, that of a discourse of pregnancy. This discourse integrated the

data of the women and midwife participants. The discourse of pregnancy was also the most taken for granted in the data and formed the basis of all that was discussed in the interviews. It could be debated that pregnancy is a normal physiological process for the woman, and certainly the Partnership Model (Guilliland & Pairman, 1995) argues that 'pregnancy and childbirth are normal and healthy activities' (p.35). How then is pregnancy a discourse?

While it is obvious that pregnancy is a physiological process pertaining to women, I posit that the lens through which a pregnancy is viewed or interpreted is discourse. The participants who are mothers make themselves visible to the discourse and become subject to surveillance. The pregnancy is defined for the mothers by forces outside themselves. Foucault states that within a discourse knowledge is related intimately to power and the associated disciplinary practices regulate the behaviour of the subject (McHoul & Grace, p.71).Thus as the participants seek out care, they are also entering into the discourse.

The following data is from a participant who had experienced her first pregnancy and labour.

> *The first time I went to my GP [to have her pregnancy confirmed] and she never mentioned a midwife to me…I was sort of a bit lost then because I wasn't quite sure…but then they got me to sign a form and say yes you are pregnant and that was it.* (K).

K went to her General Practitioner (GP) to have her pregnancy confirmed but did not acquire information about a midwife. The data does not state why K expected this advice: this reflection may have arisen after her birth experience. She is aware that she requires care during her pregnancy and her data indicates that she believed her GP to be the entry point for care. K reports that she felt 'lost' when advice she was expecting is not proffered but she co-operates with the GP in signing a form to say she is pregnant. There is an expectation placed on K to sign the form about her pregnancy—'they got me to sign a form'—but she feels unable to clarify what she wants and does not ask for further information and remains feeling 'lost'. K goes on to say:

> *They said, "oh you know when your next appointment is"...and I thought oh, okay—I am just going back to them and they will arrange something else. So I just carried on.*

'They' appear repeatedly not only in the data for this project but in other works on the woman/professional relationship (Smythe, 1998, p.183). 'They' are always separate from and in a perceived position of power to the woman. In the above extract, K feels that it is necessary to sign the form for her GP, despite not being wholly satisfied with the meeting.

The above data illustrates the participant's entry into the discourse of pregnancy and a limited acceptance of the discipline of the discourse. K accords her GP greater knowledge than her and the authority to demand that

she sign a form. She accepts the appointment made for her, although with reservations, and her expectation is that 'they will arrange something'. The data is unclear whether this expectation is related to finding a midwife.

Participant V, likewise perceived her access to care as being through her doctor, in this case a specialist with whom she has prior contact. Like K, she is a first time mother.

> *We went to see the specialist when I was five weeks pregnant, I had just found out…I had seen her previously…so basically, as soon as I got a positive test I went and saw her…it was really exciting because she said, "see, I told you it would happen".*

When she returned to the specialist for another visit, the specialist had arranged for V to see a midwife

> *Anyway, she organised* (midwife) *to be our midwife.*

It is possible to deduce that, being a first time mother, V should have a similar knowledge base to K regarding care in pregnancy. I did not elicit from individual participants how well informed they were about care prior to their pregnancies. Participant V goes on to say:

> *We obviously just continued with our specialist because we had already seen her a couple of times. But even if we hadn't seen her prior to that I think we still would have gone done the line of seeing her or* (doctor), *I guess.*

V's data implies that she feels more at ease because of her previous contact with the specialist. The above quotation denotes some prior knowledge as V considers that she would have selected this option even if she had not met the specialist. In addition, V does not seek information about a midwife: she accepts that 'her' specialist will organise the care required for labour.

Both seek confirmation of their new status as pregnant women or mothers-to-be by attending a doctor, and both attend early in pregnancy, five weeks for V and prior to twelve weeks for K. Both women are unsure what to expect .

It was the first time and not knowing what was going to happen (V).

I wasn't quite sure who I was supposed to deal with (K).

Both women, however, access care through contact with a doctor or specialist. In the course of this contact both receive confirmation of being a pregnant person, through the signing of a form (p. 100) or the approbation of a specialist (p.101).

The above data indicates that K and V entered into a discourse of pregnancy by according medical practitioners the authority to designate them as expectant women. The discipline within the discourse is illustrated by the form signed by K, by V's acceptance that her specialist will confirm her pregnancy—'see, I told you it would happen—and the requirement of maternity care. The data does not overtly demonstrate a medicalised discourse of pregnancy but

the participants use of a physician as entry into the care system is suggestive thereof. The authority noted above, which recognises K and V as pregnant persons, is not repressive power. Foucault states that 'Power is everywhere; not because it embraces everything, but because it comes from everywhere' (Foucault, 1978, p. 93). Foucault goes on to note that 'power is not an institution, and not a structure' (Foucault, 1978, p. 93). K and V's entry into the discourse is an entry into a power relationship. This relationship is not confining but is perceived by the participants as enabling in that it allows them to access care. The discipline of the discourse, and here discipline is linked with bodies of knowledge as well as restrictive practices, suggests that the pregnancy discourse is linked with medicine and the institution of the hospital.

Pregnancy as risk.

Concurrent with the participants' entry into the care system, the data supports an implicit acceptance that birth occurs in the hospital environment. K states:

> *My midwife really wanted me to have a home birth…but because it was my first baby I felt better going to hospital*

Early in V's interview she stated:

> *I felt so much better when I got to the hospital…when I got to the hospital I was relieved*

Later in the interview, after describing her rapid normal birth, V speaks of a friend's planning home birth:

...I wouldn't entertain it [a home birth]...I am going to the hospital because I want to go to the hospital to have my baby and then everyone's there if they need to be there...

Both women suggest that as it is their first babies they are safer in hospital. V felt that a first baby is an unknown quantity

because it was my first birth definitely wanted to [go to the hospital]--it is just that unknown...

and K stated:

because it was my first baby I felt better going to hospital.

The implication in the data, therefore, is that birthing outside the hospital may be considered less than certain. For V, going into the hospital is associated with feeling 'better', being 'relieved'. Moreover, there is some suggestion that it is inherently problematic being women having their first babies.

The data regarding the place of birth opens a sub-discourse of pregnancy as a time of risk. Saxell (2000) cites Douglas in stating that the connotations of risk do not include the possibility of a positive outcome but is entirely negative: risk 'has come to mean danger'. A 'high risk' pregnancy, therefore, is fraught with danger (p.90). In the above data, the participants do not mention risk but associate the hospital with a place of safety, especially for their babies. V states: *I want to go to the hospital to have my baby then*

everyone's there if they need to be there. By implication, the uncertainty of having a baby requires extra assistance.

Both K and V speak of the particular uncertainty of having first babies. Davis-Floyd (1992) notes that women seek 'a kind of psychological reassurance...individually face...unknowns'. She goes on to say that women are provided with 'at least a sense of certainty and security that their babies will get born, and that neither they nor their babies will die' (p.64). Davis-Floyd describes the ritual that surrounds hospital birth to be perceived by women as re-assuring, that terrifying natural processes are understood and controlled (p.64): I would argue that while institutional care may be less ritualised than the American birth setting of Davis-Floyd, the data above supports the supposition that the participants view birth in hospital as re-assuring. Indeed, V speaks of being 'relieved' when she reached hospital.

When the participants leave hospital after the birth, there is hesitation about leaving the ward environment:

> *By Sunday I wanted to go home but I was absolutely terrified. I was crying my eyes out leaving the hospital, just because it was nice and safe and secure in there and you press a button and some-one comes* (V).

In describing the ward as 'safe and secure', V obviously feels vulnerable going back to her home environment. Moreover she enjoys the sensation that there is

help at hand. It is noteworthy, however, that V calls the midwives employed by the hospital as nurses:

I buzzed the nurse and the nurse came along and said…

From her data I would surmise that V sees the employed midwives as nurses as they work in the hospital environment and wear a uniform. Her continuity midwife, however, is called by her first name or '*my midwife'*.

K also found coming home difficult but her reasoning is different:

I think the hardest thing I found was coming home…I had come home and had this little person—what was I to do with her?

As a first time mother K was aware of having the responsibility of a baby to care for. She did not feel attached to the hospital environment. The midwives in the hospital, however, considered that she should not go home:

One of the midwives there didn't want me to go home and she rang my midwife and made us feel terrible…my husband and I were about to leave and she said, "Oh, I don't think you should go home" and she made us feel like children.

In the above extract the participant feels happy to go home. She is cognisant of the responsibility she has for her baby but is unafraid. Her data portrays she is challenged rather than afraid. Conversely, it is the hospital staff that feel she is unready to leave and contact her LMC midwife. This data

demonstrates staff feeling that they have the right to challenge K's decision: K accords them some power by permitting a staff member to contact her midwife and then justifies her reasons to leave:

> *I said to her "I have lots of support and I would feel better in my own home".*

K's feeling of belittlement and her need to justify her decision denotes her belief that the institution has some authority over her. In order to have the security of a hospital birth (p.119), she must become part of a discourse that states that pregnancy is a time of risk and that the institution can negate or reduce that risk. After the birth, when she wishes to leave the unit, the same authority she granted the hospital is used to challenge her decision to go home.

The data quoted above indicates that the participants considered birth, particularly a first birth, to be risky (p.119). For V, the need for security continued into the postpartum period, whereas K felt more at ease. Moreover, the staff of the unit felt that K required a longer stay than she did and challenged her decision to leave thus demonstrating that they too felt that K was at risk going home. That K permitted this challenge, and felt belittled by it, expresses her belief that the institution or the people within the institution, are able to countermand her decisions. McHoul and Grace (1993) state that 'the types of instruments and techniques used by the operations of disciplinary power can be taken over and used by any institution' (p.66): thus although the

building itself is not seeking to prevent K from leaving, her associations with the institution cause her to feel she should ask permission or provide an explanation. One is 'admitted' and 'discharged' from a hospital by some-one: one does not come and go, as in one's own home. In addition, the staff were perceived as 'nurses' (p.121) rather than midwives, perhaps linking to the suggestion of less than complete autonomy found in Midwife MA's data(p.110).

Risk and surveillance.

This sense of pregnancy as a time of risk is echoed in the midwifery data. Midwife MA is speaking of the institution where most of her clients birth, and of the third stage of labour:

> *The institution where I currently work is certainly opposed to physiological management... If a woman wants to have a postpartum haemorrhage to some degree and you hadn't given active management or you hadn't offered it to the woman...then I do think, actually, your head might roll...*

Midwife MA considers that even if a woman were fully aware of the risks of postpartum haemorrhage and preferred to have a bleed rather than receive drugs then this would be frowned upon in the institutional environment. Midwife MA's data introduces a further strand within the midwifery data pertaining to pregnancy as risk, that of being observed from outside midwifery practice.

In her data Midwife S suggests that in some circumstances midwives consider that they are being observed:

> *I was an LMC midwife in [town] and I was lucky enough they didn't really have anyone peering over my shoulder telling me what to do.*

Midwife M reflects this concern of being observed in her data in relation to time for the birth of the whenua:

> *That hour is still in the back of my mind. And I think it is true if you transfer someone [from a homebirth] I am conscious that the doctors look at you if it has been longer than an hour...I think that...you are held negligent if you had left it too long or brought in a severely compromised woman...your management might be looked at in a big way.*

All the above participants are identifying a view of their practice that comes from outside the midwife-woman relationship. Such observation may be from the institution, from medical staff or possibly from colleagues but it is separate from the midwife participants and impacts upon their practice and by implication, on their care of the woman. There is an impression, especially from Midwife M's data above, of the entity outside the midwife being able to restrict and/or judge the midwife's practice even if it occurs outside the institution. I would also conjecture that such judgement could occur even if the midwife were upholding the woman's wishes.

Midwife MA's contention that a woman may choose to bleed instead of receiving routine care is contentious but illustrates the awareness of friction between institutional demands and that of the woman's choice. In Chapter Two, page 49, I pointed out that research does not define if there can be too little blood loss after a birth (Gyte, 1992). Texts on Maternal physiology (Blackburn, 2003; Coad, 2001; Stables, 1999) indicate that maternal physiology is superbly adapted to accept blood loss at birth. Midwife MA's data, however, suggests an awareness of a discourse that over-rides the choice and understanding of the woman and/or midwife.

Choice and clinical judgement.

Choice is a huge issue in healthcare today and particularly in maternity care. Section 88 (Notice pursuant to section 88 of the New Zealand Public Health and Disability Act 2000), which governs maternity care in New Zealand states in its opening pages:

> Each woman, and her whanau and family, will have every opportunity to have a fulfilling outcome to her pregnancy ad childbirth, through the provision of services that are safe and based on partnership, information and *choice* (p.11, my emphasis).

Standard two in the New Zealand College of Midwives Standards for Practice (2002) is stated as follows:

> The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience (p.9).

It goes on to say that the midwife:

- Shares relevant information, including birth options, and is satisfied that the woman understands the implications of her choices.
- Respects the woman's right to decline treatments or procedures.
- Clearly states when her professional judgement is in conflict with the decision or plans of the woman (p.9).

Both the law and the NZCOM standards pertaining to midwives, therefore, support choice. Do the data support this in the interviews of midwife participants and the reflections of the participants who had given birth? The data cited here is in relation to choices made by women for the birth of the *whenua*.

Most of the participants discussed the birth of the whenua with the woman in the antenatal period.

> *I always discuss the third stage of labour at some point in the pregnancy usually you know after midway when we are heading up to start to think about birth issues more…and I have a little booklet that I put together and I use that as a discussion document (Midwife C, booklet, Appendix I).*

Midwife M also uses a self-written document to assist women in understanding the choices of care for the birth of the whenua.

> **Researcher: What is your usual practice in the third stage of labour?**

Usually there is a handout that I have developed myself that I give out to women. So that is usually discussed antenatally (Midwife M).

Midwife M goes on to talk about the actual birth of the whenua. She says:

I think my tolerance for the bleed though is a wee bit lower than what it used to be, because I have been caught on a few where several gushes [have occurred] and when you add them up, have been quite a significant bleed.

Midwife M discusses care for the third stage with the woman but places limitations on the process if the blood loss appears excessive. The data did not denote whether the above possibility was discussed with the woman but I would surmise that Midwife M would judge/assess the situation at the time of birth.

Midwife M's data describes a situation where she provides the woman with the information to enable her to choose between active and physiological care but also leaves scope for her [the midwife] to exercise her clinical judgement at the time of the birth. In Midwife M's data are the boundaries that she has placed around preventing the woman having excessive postpartum blood loss.

Midwife J does not use a leaflet but also discusses care for the birth of the whenua in the antenatal period. She is specific about what she tells the women:

I always talk about [the third stage] when we sort of start going through the birth plan. So we usually do that over four or five or six sessions and part of that is talking about what is normal in labour…and what happens when things are not okay, or go wrong…so when I talk about what is normal in labour I talk about the latent phase, the first stage, second stage and third stage. I talk about the normal physiological pattern of what happens with the uterus…the contractions and the placenta peels off and that is when there is bleeding and that's when…you push the placenta out.

When discussing the birth plan Midwife J locates the birth of the whenua within the labour and describes the physiology pertaining to this specific aspect of birth. She expresses the labour continuum by giving equal weight to the first, second and third stages of labour. Midwife J does not pretend that the process is always straightforward but describes the normal physiology of labour prior to discussing any pharmacological assistance:

When I am talking about the normal, what's normal in labour at this stage I mention Syntocinon and how Syntocinon works. And how I always have Syntocinon available in the room.

As with Midwife M above, Midwife J's data implies a boundary of normal for her. Midwife J describes the normal third stage to the pregnant woman and drugs available if required. Midwife J's data intimates that within the setting of a

normal labour (p. 145, above) physiological care for the birth of the whenua is normal; in circumstances where drugs are needed, they are available. The data does not support routine, non-individualised care for the labouring woman. In addition, both Midwife J and Midwife M describe boundaries, Midwife M more clearly. Both participants reserve space in the labour situation for the application of their clinical judgement and the use of interventions when required.

The data of Midwife S illustrates a further aspect of choosing a mode of care:

> *... my feeling from the evidence is that physiological (care) is a reasonable thing to do. I know the woman very very well, that's something else that makes a big impact on my practice if I have known a woman for six months.*

Two factors can be identified from Midwife S's data: she regards her knowledge of the woman as very important to her care, and I would surmise from the above section that it is knowledge of the whole woman, not just her choices. Midwife S combines this with knowledge of the 'evidence' pertaining to the third stage. Such juxtaposition would suggest that both influence Midwife S's care. Midwife S sums this up as:

> *What the evidence is, what my clinical judgement is, what is going on with the woman [at that time in the labour].*

Midwife S's quote above is a concise summary of a complex decision: to determine a choice of care is not only weighing option A against option B but an interaction between carer and recipient during the course of the labour. Moreover, whatever decisions regarding care in the third stage are made in the antenatal period, the midwife may use her clinical judgement to implement other cares at the time of birth to maintain the wellbeing of the woman.

Midwife C also discusses with the woman circumstances when she may need to intervene:

Researcher: But there is still space for your clinical judgement?

I discuss with the woman that the situation can change and…I would discuss the fact that if I felt it necessary I would let them know…and I do say, " I feel that we should now give you something".

Researcher: So they really have got…great confidence in your clinical judgement…

Yes and I have never had anyone question me on that aspect of the care.

Although Midwife C implies that she will act if she feels the situation may be detrimental to the mother 'if I felt it necessary', in the interview, I emphasise that she is reliant on her judgement. Midwife C confirms this and adds that she has not been questioned on her care. I would surmise that Midwife C's

knowledge of the woman and her situation, accompanied by an explanation to the woman, should support her actions.

The space created by the midwife participants for clinical judgement and an awareness of maintaining the wellbeing of the birthing woman introduces the next section of the data. Midwife S's data, as stated above, illustrates that choice is far more than A over B: even if the woman has made a specific choice of care the midwife retains the discretion to act, to use her 'clinical judgement'. From the data cited above from Midwives M and J, the implication is the use of medical assistance to prevent compromise to the woman. The following data illustrates, however, that the midwife participants judge when it is suitable not to perform active care, even if chosen by the woman.

Midwife S describes how she feels when providing active care for the birth of the *whenua*:

> *When I do active [management] I get anxious about it because now it feels so strange...it just feels dangerous because I am pulling this placenta out of a woman.*

She goes on to say about choices for third stage care:

> *I don't really give them a choice about third stage now. I would have done but I don't really because I don't give women choices over what I call my* routine practice*...do we need to go through this menu choice*

thing with third stage? And I was thinking no, I don't need to do that, physiological management is routine *for me. (My emphasis).*

I have singled out this data for two reasons: firstly because of its apparent contradiction with Midwife S's earlier data, in which she states that she takes into account the evidence, the events at the time and her own judgement and then that she describes part of her practice as 'routine'. In the Literature Review I ask 'whether routine application of active management is efficacious for all labours' (p. 52). Midwife S's statements appear to imply that the application of physiological care is suitable for all labours. Yet taken in association with her previous assertion of considering the birthing situation, I posit that Midwife S is stating that no other care is required in a normal labour. If the labour is uneventful then the birth of the whenua should be uneventful or 'routine'. I would suggest that 'routine' in the above data has the implication of 'usual' or 'commonplace, just as one would surmise that a woman being pregnant is 'commonplace', perhaps being noticeable rather than notable. Midwife S's data carries the expectation of normality: indeed, her quote about active care feeling 'dangerous' suggests that she regards this type of care as being abnormal.

In Midwife J's data there is a suggestion of both clinical judgement in normal situations and her awareness of practicing in a wider situation:

Even in the hospital and there is someone tricky and I am in the room by myself and they [medical staff] are saying active I just sneak in a physiological third stage and then they[the woman] can have some Syntocinon.

Midwife J will try to do physiological care even when directed to do active care, giving an ecbolic drug after the birth of the whenua rather than using it prophylactically. Her belief in the efficacy of physiological care stems from her experience abroad in a developing country where she felt that ecbolic drugs heightened the risk of retained placenta.

In the data it would appear that while the midwife participants overtly support the rhetoric of choice and the standards of practice (NZCOM, 2002), they reserve for themselves the right to make clinical judgements. The participants who are mothers echo this:

Then the pain was getting quite intense because you get those pains to deliver it. And I said "oh you know that injection which is the one you get to deliver it, why don't you give me one of them…then it will stop the pain". And she said, "No you don't really want that, T". [I said] "oh yes I do, go and get it".

T's midwife goes and while she is away T births her *whenua.* When asked if the midwife returned with the uterotonic, T says

Well, no, she didn't go to get it she was just ignoring me…I delivered it (the whenua).

Similarly K concedes to her midwife's suggestion:

We had planned not to have the injection…we were going to do it naturally…but once again I just put that injection side of it in the midwife's hands…she said to me "oh you know we are going to put an injection in because it is safer to get it out now".

In both of these instances the women had chosen to have a particular type care for the third stage of labour and in both cases the midwife appeared to over-ride their decisions. In her data, T believes that the injection will assist with relieving her pain but a uterotonic will increase not decrease uterine activity. With K, an assisted birth usually requires a uterotonic as postpartum haemorrhage is more likely following intervention (ALSO, 2001, Section J, p.3). The midwife reasoning was justifiable but not in line with the woman's choice.

Midwife MA also offers a view on women's choice when discussing the Consensus statement on the third stage issued by the New Zealand College of Midwives (Appendix A):

So they [the College of Midwives] weigh quite heavily on [choice], every midwife has to go with the woman's choice but what has always amazed me about those kind of statements and type of protocol things, is it alright to say go with the woman's choice but how do women choose? How

much information, are we giving the right information, do they even understand the information we are giving them?

Midwife MA recognises the concept of a woman choosing care but is concerned about the ability of the woman to make a choice. I would conjecture that, from the above quote, that she is questioning whether the information a midwife gives for making a choice is sufficient, and whether she can be sure the woman understands the consequences of her choice. It is in such circumstances I posit the midwife participants reserve for themselves the necessity of applying their clinical judgement.

The data of the midwife participants and the women who have birthed denotes that choice is an important value to them but it is not without limitations. The limitations are described as clinical judgement and would appear to be the midwife's use of her experience/knowledge of labour and birth used for the benefit of the labouring woman. Midwife S's data, however, raises the question of firstly, routinised care based on midwifery knowledge; Midwife J's data suggests that it is her agenda rather than that of the woman or the situation that affects her clinical practice when she says

[When] I am in the room by myself and they (medical staff) *are saying, active, I just sneak in a physiological third stage…*

I feel convinced that Midwife J considers that she is safeguarding her client by 'sneak(ing) in a physiological third stage' but it does suggest, as do the data of

Midwife S (see pp. 131-2) and Midwife MA (see p. 134) that the intent is to retain some power or influence over the choice of the woman. In addition, the data of Midwife MA returns to the concern of surveillance: how does the midwife know that the woman understands the information and knows the implication of what she is choosing. By retaining a space for clinical judgement do the midwife participants retain for themselves the option of disregarding the choice of the woman should they feel that either she or themselves as professionals, are in jeopardy?

'Handing over'.

An adjunct to clinical judgement for the participants who had give birth was the ability to 'hand over' to a professional a choice: 'handing over' might occur, for example in labour or if the participant felt unable to make a decision. K 'hands over' to her carers when asked by medical staff to make a decision in the course of her labour:

> *I just let* (midwife) *take over really.*
>
> **Researcher: So you felt confident enough to trust her to support you and your husband?**
>
> *...he said they [the doctor] asked me if I should do it and I didn't quite know what to answer and I just looked at the midwife.*

The 'handing over' in this extract appears equitable in that it allows K to concentrate on her labour and birth. It is not without some unease, however, as the midwife directs K to get onto the bed to facilitate an assisted birth:

> *I planned to have E on all fours but the doctor said, "No, you have to get on the bed". And I said, "Oh, I don't want to" but she [the midwife] said "Come on you need to get on the bed".*

K goes on to say that although she wanted to birth her child on all fours she assented to the request because

> *In the end I thought, no, she [the midwife] knows, you know.*

K has some reservations but assents to the requests of the midwife and doctor because she ascribes to them, particularly her midwife, a greater knowledge of the situation than she has.

V identifies an entirely different position for her 'handing over': she places herself in the hands of her caregivers as professionals:

> *I said okay what's this birthing plan…she said basically the plan is you meet me at the hospital and we deliver your baby…between you and me and the specialist we safely deliver your baby, that's the plan…when she said that it was like that just click with me, sort of like, effectively* <u>I am paying you to safely deliver my baby</u> (my emphasis).

V equates professionalism with a financial arrangement and that her caregivers, midwife and obstetrician, are persons in her employ. Cronk (2000) points out that being in the woman's employ places the caregiver in the role of

'professional servant' (p.21) and this is clearly how V regards her caregivers. By paying for her care, directly or indirectly, she implies that she can 'hand over' to her caregivers, for them to do the job for which she employs them. Although V hands over to her caregivers, she states' I give *you a right:* the dynamic remains that of V being in control, it is not something she is permitted to have by her caregivers. Cronk (2000) states:

> As thinking professionals, we do not demean ourselves as professionals by fostering an adult-to-adult relationship between us and the people for whose benefit we practice and by who we are paid, directly or indirectly, to give a professional service (p.26).

'Handing over', therefore, is a facet of clinical judgement, whether the woman ascribes greater knowledge to her caregiver as K does (p.137) or because she feels that she is employing a professional to care for her as V does. 'Handing over' suggests that the participants are able to relinquish part of the responsibility for a choice to their caregivers. Indeed, V's data implies that 'handing over' is necessary to achieve a safe birth. V is not asked to undertake specific decisions regarding her care but that 'between you and me and the specialist we safely deliver your baby'.

I would conjecture, therefore, that 'handing over' and clinical judgement are linked in that the practitioners retain a space for clinical judgement, to act for and on behalf of the woman, and that the woman, in 'handing over' agrees to

the practitioner retaining that power. As such, both clinical judgement and 'handing over' relate back to the perception of risk in pregnancy. It would appear that in arguing for the necessity of clinical judgement the practitioner retains for herself the right to judge risk to the woman.

Summary

While this has not been an exhaustive examination of the data, three main discourses were located. One discourse was located in the data of the midwife participants and pertained to the discourse of midwifery education. The majority of the participants, on mature reflection, felt that their training disciplined them in the sense that they accepted information unequivocally. One participant was obliged to use her non-dominant hand as to be left-handed was 'unprofessional'. Despite their reflection and a desire to practice indifferently, the participants appeared to regard their training as 'good' (p. 112).

The discourse of pregnancy pervaded the data of both the women and midwife participants and was largely taken for granted by the participants and the interviewer. Pregnancy is a natural condition for women but can be viewed through various lenses—medicine or birthing at home, for example. The discourse in the data located the pregnancy in a risk framework. As such, the participants who had birthed felt more at ease in the hospital environment where they felt reassured that assistance was at hand. As Saxell (2000) notes, risk is rarely associated with a positive outcome.

Risk contributes to the midwife participants' feelings of surveillance. This was not a large part of the data but was significant in that the midwife participants felt that it affected their practice even when outside the hospital, and that those reviewing their practice were outside the midwifery context (p.124).

Choice and clinical judgement were also evident in the data. Choice is prominent in the literature from the New Zealand College of Midwives (2002) and in section 88 (Notice pursuant to section 88 of the New Zealand Public Health and Disability Act 2000) the importance of choice is emphasised. The midwife participants describe how they assist the women to make choices but reserve for themselves clinical judgement, which is applied if the midwife considers the woman's wellbeing is at stake. This reservation for clinical reasoning appears to reserve for the practitioner the power to override or disregard the choice of the woman in her care.

The presence of clinical judgement is reflected in the data of the women who have birthed in that they feel able to 'hand over' to the practitioner part of the responsibility for a decision, feeling that the practitioner has greater knowledge. One participant remarked that she was paying for professional advice (p.137).

In the final chapter of this thesis I discuss how this project has addressed the question of choices of care in the third stage of labour, the limitations of the study, the implications for education and practice and the suggestions for future research.

Breathing

It was a good idea she said to

keep breathing and I discovered she was right

not long after I stopped.

The stillness unnerved me so

quiet all that remained drumbeat strain

as that faded I thought

(though it was far away and small)

I heard a voice saying

0.0042…

your 0.0042 is too short for perfection

but maybe you

will not die foolish.

So sighing perhaps not and hearing soul's systems boot reboot

I began again.

Kate Alice

August, 2004.

CHAPTER SIX

Discussion

> 'Decisions about individual care should take into account the weights placed by pregnant women and their caregivers on PPH and blood transfusion compared with an intervention-free third stage' (Elbourne et al, 1998, p.698).

> 'the Hinchingbrooke trial makes it difficult to advise expectant management of the third stage of labour under any circumstances. It is difficult to understand how a woman who has not had appropriate counselling would decide to have expectant management' (Prendiville, 1998, p.1959).

Introduction.

The title of this study is 'Choices of care in the third stage of labour-a discourse analysis'. I have chosen to open this final chapter of the project with quotes from the Hinchingbrooke trial and correspondence following its publication, as I consider that the data examined reflects the difficulties faced by practitioners when addressing the complex interaction between 'choice' and 'clinical judgement'.

This chapter seeks to identify whether the study has addressed the research question, identifies the limitations of the project and makes recommendations for education, practice and further study. Although care for the birth of the *whenua* has been studied intensively, I question whether the studies have explicated the nature of choices made by the women.

The discourse of pregnancy.

The discourse of pregnancy runs throughout the project and is taken for granted by the literature, the participants and the researcher. It forms the basis of all questions and studies and is, paradoxically, the most difficult to identify. Throughout the project I efer to texts that regard pregnancy as a normal, if not everyday, condition for women (Guilliland & Pairman, 1995; New Zealand College of Midwives standards for practice, 2002; Notice pursuant to section 88 of the New Zealand Public Health and Disability Act 2000). I was questioned, late into the study, as to whether pregnancy was not just 'a state of being' (Benn, 2004, personal communication) for the woman. While pregnancy is a state of being for the woman, I posit that the manner in which a pregnancy is viewed by the woman and midwife is negotiated by and through discourse. In the project I identified a discourse of pregnancy as risk and uncertainty that caused the participants who were women to consider the hospital as a place of safety, a more certain situation in which to birth their babies, especially first born babies (p.119). For one participant, this feeling of security extended into fear of leaving the hospital with her new baby (p.120). Staff members also believed

that the hospital was protective of mothers and questioned the decision of one participant to leave the unit (p.121).

The discourse of pregnancy in the data of the mothers, therefore, was one of risk, with more certainty being attached to birth in the institution. This risk discourse was reflected in the midwife participants' data in that they had a sense of being overlooked in their practice to some degree. The data does not indicate whether or not they considered this surveillance to be supportive or not, but it was perceived to be extrinsic to their practice. Two midwife participants identified a sensation of being critiqued in the practice (Midwife MA, p123; Midwife M, p.124), even if they were co-operating with a woman's choice of care. The area in the data dealing directly with surveillance is small but it could be surmised that much of the detailed discussion the midwife participants have with women around choice is based upon an awareness of the possibility of critical assessment of the choices made for care. Midwife MA states:

> *... If a woman wants to have a postpartum haemorrhage to some degree and you hadn't given active management, or you hadn't offered it[active management] to the woman...then I do think actually [that] your head might roll...*

Choice and clinical judgement.

Midwife MA's data directly contradicts the quote from Elbourne et al which indicates that the woman's preferences should be consulted before

deciding on care for the birth of the *whenua* and falls more into line with Prendiville's assertion that with 'appropriate counselling' all women would choose intervention for the third stage. Moreover, Midwife MA implies that in the event of a postpartum haemorrhage her care, and perhaps the information she had supplied, would be in question; her 'head would roll', she would be to blame.

The sense in the midwife participants' data that they were under scrutiny relating to the choices made by the women in their care linked to the major discourse in the data, that of choice. I was not surprised that "having choices" featured so prominently in the data, as is it is a dominant feature in healthcare today (www.moh.govt.nz). A sub-discourse of choice, however, was clinical judgement and its presence in the data was closely associated with the practitioners retaining the power to decide on a course of action for the good of the woman, even if it went against the stated choice of the woman. When viewed in this light, the participants reserving the right to over-ride a stated decision, it appears that despite the rhetoric of choice, despite a wealth of information, the midwife participants preserved the final decision on care for the birth of the *whenua* for themselves. The justifications for clinical judgement appear sound: Midwife S bases her decisions on knowing the woman in her care and her experience of labouring women. Midwife C considers that when she feels that the situation warrants intervention her knowledge of the woman

and the situation causes her client to agree with her decision: *I have never had anyone question me on that aspect of the care.*

Based on the midwife participants' description of extrinsic surveillance, however, I would posit that the midwife participants' retain this power of clinical judgement for three reasons: firstly because they consider that their decisions will be reviewed if the outcome is less than positive or requires medical assistance (Midwife MA, p.123; Midwife M, p.124); secondly, they may feel uncertain about the ability of the woman to make a decision (Midwife MA, p. 134) and lastly the woman herself expects the practitioner to be able to assist her in making a decision. Data available from the MIDIRS website (http://www.infochoice.org/) demonstrates that midwifery worldwide is seeking to provide 'clear, unbiased, comprehensible information' on which a woman may base her decisions: if, however, the practitioner reserves the power to overturn these choices, are these decisions then rendered invalid and without true import?

The data on midwife participants' doubting the ability to make an adequate choice is sparse, and may be linked to the sense of being under surveillance. One midwife asks:

> *It is all right to say go with the woman's choice but how do women choose? How much information, are we giving the right information, do they even understand the information we are giving them?*

In circumstances where a practitioner is uncertain that a woman understands the 'implications of her choices' (NZCOM, 2002, p. 9), it will appear reasonable that the practitioner reserves the right to exercise her clinical judgement on a situation. Nevertheless, New Zealand law only demands that we provide information, it does not demand that we ascertain if a person understands that information (Court, personal communication, July 2003). While part of giving information is to present possible implications of taking on/up particular choices, judging whether a woman understands the implications of her choices may not be open to objective assessment.

One of the midwife participants was noticeable in her statements about care for the birth of the *whenua.* Midwife S stated:

> *I don't really give them a choice about third stage now. I would have done but I don't really because I don't give women choices over what I call my* routine practice*...do we need to go through this menu choice thing with third stage? And I was thinking no, I don't need to do that, physiological management is* routine *for me. (My emphasis).*

In Chapter One I asked if the normality of childbirth had become rhetoric and that in the birth of the *whenua* midwives returned to the comfort zone of 'routine, medicalised childbirth'. Midwife S's data does appear to support some form of routinised childbirth but is it more a midwifery routine of normalising childbirth but retaining clinical judgement to use intervention if the situation calls

for it. Indeed, the call for intervention may be ignored if the midwife judges that the woman is not in need of it, as was the case in Woman T's experience.

'Handing over'

The data in which the mothers describe leaving decisions to their caregivers I have designated 'handing over'. The process is one whereby the participant allows the practitioner to make a decision regarding care, either because the woman feels that the practitioner has more knowledge than she (p. 137) or because she views the relationship as both professional and commercial (p137). The mothers in this study do not seem to regard 'handing over' as disempowering: rather they ascribe to the view that, either through greater knowledge or other means, the practitioner caring for them is more able to make a sound decision. From the midwife participants' data it would appear that by retaining the right to make a clinical judgement based on the events of the labour, the midwife participants make it possible for women to 'hand over' decisions to them.

The concept of handing over a decision to a practitioner on the basis of clinical judgement is both alluring and problematic for a practitioner. It makes possible clinical actions based on current information of the labour and it enables the practitioner to disregard what s/he may consider unsafe or unwise decisions by the woman and her family/whanau. It is problematic in that it may, in some circumstances be seen to over-ride the autonomous decision of an

adult (Court, personal communication, July 2003). The questions of appropriate choices and safe decision making are significant and outside the range of this project but are certainly raised by the data from all the participants in the study.

Limitations of the study.

It was unfortunate that the study did not recruit any midwives employed by the facility. Practitioners in the facility, midwifery and medical, feel at times that they are 'the ambulance at the bottom of the cliff' (Tout, personal communication, July 2003), the last resort after an inappropriate decision or action has compromised the wellbeing of the woman. Their views on women and midwives choosing methods of care, which could be seen as unsuitable to the situation, are thus missing from the project. Moreover, the facility midwives may feel that the conditions of their employ oblige them to follow the guidelines in Appendix A. I do not suggest that employed midwives are any less autonomous in law than their self-employed colleagues but they may perceive their obligations differently.

Maori mothers and midwives were likewise barely represented in the project. I did not ascertain the ethnicity of the participants but I was aware when recruiting for the study that Maori represented approximately 6% (www.nzhis.govt.nz/publications/maternityreport02) of the population of the area. As identified in Chapter One (p.7), my experiential knowledge is that Maori deal with the *whenua* differently and the lack of Maori participants meant

that this facet of the birth of *whenua,* its handling and disposal after the birth, have not been part of the study.

A further limitation to the study has been the small number of participants recruited. As noted in Chapter Four, (p.92) six midwife participants were recruited to the study and four women who had given birth. Data collected from the participants who had given birth was sparse around the choices pertaining to the birth of the *whenua*: the paucity of data in the participants' accounts does not, I suggest, indicate disinterest but that their focus was on the baby rather than the birth of the *whenua*. A larger group of participants would be needed to confirm or refute this supposition. Moreover, the group did not contain any mothers who had birthed at home: Banks (2000) considers that in home birthing there is much more to be considered than the need or not for 'synthetic hormones': 'the woman's nutritional status, confidence in the birthing...the calmness of the birth scene' (p.183). Mothers who birthed in a known environment with a known caregiver are missing from my study. Indeed data pertaining to the birth of the *whenua* at home is limited in the literature to a retrospective postal survey conducted by Pritchard, O'Boyle and Hodgen (1992).

Recommendations for education.

As noted at the beginning of this chapter, Elbourne et al recommended that both practitioners and mothers should weigh the relative benefits and risks

associated with both active and physiological care. The data demonstrates that mothers largely disregard the birth of the *whenua,* focussing on the baby. Nevertheless, postpartum haemorrhage still has significant morbidity so midwives beginning or new to practice need to be able make women aware of the implications of their choices, particularly when those choices go against the recommended practice of either the practitioner or the institution (Cochrane Database of Systemic Reviews, 2002).

Elbourne et al state 'Midwives need to be competent and confident in both approaches' (p.698). Practitioners new to midwifery, therefore, need to be confident and competent in both physiological and active cares when birthing the *whenua*. Such competence may not be easy to attain in the institutional environment but practitioners should not use active care as their 'fall back' position: active care is used at the express choice of the woman or if the situation demands it. Beginning practitioners should beware of providing 'piecemeal' care that is neither active nor physiological care and has the potential to be unsafe (Featherstone, 1999).

Recommendations for practice.

This study neither aimed to replicate any of the randomised controlled trials mentioned in Chapter Two, nor did it seek to critique methods of care when birthing the *whenua*. The results of this study, therefore, will not impact directly upon clinical practice. I would suggest, however, that opening up a

further consideration of how choices are made by pregnant women and causing midwives to be aware of when and how they use clinical judgement may facilitate greater understanding in the midwifery relationship and minimise the possibility of erroneously disregarding the considered decisions of a fully aware autonomous person.

Recommendations for further study.

The small number of participants in this study obviously limited its scope, especially as data was scant around choices relating particularly to the birth of the *whenua.* A further study with a greater number of participants who were mothers may gather more data in this area or confirm the 'handing over' of some of the responsibility at that time to the clinical judgement of the practitioner.

The lack of participants who identified themselves as Maori in both the mothers and the midwife participants is a further area for study. It may be that such a project is more suited to a Maori practitioner but investigation into the value of the *whenua* to Maori, and its handling and disposal after the birthing would contribute to our understanding of the cultural significance of and different cultural practices related to the *whenua.*

As noted above, no mothers who had birthed at home were recruited into the study and there is little in the literature about this small group of women.

Current data on the number of women birthing at home is inaccurate, as statistics have not been collected from all homebirth midwives but approximately 5% of births were at home in 1997(Banks, 2000, p.119). Any study conducted on this small self-selected group of women would require recruitment from a wide area in order to obtain a representative selection of mothers.

The discourse(s) of pregnancy are ripe for further investigation: the discourse of pregnancy within the data of this project is taken for granted by the participants and the researcher yet forms the basis and background of the study, the literature reviewed and the data collected. A fruitful area of study would be the popular construction of pregnancy within the media, which is available to women prior to having their first baby. I surmise that it is the popular discourse on the Internet, television and in media such as 'Women's magazines' that shapes the discourse that denotes pregnancy as a time of risk.

As noted above, choice is a word used liberally in healthcare: the discourse of having choice, particularly as it pertains to and is limited by clinical judgement, merits further detailed study. Having Choice as a discourse used by the participants, and in the literature studied, is in danger of becoming rhetoric if the considered choices of women can be overturned by practitioners who feel themselves at risk from the decision and who thus implement clinical judgement for their own protection. The quote from Prendiville, which opened this chapter,

illustrates a belief that appropriate counselling will lead a woman to take the advice of her caregiver specifically against the choice of the dominant active management. A choice that challenges that advice, or an informed refusal, is worthy of further consideration. Moreover, investigation of events where clinical judgement has dictated a course of action which is inimical to the mother and her family/whanau would be of benefit in the increasingly litigious climate of maternity care.

Summary

This study has limited itself to consideration of the choices of care in the third stage of labour. The data, however, indicates that the birth of the *whenua* is intrinsic to the whole pregnancy and birth. For the mothers its importance is secondary to the birth of the baby and care and decisions may be 'handed over' to the caregiver to enable focus on the newborn child. Choice has a vital part to play, and the midwife participants' data illustrates that third stage care is part of their birth planning, even to the extent of producing a leaflet for the women in their care (Appendix I). Choice, however, can be secondary to clinical judgement for both practitioners and mothers in this study indicating that they find this to be acceptable. Where there is a clash of beliefs or discourses, however, the relationship between choice and clinical judgement would be disturbed, perhaps even destructive.

Wishes

My mother always said

if wishes were horses

then beggars would ride.

I never really understood

though I would not have

said no

to a sweet little pony

with sugar-lump breath.

She told me to

take care of my feet and teeth

short curly hair

suited me (even when I was

punked to my pierced eyebrows).

She worried I would catch

cold (Mother, I am *thirty-two*).

She told me

that being an eternal student

just isn't good enough

and really Kate

just how many letters after your name do you need to be a midwife anyway?

She told me

of love so painful

a fathomless deep

stark cloudless starlit night,

that the labour of childbirth

was a day but

the birth of a parent

a lifetime

renewed each day

never going away.

(but you have

gone away and so *far*).

Right now

I have only one wish

such a small pony, barely

even a Shetland…

I wish

I could tell her

she was right.

Kate Alice, 22/07/08

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APPENDICES.

Endpiece

I did not think

until today

what I had missed.

I did not feel

what he lost

until watching man and boy.

But it is too late and now

I think about what grew me

how wide, how deep, how rich.

What would you make of

woman, mother, wife

you who

saw only child, teenager, daughter?

Now as adult to adult

as parent to parent

in this last, final space

I could not and do not

want for more.

Kate Alice

March, 2005

NZCOM CONSENSUS STATEMENT

Management of Third Stage of Labour

This Consensus Statement was ratified at National Committee Meeting 11 May 1996

The New Zealand College of Midwives (Inc) recognises that women can anticipate the occurrence of a physiological third stage when it is preceded by a physiological labour and birth.

Where there has been intervention and/or increased risk of post partum haemorrhage (PPH) exists labour and/or birth is no longer physiological and active management of the third stage must be considered.

Guidelines:
Examples of indicators that may require the judicial use of oxytocics and active management of the third stage include:

- Induction
- Augmentation
- Narcotic analgesics
- Instrumental delivery, eg forceps/ventouse
- Epidural anaesthesia
- Coagulation disorders
- Anticoagulant therapy
- Pre-existing medical conditions

It is the midwives responsibility to be informed on the difference between active management and physiological expulsion of the third stage of labour.

Active management of the Third Stage of Labour
- Oxytocic drug of choice, administered as soon as possible after birth of anterior shoulder.
- Cord clamped and cut as soon as possible after birth of baby.
- Delivery of placenta by maternal effort or controlled cord traction.

Physiological Expulsion of the Placenta in the Third Stage of Labour
- No prophylactic oxytocic drug administered.
- Cord left attached to the baby until the placenta is delivered.
- If cord needs to be clamped and cut prior to placenta delivery, the placenta end is to be released.
- Once the placenta is in the vagina the cord may be used to GENTLY GUIDE the placenta out.
- Controlled cord traction must NOT BE USED if an oxytocic drug has not been administered.

Midwives must always have oxytocic drugs and the necessary emergency equipment immediately at hand when attending a birth.

Midwives must ensure that all oxytocic drugs are stored according to the manufacturer's recommendation.

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Source	Cochrane Review
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Source:	J Rogers, J Wood, R McCandlish et al

SERVICE: Maternity

NORMAL LABOUR – MIDWIFERY CARE

OBJECTIVES:

- ⇒ To ensure the safety of the mother
- ⇒ To ensure a live healthy baby
- ⇒ Ensure to plan care with the woman, meeting her specific needs and expectations
- ⇒ To ensure appropriate assessment of maternal and fetal well being

PERSONNEL ABLE TO PERFORM PROCEDURE:

- ⇒ Midwife
- ⇒ Obstetric Nurse under supervision of Midwife
- ⇒ Student Midwife under supervision of Midwife

EQUIPMENT:

- ⇒ Treatment and Progress Notes
- ⇒ Partogram Concord 123
- ⇒ Delivery Trolley
- ⇒ Safety Goggles / Plastic Aprons
- ⇒ Computer Delivery Sheet

ASSOCIATED OUTCOME AND PROCESS STANDARDS:

- ⇒ Admission to Labour Ward WHD/OPS/M/48
- ⇒ Vaginal Assessment WHD/OPS/M/263
- ⇒ Epidural – Midwifery Care WHD/OPS/M/16
- ⇒ Placenta (Pito) – Handling, Transportation & Disposal of WHD/OPS/C/169

	PROCESS STEPS:	RATIONALE:
⇒	Be available to greet woman on arrival to Labour Ward.	A welcoming smile may help to break down barriers and offer reassurance to the woman and her support person. Commence assessment of the labour process and help prioritise the woman's care.
⇒	Commence care as per OP Standard Admission to Labour Ward WHD/OPS/M/48, noting relevant information from the booking sheet and notes.	Completes admission process, initial baseline recordings and CTG.
⇒	**Core Midwives** obtain a verbal history from the woman, read the antenatal notes she has brought with her. Ascertain if she has old notes or previous admissions here.	May indicate risk factors i.e. rhesus negative status, or previous postpartum haemorrhage. Will be able to assess the pattern of uterine activity whilst collecting the history and also determine the woman's coping mechanisms.
⇒	Ascertain the woman's special wishes, birth plan, requirements, expectations and attempt to incorporate this into your care of the woman. Obtain from the woman her history prior to admission e.g. history of contractions etc.	The role of the midwife should involve advocacy, respect of the woman's wishes and her involvement in decision making, allowing her to retain control of the labour events (Morrin, 1997; Hawkins, 1998). Helps alleviate communication problems between staff and the woman.
⇒	Perform abdominal palpation. Listen to the fetal heart for one full minute.	Helps develop a full assessment of the labouring woman, informing you of abdominal descent, lie, presentation and position of the fetus.
⇒	Perform a Vaginal examination as per OP Standard Vaginal Examination WHD/OPS/M/263, after obtaining consent from the woman. Document the findings clearly, noting if there is evidence of amniotic fluid, meconium or abnormalities and inform medical staff.	To confirm the onset of labour and to establish a baseline for further progress (Morrin, 1997). Complies with right to dignity, right to effective communication, right to be fully informed and the right to make an informed choice and give informed consent (Health and Disability Commissioner).

	PROCESS STEPS:	RATIONALE:
⇒	**Core Midwives** contact the GP if they are the LMC to come and assess the woman. Wait for further instruction from the LMC (GP).	Fulfils requirements of Section 51.
⇒	Maintain regular observations documented on the partogram. If the CTG is reactive and within normal parameters, you may wish to consider using a sonicaid and listening for one minute after a contraction every 15 minutes in first stage of labour and after each push in the second stage of labour.	
⇒	Be prepared to stay with the labouring woman.	Helps to build a relationship of mutual trust and create an environment in which expectations, wishes, fears and anxieties can be readily discussed. Continuous support is associated with lower use of analgesia and fewer epidurals (Munro & Spiby, 1998).
⇒	There should be a free flow of information between the midwife and the woman, facilitating open discussion of findings gained from examinations, allowing the woman to have control over the decisions made.	Being fully informed and involved in decision making helps the woman retain a sense of autonomy and control (Morrin, 1997; Health and Disability Commissioner, 1994; Guilliland & Pairman, 1995).
⇒	Encourage the woman to ambulate during labour.	Upright positions have proven physiological advantages enhancing uterine activity and increasing cervical dilation (Morrin, 1997; Munro & Spiby, 1998). In a review of trials Morrin, further discusses it has been noted women who remained upright had, on average, shorter labours, need less analgesia, required less augmentation and newborns had on average higher apgar scores.

	PROCESS STEPS:	RATIONALE:
⇒	Encourage the woman to empty her bladder two hourly.	A full bladder can inhibit the descent of the fetus if it is above the ischial spines. Pressure on the distended bladder by the fetal head may give rise to oedema and bruising, leading onto possible difficulties in micturition postpartum (Morrin, 1997).
⇒	Refer deviations from normal to the appropriate medical practitioner.	
⇒	Inform the Charge Midwife of progress periodically.	Allows a comprehensive overview of Labour Ward and assists with staff distribution.
⇒	Amniotomy is not part of normal physiological labour (Munro & Spiby, 1998; Morrin, 1997; Cassidy, 1993).	The significant benefits of intact membranes are the maintenance of even hydrostatic pressure to the whole fetal surface during labour, this results in reduced cord compression. Fetal hypoxia is less likely, and a reduced likelihood of infection (Cooke, 1997).
⇒	Nutrition in labour can allow a woman to feel normal and healthy. The diet offered should be light, nutritious and easily absorbed (Munro & Spiby, 1998).	If a suitable carbohydrate source is not available body fat will be utilised resulting in ketones, giving rise to ketacidosis (Morrin, 1997).
⇒	If pharmacological analgesia, epidural or nitrous oxide is required, **the woman should stop eating and drinking be reduced to sips of water** (Munro & Spiby, 1998). Clear fluids, dilute orange juice, weak cordial, or non-carbonated electrolyte drinks are acceptable (N. Skjellerup, personal communication, July 12, 1999). Please refer to OP Standard Epidural – Midwifery Care WHD/OPS/M/16	Narcotics delay stomach emptying. Use of an epidural is an indicator of an abnormal labour, therefore the woman is at a greater risk of requiring a general anaesthetic. Nitrous oxide can cause nausea. If used incorrectly and without supervision can lead to the woman becoming unconscious. Tea and coffee are considered to be food. They increase the stomach volume, therefore are an anaesthetic risk (N. Skjellerup, personal communication, July 12, 1999).
⇒	Second stage is completed safely with a	

	PROCESS STEPS:	RATIONALE:
	second midwife / obstetric nurse present. Safety goggles should be applied as per Canterbury Health Infection Control Manual, Vol. 10A. Listen to the fetal heart after each push. Ascertain there is descent with pushing. Notify the medical team if there is fetal distress or no descent.	
⇒	Third stage is complete via active or physiological management. The placenta is handled and disposed of as per OP Standard Placenta (Pito) – Handling, Transportation & Disposal of WHD/OPS/C/169.	Active management is superior to physiological in terms of blood loss. Physiological management is only appropriate for women with low risk of postpartum haemorrhage and who have had a normal physiological labour (Munro & Spiby, 1998).
⇒	Complete a Perineal examination and suture as required.	Identifies traumatised tissue and facilitates healing.
⇒	Immediate postpartum observations of temperature, pulse, blood pressure, fundus and lochia.	Identifies any deviations from normal. Ensures the uterus is well contracted and blood loss per vagina is not excessive.
⇒	Facilitate bonding with the family unit, and encourage early feeding if the mother plans to breastfeed.	The baby is alert and receptive to feeding. A successful first feed can have a positive effect on the mother's confidence (Seridan, 1997).
⇒	Offer a light meal to the couple.	
⇒	Offer the telephone.	
⇒	Complete all documentation including the computer sheet. Give completed computer sheet to ward clerk who completes the data entry & returns relevant paperwork to you.	
⇒	Frequently check the fundus to determine it is well contracted and check the lochia.	A full bladder can prevent the uterus contracting, resulting in a heavy blood loss.

PROCESS STEPS:	RATIONALE:
⇒ When you are satisfied the woman's condition is stable and she is comfortable, contact the ward and arrange for transfer to the ward.	

AUTHOR OF PROCEDURE: **Rae Green RN RM**
Joyce Cochrane RN RM
Rayoni Keith RN RM

VALIDATED BY: **Debbie Earl, Charge Midwife**

APPROVAL: **Outcome & Process Standard Group**
July 1999

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Lincoln, Rangiora, Midwifery Educator
Parent Education, Maternity Services Manager

SERVICE: Maternity

PRE ECLAMPSIA – IOL and Labour - Midwifery Care

OBJECTIVES:

⇒ To ensure the maternal and fetal well being are monitored and maintained within safe limits.
⇒ To ensure pre eclampsia will not progress to eclampsia.
⇒ To ensure midwifery care is based on a medical diagnosis and plan for the woman.

PERSONNEL ABLE TO PERFORM PROCEDURE:

⇒ Midwife, orientated to labour ward and to Women's Health Division Outcome and Process Standards.
⇒ Midwife with an Access Agreement to CWH or employee of Women's Health Division.
⇒ Note: If the woman's physical condition indicates secondary care is necessary then her care will be handed to a core midwife (CWH).

EQUIPMENT:

⇒ A room containing oxygen and suction, preferably room 1 (for severe pre-eclamptic woman).
⇒ Sealed Resuscitation Box
⇒ PET box which includes drugs. May need to add diazepam ampoule.
⇒ IV trolley.
⇒ Bed with removable head
⇒ Women's Treatment & Progress Notes including:
    WHD Intensive Care Flow Chart – Maternity WHD 9825 (prn)
    Fluid Balance 24 hour form, QF 372
    IV Fluid Prescription Chart, QMR 4B
    Drug Treatment sheet, QMR 4
    Serial Recordings for PET Form WHD 9795
    Partogram, concord 123
    Clinical Notes QMR 3

If the woman has severe PET the WHD Intensive Care Flow Chart – Maternity WHD 9825 should be used to document and record care.

ASSOCIATED OUTCOME AND PROCESS STANDARDS:

⇒ Observations – Blood Pressure WHD/OPS/C/19
⇒ Observations – Pulse WHD/OPS/C/18
⇒ CTG – External Intermittent or Continuous Monitoring WHD/OPS/M/167
⇒ Magnesium Sulphate $MgSO_4$ – Midwifery Care in Labour Ward WHD/OPS/M/31
⇒ Intravenous Labetalol – use of WHD/OPS/C/193
⇒ Urine Collection (24 hour) for Protein & Creatinine WHD/OPS/C/177
⇒ Cord Blood pH – Obtaining WHD/OPS/M/259

	PROCESS STEPS:	RATIONALE:
⇒	Diagnosis must be made by medical team and a plan for the woman's labour and delivery clearly documented in the clinical notes QMR 3. A midwife will provide midwifery care and delegated medical care of a woman with PET or Eclampsia.	Rise in blood pressure of > 15 mmHg diastolic or 25mmHg systolic from measurement in early pregnancy or to > 140/90 mmHg in late pregnancy if no early reading available; plus Proteinuria (>3g per 24h); and/or Oedema Pre-eclampsia is a multi-system disorder of no known aetiology and develops in 5-10% of pregnancies. The presence of hyper-reflexia or clonus should be taken seriously as well as a poor or absent urine output (<1/2 ml kg 1hr)
⇒	I.V. access is required.	For access of administration of I.V. drugs to expediate the control of a hypertensive crisis.
⇒	**Cardiovascular System monitoring:** Use a Dynamap or Propac to record BP, Pulse, at a frequency requested by medical staff. Probably ½ - 1 hourly intervals depnding on trends in recordings.	To standardise recordings thereby eliminating operator variation. To detect an increase in blood pressure and prevention of a hypertensive crisis. (CVA, MI, abruptio placentae, IU fetal demise)
⇒	Assess woman for symptoms of P.E.T. that	Indication of cerebral oedema and irritability.

	PROCESS STEPS:	RATIONALE:
	may indicate CNS and hepatic, involvement: • Headache • Visual Disturbances • Epigastric pain • Vomiting • General appearance / Oedema • Speech • Level of conciousness • Reflexes	Indications of hepatic involvement.
⇒	**Fetal monitoring:** Attend to admission CTG Hourly monitoring for one full minute until the woman is in labour and then continuous CTG monitoring or as requested by the obstetrician.	Fetus is at risk of compromise because of vasospasm due to arterial hypertension, decrease in circulating volume and an increase risk of abruption.
⇒	Peadiatrician should be informed if the gestation or growth is outside the normal parameters i.e. <37 weeks or <10% growth, or abnormal dopplers.	They can be prepared to help meet the baby's needs when it is born.
⇒	**Laboratory investigations:** Blood tests are taken as requested by doctors and the results recorded on Serial Recordings for PET form (WHD9795) Obtain a full blood count and coag screen.	Detection of deviations that may indicate haematological abnormalities such as DIC, thrombocytopenia, HELLp syndrome. If an epidural is likely the haematological parameters will need to be reviewed by the anaesthetist to Prevent epidural haematoma in the presence of coagulopathy.
⇒	**Fluid Balance:** Fluid balance must be accurate. Both intake and output needs to be documented on a Fluid Balance 24hr form QF 372 or the WHD Intensive Care Flow Chart – Maternity WHD9825. Intravenous fluids are prescribed on IV Fluid Prescription Chart QMR 4B.	Indication of renal function and deterioration as a result of hypertension.

	PROCESS STEPS:	RATIONALE:
	IVAC pumps must be used to accurately administer any specific hourly volumes. Urine output is measured hourly if woman has an indwelling catheter insitu (use 24hr urine bag). Test urine each 8 hour period for pretein. Consider testing for haemoglobin in urine is dark.	
⇒	If protein present in urine, on admission it is worthwhile taking a MSU.	Exclude an underlying UTI.
⇒	Continue or commence 24 hour urine collection if requested. See WHD/OPS/C/177.	Measure 24hr protein, urea and creatinine clearance to indicate renal function.
⇒	Administer medication as prescribed. If $MgSO_4$ is used, refer to OP Standard Magnesium Sulphate $MgSO_4$ – Midwifery Care in Labour Ward (WHD/OPS/M/31) for the midwifery care required.	To keep BP at a baseline to prevent hypertensive crisis.
⇒	If syntocinon is prescribed to augment labour then observe for fluid overload. It is possible to have syntocinon prescribed at a higher concentration.	Syntocinon has an antidiuretic effect.
⇒	If Labetalol is prescribed & administered then commence as per OP Standard – Intravenous Labetalol use of (WHD/OPS/C/193). Then return to ½ hourly observations.	

	PROCESS STEPS:	RATIONALE:
⇒	Provide pain relief in labour as requested by the woman. A spa bath for women with mild PET may be an option. Inform the woman there is an increased likelihood of using epidural analgesia with PET as requested by Medical Staff.	Recent research suggests that opioid receptors have a role in the prodcution of seizures (Macdonald, 1994) therefore pethidine can be dangerous when there are signs of CNS involvement. The epidural is used to improve placental blood flow, confer haemodynamic stability and the block can easily be extended should operative delivery be necessary.
⇒	Liaise closely with the anaesthetic team, obstetric team and Dr Moore, plus any other health professionals involved.	Accurate communication to best meet the needs of the woman. The woman and her support person(s) will understand PET and the implications antenatally, intrapartum and postnatally.
⇒	Labour is monitored for progress and recorded on the partogram. Continue normal labour recordings e.g. Temperature 4 hourly or 2 hourly if spontaneous rupture of membranes, descent of the presenting part, etc.	
⇒	At all times keep the woman and her support person(s) informed of tests requested, results and their significance. Take into consideration the birth plan requests helping the woman to make informed choices where the severity of the pre-eclampsia may make some choices unsafe, for example: • Labouring in the bath • A physiological 3rd stage • Intermittent fetal heart monitoring	Legal requirement for woman to be informed and thus be able to make choices (The Health & Disability Commissioner, 1996; Health & Disabilities Service Act, 1993)

	PROCESS STEPS:	RATIONALE:
⇒	Second stage of labour should be managed as recommended by the medical team and discussed as fully as possible with the consenting woman.	Avoidance of raised BP with pushing.
⇒	Third stage of labour should be managed actively with the use of syntocinon only.	Never use ergometrine or syntometrine as it causes intense peripheral vasoconstriction and increases the hypertension.
⇒	Take an arterial and venous cord blood pH specimen. See WHD/OPS/M/259.	Indicate placental function and effect of PET on the neonate.
⇒	Postpartum plan for post partum period must be documented including when woman and baby can be transferred to post natal ward.	

AUTHOR OF PROCEDURE: **Sue Dearlove, Charge Midwife**

VALIDATED BY: **Di Ballantyne, Charge Midwife, Rayoni Keith, RN. Risk Management.**

APPROVAL: **Outcome & Process Standard Group July 1999**

REFERENCES:

Macdonald, R. (1994). The Obstetric Anaesthetist and the Sick Obstetric Patient. Midwives Chronicle and Nursing Notes. February. P44-48.

The Health & Disability Commissioner, (1996). Code of Health & Disability Services Consumers' Rights Auckland: Health & Disability Dept.

Health & Disabilities Service Act, 1993.

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DISTRIBUTION: **Labour Ward, Parent Education, CWH Community Midwives, Midwifery Educator, Maternity Service Manager**

INTRAPARTUM CARE – NORMAL LABOUR & BIRTH

Overview

Labour and birth is a normal physiological event.

Objective

To ensure staff are aware of the recommended best practices to follow for Intrapartum Care in normal labour and birth.

Responsibility

National Women's midwifery and medical staff.

A midwife will

- Understand and implement life saving skills, including the use of technology, in a timely and appropriate manner when there is a clear and present danger to the health of pregnant women and/or their babies.
- Take measures to avoid unnecessary interference in the progress of normal labour and birth.

(Ref: International Confederation of Midwives Council, May 1999)

- Recognise deviations from normal labour and birth and refers appropriately.

Continued on next page

INTRAPARTUM CARE – NORMAL LABOUR & BIRTH

Overview, continued

Associated documents

The table below indicates other documents and sources associated with this recommended best practice.

Type	Document Title(s)
Board Policy	- Informed Consent.
Hospital Policy	- Cord Blood – Haematology. - Hepatitis B Vaccination Regime for Newborn.
National Women's Nursing & Midwifery Practice	- Admission to Delivery Unit – Unbooked Women. - Bladder Care Management – Intrapartum. - Cardiotocograph. - Fetal Haemoglobin - APT & Downey Test. - Fetal Scalp pH. - Identification of Newborn Infants. - IV Cannulation. - Observations Postpartum – Maternal. - PPH – Primary. - PPH – Secondary. - Resuscitation at Delivery – Newborn. - Retained Placenta – Management of. - Suturing. - National Women's Hospital Birth Plan.
References	- British Journal of Midwifery, January 1998, Vol 6 No1. A trial of cetrimide/chlorhexidine or tap water for perineal cleaning. - Cochrane Review: Syntocinon vs Syntometrine intramuscularly. - 2002 Medline Review: Pushing vs delayed pushing in second stage. - 2000 Cochrane Review: Active vs expectant management third stage. - World Health Organisation, Geneva, 1996. Care in normal birth: A practical guide. - 2002 Cochrane Review: Episiotomy for vaginal birth. - MOH Guidelines for Consultation with Obstetric and Related Specialist Medical Services. - British Journal of Midwifery, July 1997, Vol 5 No1. Restriction of oral intake for women in labour. - Royal College of Obstetricians and Gynaecologists. The Use of Electronic Fetal Monitoring.

INTRAPARTUM CARE – NORMAL LABOUR & BIRTH

Management in the third stage

Active management should always be encouraged for woman at risk of postpartum haemorrhage. There is good evidence that woman who are not at risk would also benefit from active management of the third stage.

Recommended best practice

Follow the steps below to actively manage the third stage to reduce the incidence of postpartum haemorrhage and the need for blood transfusion.

Active management

Step	Action
1	Give 10iu syntocinon intramuscularly with the birth of the baby or immediately afterwards.
2	Clamp and cut the cord.
3	Wait for signs of separation.
4	Guard the uterus by providing counter-traction with hand suprapubically. With other hand, provide controlled cord traction by exerting steady downward traction to deliver placenta.
5	No fundal pressure should be applied.

Continued on next page

INTRAPARTUM CARE – NORMAL LABOUR & BIRTH

Management in the third stage, continued

If after full discussion the woman chooses a physiological third stage, the following is the recommended procedure.

Physiological management

Step	Action
1	Omit ecbolic.
2	Postpone clamping and cutting of the cord until the cord has stopped pulsating, or after the placenta has been born.
3	Do not use fundal massage or cord traction.
4	Assist the baby to breastfeed as soon as possible.
5	Wait for signs of separation.
6	Encourage the women to push in a position that is comfortable.
7	Where there is any deviation from the expected outcome, active management should be initiated.
N.B.	If at any stage there is a delay in delivering the placenta (>1 hour), ensure that the bladder is empty, either by the woman passing urine or insertion of an in/out catheter if unable to void.

Continued on next page

INTRAPARTUM CARE – NORMAL LABOUR & BIRTH

Management in the third stage, continued

After delivery of placenta

Step	Action
1	Check the uterus is well contracted following delivery of the placenta and estimate blood loss. Check labia, perineum and vagina for lacerations. Repair trauma as indicated as soon as possible.
2	Examine the appearance and completeness of the placenta and membranes. Take cord blood samples. With the exception of cord blood gases, cord samples should be avoided until after the placenta is delivered to prevent blood accidents. Ascertain number of cord vessels. Confirm whether the woman would like to take her placenta home. Weigh placenta and document findings on Delivery Summary.
3	Remove soiled linen and ensure that the woman is clean, dry and comfortable. Place sanitary pad in situ.
4	The practitioner conducting the birth is responsible for cleaning up the delivery equipment/trolley. Instruments and swabs to be accounted for. Dispose of sharps appropriately. Tidy trolley. Clean bowls and kidney dishes in sink. Put placenta into two plastic bags, label plastic bag and return or dispose of according to the woman's wishes.
5	Complete documentation – labour Partogram, Delivery Summary (CC029), Placenta Release Form (CR2025) and Clinical Record. Enter details on the computer.

Management of the third stage of labour.

Procedure Contents .
Administration of oxytocic drugs in labour.

Purpose - To prevent Post-Partum Haemorrhage.

Scope - Women choosing 'active' versus 'physiological' management of the third stage of labour

Associated Documents - The table below indicates other documents associated with this policy:

Type	Document Title(s)
Organisation wide	
Department level	Policy for active management of the third stage of labour
References & other	Sweet, BR. Mayes' Midwifery Twelth Edition Balliere Tindall. London, Philadelphia, Toronto, Sydney, Tokyo. Odent M. Active versus expectant management of third stage of labour. Lancet 1998; 351: 1659(letter). Prendeville WJ, Harding J, Elbourne D, Stirrat G. The Bristol third stage trial: active versus expectant management of the third stage of labour. BMJ 1988; 297: 1295-300. McDonald S, Prendiville WJ, Elbourne D. Prophylactic syntometrine vs oxytocin in the third stage of labour (Cochrane Review). In: The Cochrane Library, Issue 3, 1998. Oxford, Update Software.

Definitions – *Third stage of labour* is the period following birth of the baby until complete expulsion of the placenta and membranes and the control of bleeding.
Post-partum haemorrhage (PPH) is excessive bleeding from the genital tract occurring at any time from birth of the child until the end of the puerperium. In this instance, PPH refers to a loss of 500mls or more (or any amount which adversely affects the condition of the mother) originating from the placental site.
Active management is the use of oxytocic agents to effect stimulation of uterine contraction.

Procedure

Management of the third stage of labour begins in the antenatal period when the midwife will identify women at higher risk of PPH.

Any women with a history of previous PPH may be booked for delivery at a tertiary unit. During labour, careful management and monitoring will reduce the likelihood of PPH for those women at risk.

Women who are not considered at risk may be given a choice in the method of delivering the placenta.

Oxytocic drugs available for use;

Syntocinon 10 iu (Synthetic oxytocin). To hasten placental separation, reduce blood loss and control haemorrhage. This drug is effective within 2-3 minutes of intra-muscular administration.

Syntometrine 1ml (Ergometrine maleate 500 ug and oxytocin 5 units). This drug induces uterine contraction within 2-3 minutes of intra-muscular administration.
Contraindications; Raised blood pressure in labour,women with a history of hypertension.

Administration of oxytocic drugs:

Verbal consent should be obtained from the woman. This should follow her perusal of the 'NZCOM Consensus Statement Management of third stage of labour' document and discussion with her LMC regarding the research and findings surrounding this method of managing the third stage of her labour.

Administer the oxytocic agent of choice by IM injection following delivery of the anterior shoulder.

Await signs of placental separation (trickle of blood vaginally, lengthening of the umbilical cord, narrowing and hardening of the uterine fundus).

'Guard' the uterus with the palm of the left hand and apply 'controlled cord traction' downwards on the cord with the right hand to facilitate removal of the separated placenta.

Inspect the placenta and membranes to ensure complete expulsion/exclude possibility of retained products of conception.

Monitor vaginal blood loss following procedure.

Complete records;
Record drug, route and time given. Record estimated blood loss. Monitor maternal vital signs. Bag the placenta safely if the mother wishes to keep it. Otherwise, dispose of placenta per hospital policy. Ensure the fundus is well contracted and the lochia is normal.

Otago
District Health Board

Queen Mary Maternity Services
Dunedin Hospital
kate.Spenceley@healthotago.co.nz

17/05/02

Dear Birth Suite Manager

I am a student at Massey University and Clinical Charge Midwife at Queen Mary in Dunedin. I am currently looking at practices around the third stage of labour. I am making a presentation to medical staff in the Queen Mary and as part of that would like to identify guidelines used at Maternity units around New Zealand. Currently at Queen Mary we have only implied guidelines.
Would you be willing to share your guidelines/procedures relating to care in the third stage of labour? I am particularly interested in the informed choice of the woman, type of ecbolic recommended and any time limits placed on the third stage. I will, of course, reference any use of your information to its source.
If you are able to send a copy of your guidelines, I have enclosed a stamped addressed envelope for your use or you may send me an electronic copy on the above e-mail address.

Thank you for your help.

Yours sincerely,

Kate Spenceley, Clinical Charge Midwife, Queen Mary Maternity Service.

Otago
District Health Board

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If you are able to send a copy of your guidelines, I have enclosed a stamped addressed envelope for your use or you may send me an electronic copy on the above e-mail address.

Thank you for your help.

Yours sincerely,

Kate Spenceley, Clinical Charge Midwife, Queen Mary Maternity Service.

We don't have written guidelines or protocols. It is up to the professional judgment of the practitioner to inform the woman and advise etc.

Celia Butler Unit Manager.

201 Great King Street, Private Bag 1921, Dunedin, New Zealand. Telephone 03 474 0999 Facsimile 03 474 7623

Kate Spenceley

From: Gina Meredith [GinaM@adhb.govt.nz]
Sent: Wednesday, 29 May 2002 13:45
To: Kate Spenceley
Subject: Third stage of labour

Dear Kate

Thank you for your letter dated 17.5.02. Sorry for the late reply, with current changes within National Women's I've been a little tied up. I am very happy to give you the following information regarding management of the third stage. We are currently updating the guidelines around care of women in normal labour, this includes informed choice, which is offered to all women regarding the management of their third stage, we discuss physiological 3rd stage as an option, but NWH recommends administration of an ecbolic and active management. Our new guidelines suggest administring syntocinon 10 i.u. IM rather than syntometrine, in line with current evidence. The guidelines then discuss managment of both physiological and active 3rd stages. Once these guidelines have been finalised I will be happy to send you a copy, it is currently in it's 6th draft and should be finalised within the next 2 weeks.

Hope this is useful, please do not hesitate to contact me for any further information.
Regards
Gina Meredith
Acting Unit Manager
National Women's Hospital
Extn: 3349
Loc: 934941
Mob: 021 2971224

THIRD STAGE OF LABOUR

PROTOCOL

Standard

That the 3rd stage of labour will be conducted safely whether using physiological or active management, and that the placenta (whenua) will be treated in a culturally sensitive manner.

Criteria

- The placenta and membranes are delivered complete.
- Excessive bleeding or haemorrhage is treated appropriately

PROCEDURE

- Where an ecbolic has been administered: ie 1 amp Syntometrine or Syntocinon 10 units.

1. To be given with the delivery of the anterior shoulder.
2. Check the uterus is well contracted.
3. Support the uterus before applying controlled cord traction.

- Where an ecbolic has not been administered:

1. Await signs of separation
2. Encourage maternal effort

- Check placenta and membranes are complete and the uterus is well contracted.
- Obtain cord bloods as indicated
- Manage PPH as per PPH protocol.
- If retained placenta - prepare for O.T.(See Retained placenta protocol)
- Inspect genitalia and perform a rectal examination to determine any trauma and initiate repair if indicated
- Complete documentation.

GUIDELINES

- Obstetricians locally recommend active management of third stage.
- Consider active management of 3rd stage for woman who have a history of previous PPH.
- If diastolic Blood Pressure is above 90, Heart disease, Cardiac cases or any previous nausea with the use of syntometrine, GIVE Syntocinon 10 units intramuscularly.
- Confirm birth plan on third stage management and disposal of placenta/whenua.
- The whenua/placenta is recognised as the property of the parents and parental consent is gained for its disposal.
- The whenua is not stored with food. Place the placenta in a clear plastic bag then into placenta bucket.

- Or if the placenta is to be kept - Place in plastic bag and then into a brown paper bag, label with the mother's bradma label, phone number and date of baby's birth and place in freezer. Encourage the parents to take the placenta home the same day if possible. Remind parents to pick up placenta on discharge from the postnatal ward, this is the responsibility of Midwife/Nurse discharging the client. It will be stored for 21 days and disposed of in the usual manner after this time.
- Rh neg mother/maternal blood group unknown or other medical indication exists - 10 mls into two tubes, 1 x EDTA, 1 x red top.
- Label and bag specimens in room and register baby on computer to obtain baby's UR number prior to forwarding specimens to lab.
- Document a description of lacerations/grazes and name of person who has inspected or repaired genitalia. Refer to Repair of Perineum Protocol.
- Document whether placenta stored in the LW freezer or disposed of.

Measure

- Delivery of placenta correctly documented in labour records
- Data re Post-partum haemorrhage maintained

Hazards

Hazard	Prevention
Blood contamination	• Instruction to woman re high infectious risk • Universal blood precautions • Protective equipment for staff
Needle stick injury	• Use of holders • Health & Safety protocol for needle stick injury

Supporting Information

- Health & Safety Protocols
- British Journal of Midwifery April 1999 Vol 7 – Physiological Third Stage of labour
- A Guide to Effective Care in Pregnancy & Childbirth. Enkin et al.

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

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Auckland
New Zealand
Service:
Phone:
Ext:
Fax:

25th June 2002

K Spenceley
Clinical Charge Midwife
Queen Mary maternity Unit
Dunedin

Gina Meredith
Charge Midwife
Delivery Unit
National Women's Hospital
Auckland

Tel: 6309919 extn 3349
Pager: 93 4941
Email: ginam@adhb.govt.nz

Dear Kate

Management of third stage protocol

Please find enclosed a copy of our recently updated protocol for third stage management. This is discussed in the antenatal period and when the woman arrives on to delivery unit, the decision is documented on the partogram. We have recently implemented the use of syntocinon over syntometrine and auditing our figures of PPH. If a woman chooses physiological birth of the placenta there are time limits applied which is documented in the protocol.

If you have any further questions, please do not hesitate to contact me. Will you be at the conference?

Thank you

Gina Meredith
Enc

Emergency
23/5/02

Dear Kate,

Enclosed is our protocol for III stage
Patients do have choices and complete a care plan.
Some midwives 1. avoid synthetocine and use instead 5-10 units syntometrine
2. avoid active management of III stage

Trust it is useful

Norman Mackey,
Clinical Director,
O+G

PROTOCOL FOR MANAGEMENT OF THIRD STAGE

1. Syntometrine (1 ampoule) intramuscular injection with delivery of anterior shoulder (unless contra-indicated - see below).

2. Prompt cord clamping (< 60 sec) after delivery of baby (except in Rh -ve mothers).

3. Await signs of placental separation (see below).

4. Gentle controlled cord traction together with counter-traction upwards on lower segment of uterus (re: Brandt-Andrews technique).

NOTE:

1. Contra-indications to Syntometrine (or Ergometrine) include:

   a. Hypertension
   b. Cardiac disease
   c. Peripheral vascular disease
   d. Rhesus disease
   e. After first twin
   f. Patient refusal.

2. Sign of Placental Separation include:

   a. Hard, contracted uterus
   b. Blood show
   c. Lengthening of cord
   d. Rise in findus.

3. Avoid maternal pushing.

4. Consider placenta retained if not delivered within 30 minutes.

INVERSION OF UTERUS:

Incidence: Rare, 1:20,000 deliveries.

Danger: Shock, hemorrhage, mortality.

Associated features:

1. Uncontrolled cord traction.
2. Failure to apply counter-traction to lower segment.
3. "Pushing" during third stage.
4. Uterine atony.
5. Adherent fundal placentation.
6. Downward pressure on fundus.

Thesis study—"Choices of care in the third stage of labour: a discourse analysis".

Can you help?

I am a midwife researching for her Masters thesis at Massey University. I wish to talk to women and midwives about the information used to assist choices in birthing the placenta.

If you have recently had a vaginal birth, and can spare an hour of your time to speak with me, please contact me for more information.

Thank you.

Kate Spenceley.

Work: 03 4740999, ext.8718
Mobile: 025 482677
e-mail: Katespen@xtra.co.nz

This study has been approved by the Otago ethics committee.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 12/138.

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Massey University
COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Health Sciences
Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 350 5668

Information for potential participants of a research study - women

Title of study—" Choices of care in the third stage of labour: a discourse analysis."

You are invited to take part in a study that looks at how women make decisions about their care in the third stage of labour. The third stage of labour is the birth of the placenta/afterbirth or *whenua*, and the control of bleeding. If you wish to be part of this study, my contact details are at the end of this information sheet.

Women use information from various sources when making decisions about care in the third stage of labour. Your midwife/doctor may make recommendations for the delivery of the afterbirth but the decision rests with you. The aim of this project is to identify some of the themes that exist within the variety information about the third stage of labour, and the value that pregnant women place upon this information when making their choices of care regarding the birth of the placenta.

What you would have to do:

If you have agreed to participate in the study we would decide on a time and place to meet to talk about the third stage of your labour. During this meeting I would ask you about your care in the third stage of labour and how you arrived at your decision. I would also ask you about what sources of information you used to make this decision. This conversation is likely to take about one hour.

With your permission, I would audio-tape our discussion. At any time during our conversation you have the right to ask me to turn the tape off, or to delete something that you have said. You also have the right to refuse to answer any particular question.

The audio-taped conversation would be transcribed by a typist who had signed a confidentiality agreement. Once typed I would give you a copy of the written record of our conversation; you would be free to correct information or cross out anything you did not wish to have included.

If you decide to take part in this study

- You are free to withdraw from the study at any time, without having to give a reason and this will not affect your continuing postnatal care.
- You can refuse to answer any particular question and request that the audio-tape be turned off at any point.

- ❖ You can ask further questions about the study that occur to you during your participation.
- ❖ No material that could identify you personally will be used in any discussion about or reports of this study.
- ❖ You will be given access to a summary of the findings from the study when it is completed.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact a Health and Disability Advocate, telephone (03) 479 0265 or 0800 377 766.

About the researcher:

My name is Kate Spenceley and I am a student researcher enrolled in the Masters programme at Massey University at Palmerston North. I am also a midwife working in the Queen Mary maternity unit in Dunedin.

My supervisor is Dr. Cheryl Benn. She can be contacted through Massey University on 06 350 5799 ext 2543, email C.A. Benn@massey.ac.nz.

How I can be contacted:

My contact number in the daytime is 03 4740999, ext. 8718, pager 6307.

My cellphone is 025 482677. If I do not answer please leave your name and number I will call you directly.

My postal address is Queen Mary Maternity Unit, Dunedin Hospital, Dunedin.

If you are interested in taking part in this study, please contact the researcher on the above telephone numbers.

Thank you for considering this request.

This study has been approved by the Otago Ethics Committee.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/138. If you have any concerns about the conduct of this project, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee, Palmerston North, telephone 06 350 5249, e-mail S.V.Rumball@massey.ac.nz.

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Information for potential *midwife* participants of a research study

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You are invited to take part in a project that looks at how women make decisions about their care in the third stage of labour. If you wish to be part of this study, my contact details are at the end of this information sheet.

Women use information from various sources when making decisions about care in the third stage of labour, the birth of the placenta or *whenua*, and the control of bleeding. As a Lead Maternity Caregiver (LMC) you may make recommendations for the birth of the afterbirth but the decision rests with the woman.

When informing women about care and choices in the third stage of labour midwives are also aware that their practice is guided by expected standards of evidenced based care. These standards are informed by research, much of which is medically led. The Midwives' Handbook for Practice, (2002), Standard Two, clearly states that the midwife is expected to facilitate the woman's choice even when the woman's decisions regarding care goes against the midwife's professional judgement or is in conflict with her own beliefs. The midwife attempts to supply clear and unbiased information to assist the woman in her decision-making.

The aim of this project is to identify some of the themes/ideas that exist within the variety of information about the third stage of labour, and the value that pregnant women place upon this information when making their choices of care.

What you would have to do:

If you agreed to participate in the study we would decide on a time and place to meet. I would like to ask questions pertaining to sources of information for the third stage of labour, and how you assist women in making their choice of care in the third stage of labour. This would not be a critique of your knowledge but would be a discussion about the variety of information available to assist pregnant women in their decision making. This conversation is likely to take about one hour.

With your permission, I would audio-tape our discussion. At any time during our conversation you have the right to ask me to turn the tape off, or to delete something that you have said. You also have the right to refuse to answer any particular question.

The audio-taped conversation would be transcribed by a typist who had signed a confidentiality agreement. Once typed I would give you a copy of the written record of our conversation; you would be free to correct information or cross out anything you did not wish to have included.

If you agree to take part in this study

- You are free to withdraw from the study at any time, without having to give a reason.
- You can refuse to answer any particular question and request that the audio-tape be stopped at any point
- You can ask further questions about the study that occur to you during your participation
- No material which could identify you personally will be used in any discussion about or reports of this study.
- You will be given access to a summary of the findings from the study when it is completed.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact your professional organisation.

Who is the researcher:

My name is Kate Spenceley and I am a student researcher enrolled in the Masters programme at Massey University at Palmerston North. I am also a midwife working in the Queen Mary maternity unit in Dunedin.

My supervisor is Dr. Cheryl Benn. She can be contacted through Massey University on 06 350 5799 ext. 2543, email C.A.Benn@massey.ac.nz if you have any concerns about the study.

How I can be contacted:

My contact number is 03 4740999, ext. 8718, pager 6307.

I can also be contacted on 025 482677. If I do not answer please leave your name and number I will contact you directly.

My postal address is Queen Mary Maternity Unit, Dunedin Hospital, Dunedin.

If you are interested in taking part in this study, please contact the researcher on the above telephone numbers.

Thank you for your consideration.

This study has been approved by the Otago Ethics Committee.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/138. If you have any concerns about the conduct of this project, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee, Palmerston North, telephone 06 350 5249, e-mail S.V.Rumball@massey.ac.nz.

Massey University
COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Health Sciences
Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 350 5668

Consent Form

Choices of care in the third stage of labour: a discourse analysis.

I have read the Information sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction and I understand I may ask further questions at any time.

I understand that my conversation with the researcher will be audio-taped.

I also understand that I free to withdraw from this study or ask the researcher to stop the tape at any time. I may ask that information I have provided not to be included in the study. I understand that nobody will be able to identify me from the information used in the thesis.

I (Name).....wish to participate in this study under the conditions set out on the Information Sheet, of which I have a copy.

SIGNED: _____

DATE: _____

I (Name).....agree to have an audio-taped interview. I understand that I can request that the tape be turned off at any point during the interview. I also agree that non-identifiable quotes from this interview can be used subsequently in a thesis or articles related to this research.

SIGNED: _____

DATE: _____

Interviews with participants who have recently given birth:

Opening sentence for tape:
This is a recording for a Masters thesis project. It is recorded on a Sony Walkman Professional WMD6c using clip-on microphones. The Interview is being recorded by Kate Spenceley in the participant's home in Dunedin. The date is ** June, 2003.
The participant has signed a consent form for this interview but may stop the tape at any point or decline to answer any question put to her.
The background noises include……..

I am interested in the end of labour, the third stage, which is when the afterbirth is born. I would like to talk with you about you chose your care for this time in labour.

I would like to start with a few questions about you, if I may, and then move onto to the birth of your baby.

- How old are you?
- How old is your baby?
- Is this your first (second, third) baby?
- Did you have a midwife/GP/Obstetrician as your caregiver in your pregnancy?
- How early in your pregnancy did you link up with her/him?
- Why did you choose him/her?
- What sort of birth did you experience?
- Did you birth at home or in the hospital?
- Did you require any assistance?
- What sort of pain relief did you chose? Why?
- Do you mind describing the birth?
- How did you birth the placenta?
- How did you choose this care or did you give it no thought at all?
- Did you loose much blood after the birth?
- Did you experience any problems after the birth?
- Did you receive any drugs after the birth?

- Did you wish to keep or see the placenta after you have given birth?
- If you have another child, will your choice of care be the same?

I would like to ask you about your knowledge of the third stage of labour.

- How much do you know about the placenta?
- Can you describe the third stage of labour?
- How important was the third stage of labour to you?
- Were you aware of any particular dangers associated with this stage of labour?
- Where did you gain this knowledge? From
    - Family/friends
    - From your midwife/GP/obstetrician
    - Other sources—booklets, magazines, the Internet

Thank you for taking part in this interview. Is there anything that you would like to add?

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    - Other sources—booklets, magazines, the Internet

Thank you for taking part in this interview. Is there anything that you would like to add?

Interviews with participants who are midwives:

Opening sentence for tape:
This is a recording for a Masters thesis project. It is recorded on a Sony Walkman Professional WMD6C using clip-on microphones. The interview is being recorded in the participant's home/workplace/chosen location in Dunedin by Kate Spenceley. The date is ** June, 2003.
The participant has signed a consent form for this interview but may stop the tape at any point or decline to answer any question put to her.
The background noises include.....

I would like to ask you about yourself, then move onto your clinical practice as a midwife. Please be assured that this is not a critique of your clinical practice: I am interested in what knowledge(s) you use to assist women in making choices of care in the third stage of labour.

- How long have you been a midwife?
- Did you practice as a nurse prior to this or come directly into midwifery?
- Could you describe your nursing/midwifery education/ training?
- Are you involved in further education at the present? Do you plan to be?
- Are you self-employed or employed by a facility?
- In this employment, is your practice mainly LMC work or do you do Core work (episodic care) as well?
- Does your practice include doing, for example, only the birth or post-natal module of care?

The third stage of labour:
- Would you outline your most usual practice in the third stage of labour?
- Are you equally comfortable with both physiological and active care in the third stage of labour?
- Is there specific information that you give to a woman about the third stage of labour?
- Are there any circumstances where you would recommend one form of care or another?

- Could you outline those circumstances?

➢ Have there been any circumstances where you have felt disquiet about:

- The choices that a woman has made about her care?
- The information used by the woman to assist her choice?
- The recommendations made by other health care practitioners?
- The desires of the family/whanau?

➢ In relation to the above, would you explain why you had reservations?

➢ Is there any particular experience that you wish to share with the researcher with regard to your experiences of the third stage of labour?

Thank you for taking part in this interview. Is there anything that you would like to add?

Advantages of Physiological birth of the placenta;

Time to cuddle baby with no rush
No extra drugs
Reduced risk of cervix closing and trapping placenta
Allows baby to have a little circulation from the placenta while it establishes breathing.
"Natural" birth you do it yourself.
Avoids risk of side affects from medication.

Disadvantages of Physiological birth of the placenta;

All the recent research studies have suggested an increased blood loss at the time of birth with this type of birth.
(this may be due to impatience trying to hurry the process along causing partial separation of the placenta)

Usually the placenta is born within half an hour but may take twice that time.(if it takes longer it would seem to be safe to cut the cord once it has stopped pulsing and no blood is passing through it.)

If bleeding does occur and an injection of oxytocin is given later there is an increased risk of the cervix closing on the placenta causing it to be trapped.

Advantages of active birth of the placenta;

Gets the whole process complete in one go.
Statistically a reduced risk of heavier bleeding
Allows Mum to and Dad to cuddle baby without the cord being attached after it is cut.

Disadvantages of active birth of the placenta;

Increased urgency to birth the placenta
Baby has to have cord clamped early, so does not experience the gentle transition of circulation through the placenta.
Increased risk of placenta being trapped when cervix closes
If cord is unusually fragile it may detach from the placenta giving the doctor or midwife nothing to hold onto to pull the placenta out.
Risk of side affects from drugs;
Syntocinon may cause tremors "shakes" which are hard to control
Ergometrine may cause nausea and vomiting,
may cause a rise in blood pressure.

Your Decision

You can decide which method you prefer for birthing your placenta or wait and see at the time.

Physiological birth;

You may decide to birth the placenta by yourself if you have had a good labour with no help required.
It is necessary to watch for any sign of heavy bleeding and it may be necessary to have the injection if the bleeding appears too heavy.
Women do occasionally birth the placenta in the pool after a water birth but it is more usual for women to leave the pool before the placenta is born. If you remain in the water you may be asked to leave if the blood loss appears heavy.

Active birth of the placenta;

You may need to have an injection if;

- the labour is long and slow
- if your baby is large which could mean the uterus is overstretched and there is a large placental site with a potential for a large blood loss.

Or any of the previously mentioned instances.

What to do with the placenta.

Many people choose to leave their placenta at the hospital.
In this instance it is sent to the dangerous waste centre where it is heated to extreme temperatures along with other dangerous waste such as injection needles and is then sent to the Dunedin landfill site.
You can choose to take the placenta home and bury it or dispose as you wish. Some people plant it in a pot with a shrub until they are ready to put it in the garden or a favourite spot. some people store it in the deep freeze until they are ready to bury it.
Some women have a big celebration for planting the placenta others do it more privately.
It is also possible to incinerate the placenta in a hot fire at home.

Lotus Birth;

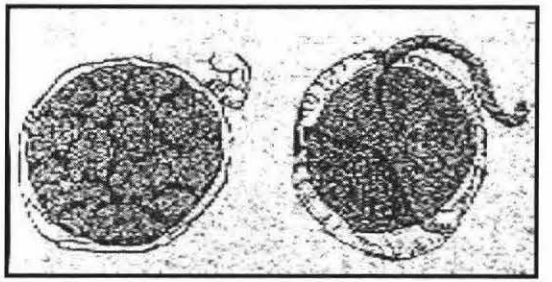
Some women choose to leave the placenta attached to the baby until the cord has separated. The cord usually separates in 2-3 days in this instance.
The hormones in the placenta help to control bleeding. In emergency situations in remote locations where there is heavy bleeding the bleeding has been said to have been controlled by touching a piece of placenta to the woman's lips.

The Wonderful Placenta

What it does;

How to birth it;

What to do with it after it is born.



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Source: British Medical Journal, Volume 297, 19th November, 1988, Pg 1295-1300

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Rogers, J. Wood, J. McCandlish, R. Ayers, A.T. Elbourne, D. Active versus expectant management of the third stage of labour: the Hinchingbrooke randomised controlled trial. The Lancet Volume 351 March 1998, 693-699

Odent, M. Active versus expectant management of the third stage of labour. The Lancet. Volume 351 May 1998, 1659

Author;
Midwife

What is the placenta?

The placenta grows along with the baby and passes food to the baby from the mothers' blood stream. It also takes waste products from the baby into the mothers' blood stream for disposal.

The placenta is a very complex organ and it changes some chemicals to make them easier for the baby to use. It also releases hormones which help to maintain the pregnancy.

The placenta protects the baby and blocks many bacteria and viruses from reaching the baby. Unfortunately it cannot block them all and some such as Listeria, Toxoplasma and German Measles can get through causing the baby to become ill or die.

Some toxic substances also damage the placenta or manage to cross to the baby, such as alcohol, tobacco and marijuana.

Where is the placenta?

Early in pregnancy the egg embeds into the uterus this then grows and the cells divide, some become the baby, some become the placenta and some become the membranes (or bag of waters around the baby)

The placenta is usually to the side and top of the uterus but can be situated anywhere in the uterus. Often at the 20 week scan the placenta is low but it usually moves up as the uterus grows. Occasionally the placenta is situated in the bottom of the uterus blocking the opening into the vagina. If this is the case then the mother may have heavy bleeding and the baby will need to be born by caesarean section.

The placenta depends on the mother having a good healthy circulation to maintain its health. If the placenta is not healthy then the baby may not be able to get the food that it needs and may loose weight or fail to grow properly.

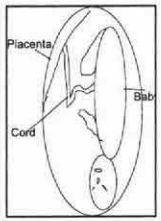
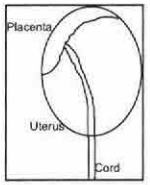


Diagram of the baby, and placenta.

What happens after the baby is born:

After a pause the uterus starts contracting again and the placenta is born, either naturally by the mother or with medical assistance.

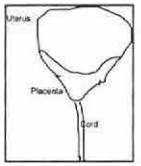
The Physiology of the birth of the placenta;



Placenta still attached to uterus after baby is born

After the baby is born it can be cuddled and held by Mum and can be held close to the breast. The baby may then begin to feed or may just snuffle and lick at the nipple. This stimulates the mother to produce hormones which cause the uterus to contract once more.

When the uterus contracts it reduces in size to at least half the size it was before. This makes the placenta peel off from the inside wall of the uterus.



Placenta separated, ready to be born.

As the uterus contracts the placenta separates and falls into the top of the vagina which makes the mother feel a slight pushing urge. She can then stand or squat and push the placenta out.
If the uterus contracts down well all the big blood vessels will be squeezed and shut off preventing bleeding.
The birth is then complete and the cord can be clamped, to prevent any bleeding from the baby, and cut.
It is important not to clamp the cord before the placenta is born as the back pressure of blood flowing to the cord might make the placenta partially separate. If this happens the uterus can not contract down on the exposed blood vessels and there may be heavy bleeding.

Active management of the birth of the placenta;

There are some situations in which you might choose, or it may be recommended that you have an injection, as the baby is born. This encourages your uterus to contract strongly and usually causes the placenta to be born quickly.
Some of the indications for this would be;

- An induced labour
- A long slow labour
- Use of Epidural
- Use of Pethidine
- Forceps or Ventouse birth
- Caesarean section
- If you have a bleeding or clotting problem
- f you have a medical condition such as diabetes.
- Some women prefer to have the injection anyway incase they have some heavy bleeding.

What happens when an injection of Oxytocin is given?
Oxytocin is an artificial form of a naturally occurring hormone which causes the uterus to contract. It is given by injection into the thigh usually as the baby is born or just after. Usually 10 units of Syntocinon is given but sometimes this is also mixed with Ergometrine in a drug called Syntometrine. Ergometrine acts quickly and Syntocinon has a more lasting affect. It can also be given intravenously and this is often done if an intravenous infusion is already running. This drug causes a very strong contraction of the uterus making the placenta separate and cutting off the blood vessels which may cause bleeding. This strong contraction could also push a lot of extra blood to the baby so it is important that the cord is clamped and cut straight away.

Delivering your placenta;
The midwife or doctor looking after you will wait until there is a small trickle of blood indicating that the placenta has separated and will then place a hand on your abdomen just above your pubic bone to protect the uterus and will hold the cord firmly and pull the placenta out. It is important that this is done within 15-20 minutes as the cervix (neck of the uterus) can sometimes close with the action of the drugs and trap the placenta requiring an anaesthetic to free it.

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Undertaking as to non-disclosure of information

Whereas I

Currently residing at

Have agreed to transcribe tapes made during interviews conducted by Kate Spenceley for the purposes of a research project. As part of the transcription process, I will hear names and other forms of identification of the people involved.

I agree that I will not, directly or indirectly, share or divulge any information concerning the identification of the participants and/or identifiable institutions to which I have been given access.

I understand that only Kate Spenceley and Dr. Cheryl Benn, the research supervisor, will be allowed to access the information in the tapes. The researcher, research supervisor and the particular research participants will have access to the transcriptions of the tapes.

I also undertake that I will not at any time, either directly or indirectly, divulge to any department, agency or institution information to which I have been access.

Name:

Signed:

Date:

Witnessed by (sign)

Name (print):

Date: