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***Decision-making in the Woman-Midwife Dyad: A
Relational Undertaking***

A thesis presented in fulfilment of the requirements for the degree
of
Doctor of Philosophy
in
Midwifery

At
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Dorothy Ann Noseworthy
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Dedication

In Loving Memory of my mother, father, and sister
Betty, Jack and Cathy Noseworthy

Abstract

Within midwifery in both Canada and New Zealand informed choice and decision-making is a strong tenet of the profession's philosophy and ethics. Through discussions and conversations, decision-making was explored in the woman-midwife dyad with birth of the placenta as the vehicle. Using various epistemological, theoretical principles and philosophical paradigms, as well as acknowledging the research journey itself, this thesis develops not only a model that increases the understanding of decision-making but a new relational research methodology that is fitting for midwifery and other health disciplines in which long-term relationships are established.

The evolving methodology developed from the challenges of the research journey and the steps undertaken to address the challenges. These steps involved consultation, professional networks, building relationships and adapting to circumstances. Participants were recruited through professional networks and involved 14 woman-midwife relationships. In total 14 women, 5 support persons, and 18 midwives were involved from New Zealand and Ontario, Canada. The stories, experiences, and thoughts of each woman, her support person, and the midwives in the childbearing relationship were gathered through recording of the decision-making discussions and conversational interviews. The resulting methodology, which is presented in the first substantive chapter, recognises the complexity of influences on the researcher and participants and their involvement together, in constructing knowledge.

Influenced by Granovetter's (1985) concepts of embeddedness and Sherwin's (1998) broader definition of relationality, the findings identify how identity projects, philosophies, socio-political, and locational events influence decision-making within the woman/family-midwife partnership. Participant's talk as a whole and in part were analysed using social theories of identity, including narrative identity, positioning, location, professional projects, and power. The central finding in this research is that decision-making in the woman/family-midwife partnership is

relational in nature, influenced by social networks and the historical, social, political, and economic contexts and locations in which they are embedded.

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To my family in Canada, it's great to be back home and thank you for your support and interest.

To my sister, Elizabeth, thank you once again for your great editorial work, even from the other side of the world.

Glossary

Third stage of labour: The stage from birth of the baby to the complete birth of the placenta and membranes.

Active management: The process where 10 iu of Oxytocin is given intramuscularly within one minute of baby's birth to facilitate delivery of the placenta and prevent postpartum haemorrhage. Once the umbilical cord has stopped pulsing, a technique called controlled cord traction is used to deliver the placenta. (FIGO/ICM, 2004)

Physiological birth of the placenta: The process whereby the body delivers the placenta with no interference from the birth attendant. Research indicates it should only be used when there has been an undisturbed, physiological labour and birth, with the woman in a warm and private environment, a relaxed state, an upright position and breastfeeding or holding baby (Stojanovic, 2012).

Lotus Birth: Refers to a style of birth and care of the placenta, whereby a physiological birth of the placenta occurs, the cord is not clamped or cut but it and the placenta remain attached to the baby until separation occurs naturally, usually within a week of birth.

Ergometrine®: a drug that acts on smooth muscle including the uterus, causing a generalised smooth muscle contraction. It is used in the initial treatment of postpartum haemorrhage.

Oxytocin: The hormone produced by the pituitary and responsible for contraction of the uterine muscle and the milk letdown reflex.

Syntocinon®/Pitocin®: The synthetic form of the hormone Oxytocin. Syntocinon is the trade name in New Zealand, Pitocin the trade name in Canada.

Lead Maternity Carer (LMC): The term used, in official documentation, in New Zealand to refer to the care provider who is responsible for the pregnancy care of the woman who is registered under her care.

[words] inserted for clarity or explanation

[word] inserted for grammatical reasons

Quotes from participants talk during the "interviews" are in Calibri font. Correspondence received via email is in Courier New font as a way of distinguishing the two.

Pseudonyms and partnerships of participants

New Zealand

Midwife	Woman	Pregnancy #	Partner/Support person (those who participated)
Andrea	Kylie	2 (with Andrea)	Rick
Cindy	Jane	3 (1 st with Cindy)	
Fran	Kate	1	
Jess	April	1	Ben
June	Mania	1	Steve
Penny	Tracey	1	
Candice	Helen	1	Tim
Jasmine	Lily	2 (1 st with Jasmine)	

Canada

Midwife	Woman	Pregnancy #	Partner/Support person (those who participated)
Genie/Alex	Ester	1	
Barb/Cherie	Hildy	1	Jim
Mary/Jenn	Hattie	3 (2 nd with these midwives)	
Ellie	Gail	3 (with Ellie)	
Erin/Karen	Catherine	6 (3 rd with these midwives)	
Tilly	Nancy	2 (1 st with Midwife)	

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Chapter 1: Introduction

According to standards of practice and codes of ethics for midwives in Ontario, Canada and New Zealand, upholding a woman's right to make informed choices during childbirth is of utmost importance (College of Midwives of Ontario, 1994a; New Zealand College of Midwives, 1996, 2007). The process of making that choice can be influenced by a number of factors, ranging from personal preference to the national organisation of maternity services, some of which may create barriers to making informed decisions. Current models of decision-making, such as shared decision-making and the informed model, depict the decision-maker as someone with the tools and skills to make a decision and who makes decisions independent of outside influence. Caregivers are characterised as either unbiased, objective providers of perfect information, as in the informed model, or as unbiased providers of information with the patient positioned as willing and able to negotiate an agreed plan of care, as in the shared model. Both models are also predicated on the assumption that there is perfect information on which to base the decision. Outside influences are often not acknowledged, and neither model fits comfortably with what experience indicates occurs in the ongoing woman-midwife relationship. Choices are influenced by complex factors and a decision made at one point may later change due to circumstances. Using the decision point of birth of the placenta, this study explores the decision-making process in the woman-midwife dyad in New Zealand and in Ontario, Canada.

The central finding in this study is that decision-making in the woman-midwife dyad is relational in nature, influenced by social networks and the social, political, economic, and historical contexts and locations in which they are embedded. The study also found that research itself is relational in nature, and, as a result, a new relational research methodology is described. This thesis provides evidence from research conducted in New Zealand and Ontario, Canada to support both findings.

This first chapter provides an overview of the research and sets out the historical context for the study. The concepts of informed choice and decision-making and their definitions, history, and legal standing are introduced and brief histories of midwifery practice in New Zealand and Canada including Ontario are outlined. A critical look at the recent evidence regarding birth of the placenta is undertaken, to provide the rationale for its use as the vehicle for this study. The objectives and methodology are stated before the chapter concludes with an overview of the structure of the thesis.

Decision-making—Historical Context

Discussion of informed decision-making as a process cannot be undertaken without positioning informed choice as the endpoint of that process. The concept of informed consent preceded discussion of appropriate processes of decision-making; however, it must be noted that informed consent and choice, although often used to mean the same thing, differ. Informed consent implies that the client agrees to a particular treatment and indicates consent after having considered all the available information provided about that treatment, while informed choice means the client has chosen among options, having full information about each option.

It is difficult to be definite about the development of informed choice because there is little discussion of informed choice in historical midwifery literature, and there is a lack of good evidence of its early existence in medicine (Faden & Beauchamp, 1986). This may be due to the fact that the concept of informed choice arose when midwifery was subordinate to medicine and within a health system where the notion of informed choice was absent. Also, it was not until the early part of the 20th century, during the struggle for emancipation of women that midwives in Europe began to organize in order to gain control of and recognition for their profession. In Canada, before the late 19th century, immigrant women, working women, and aboriginal women who attended women at birth had little opportunity to learn to read and write, so there are few historical records from this group relating to decision-making within midwifery practice (Rutherford, 2010). It

may be assumed that the same would have applied to New Zealand, which was also a British colony. There is a possibility that women coming from Ireland or England who set up practice in Canada or New Zealand in the mid to late 1800s had some training. There is evidence that there were educated midwives in Toronto in the mid 1800's. However, the histories do not discuss consent as part of their practice (Young, 2010).

Men in medicine did have the opportunity for education, and, during the enlightenment period, writers began to support information giving as a means of gaining patient understanding of and compliance with physician recommendations (Rush, 1801 as cited Faden & Beauchamp, 1987). Nevertheless, Faden and Beauchamp indicate that there is little documented evidence of the general use of informed consent until the 1960s. Early documents were in the form of codes, standards, and diaries that, although they may have professed the need for informed consent, did not guarantee the existence of informed consent in practice. It must also be considered that mention of informed consent is found in diaries and other personal recollections from the 19th century, but the understanding of rights and informed consent is different from the understanding of rights and informed choice or consent today (Faden & Beauchamp, 1986; Fox, 2003). Meaningful informed choice as we know it today, based on the idea of patient autonomy, and entrenched in legislation, did not appear until the middle of the 20th century, at which time midwifery was not legal in Canada, and midwives in New Zealand were already incorporated into the formal health care system and thus followed the practice of the institutions.

The contemporary idea of informed choice in health care and legislation on patient rights is a recent phenomenon that stemmed initially from medical atrocities that occurred in the Nazi concentration camps during the Second World War as well as later scandals in the area of medical research. After the Second World War, the 1947 Nuremberg Code was developed as a means of protecting citizens from forced treatments (ACOG, 1993; Cartwright, 1988; Coney, 1988; Timko, 2001). Although the Nuremberg and other recent codes are said to be based on the principle of

respecting autonomy, they arose out of the need to prevent harm to others (Timko, 2001). The Nuremburg code, drawn up in 1947, and the 1948 Declaration of Geneva, did not make mention of the right to informed consent (World Medical Association, 1948). In 1949, the World Medical Association (WMA) drew up an international code of medical ethics in which it indicated that the physician should respect a competent patient's right to accept or decline treatment (World Medical Association, 1949). The 1964 Helsinki Declaration from WMA and its amendments further added to the obligations of the medical professional when it came to research (World Medical Association, 2008). In a number of countries, national laws came about only after the uncovering of medical research atrocities and it was not until local laws were enacted that the national medical professions began to develop their codes with regard to patient care. At the heart of some of these codes was the recognition of human right to autonomy (Coney, 1988). In New Zealand, the uncovering of unethical medical research was the impetus for legislation on patient rights.

In New Zealand, the need for more accountability within the health profession followed the disastrous results of medical research at Auckland's National Women's Hospital and the subsequent movement for change with regard to patient rights (Coney, 1988). This Auckland research involved the uninformed participation of women in a clinical trial in which conservative treatment of cervical cancer was mandated resulting in the deaths of a number of women. The eventual outcome of the Cartwright inquiry (1988) investigating this event was the passing of legislation and the development of a patient's code of rights (Health and Disability Commissioner, 1996) which was preceded by a number of documents to inform both the public (Ministry of Women's Affairs, 1989) and health professionals (Department of Health, 1991) of their rights and obligations under the new act. Under this act, midwives are required to respect patient rights to informed choice. The Standards for Practice for midwives were first printed in 1993, three years prior to the development of the code of patient's rights, and informed choice was included as midwifery practice standard two. There had been discussion of the standards for at least two years prior to the publication of the midwifery standards

for practice (Campbell, N., personal communication, Dec. 6, 2012). A conversation with a midwife involved in providing home birth prior to formal incorporation of informed choice into the list of midwifery standards indicated that informed choice was certainly an ethos of home birth midwives at the time and a part of the ethos of the Home Birth Association which began in 1978 (Campbell, N., personal communication, Dec. 6, 2012). Formalised informed choice in New Zealand may, therefore, be characterised as emerging from grass roots women-centred midwifery practice rather than as occurring as a result of formal legislation.

In Canada, the Health Charter for Canadians (1964), which came out of the 1961 Royal Commission on Health Services, has, among its general principles, freedom of choice (Smith, 2002). Although Canada does not have a national act on patient rights, there are laws in a number of provincial jurisdictions, for example, British Columbia, Nova Scotia and Ontario, which affirm the patient's right to informed choice in health care (Government of British Columbia, 1996; Government of Nova Scotia, 2008; Government of Ontario, 2010). The Canadian Charter of Rights and Freedoms also states that everyone has the right to life, liberty, and security of the person (Government of Canada, 1982). In the 1987 report of the Task Force on the Implementation of Midwifery in Ontario (Eberts, Schwartz, Edney, & Kaufman, 1987), individual consumers and consumer support groups indicated that informed choice was an important part of what midwives provided (Eberts et al., 1987). In the same report, midwives' submissions reinforced a model of care that focused on informed choice as one of the cornerstones of their practice. Subsequent to regulation in 1994, the professional regulatory body of midwifery in Ontario drew up statements on the upholding of informed choice (College of Midwives of Ontario, 1994a, 1994d). Much informed choice legislation now requires that adequate information be given to patients so they can make a decision and have that decision respected (Government of New Zealand, 1994; Government of Ontario, 2010).

All these recent acts and codes are, in principle, based on the notion of patient autonomy. Patient rights codes and explanations indicate that the patient has the

right to make an informed decision without coercion from the informant and to have that choice respected (Health and Disability Commissioner, 1996; Legal Information Society of Nova Scotia, 2001; Public Legal Information Association of Newfoundland, 2008). The history of informed decision-making is important in understanding the context of decision-making in midwifery practice. However, knowledge of the historical context of midwifery in both New Zealand and Canada is necessary in understanding where the profession is located in their respective health care environments.

History of Midwifery in New Zealand—an Overview

Midwifery has a long history in New Zealand, with traditional Māori birth attendants and later with the settling of British trained midwives providing care to women in childbirth. Prior to the 20th century, most women gave birth at home under the care of lay midwives (New Zealand College of Midwives, 2004), with Maori women often attended by the man of the family (Stojanovic, 2012). By the latter half of the 19th century, women were being educated as midwives and British educated midwives were beginning to settle in New Zealand (Stojanovic, 2012). In 1904, despite medical opposition, the Midwives Registration Act was passed in response to the rising infant mortality rate and falling birth rates, (Douché, 2007; New Zealand College of Midwives, 2004). The Act regulated midwives' education and practice (Douché, 2007; New Zealand College of Midwives, 2004) and placed midwives under medical control, the medical gaze being enacted through the installation of District Officers of Health (Stojanovic, 2012). Lay midwives were required to have a certificate from a doctor in order to register. Subsequent to the 1904 enactment, despite opposition from the Medical Associations who were running private maternity homes, the government established the first partially subsidised St Helens hospital, which had a mandate to train midwives (Douché, 2007) with seven quickly opening across the country (Donley, 1998).

Although the St Helens public maternity hospitals with trained midwives were expanding their presence, by the 1920s and 30s there was an increasing number of

privately run maternity hospitals operated by medical doctors, under the auspices of district health boards (Donley, 1998). The 1925 Nurses and Midwives Registration Act set up boards to regulate practice and midwives came under the regulation of nurses and doctors, the predominant practitioners on the regulating board (Douché, 2007). The lure of twilight sleep saw a growing number of women move from home to hospital for their births and doctors gained an increasing foothold in maternity care (Donley, 1998) as medicalisation continued (Douché 2007). A continued rise in puerperal sepsis, attributed to the increase in forceps deliveries, raised concern. The resulting report from the Kelvin Hospital Commission indicated that there was some negligence on the part of doctors, but blame was apportioned to midwives (Douché, 2007). The Social Security Act of 1938, giving free medical care to women who gave birth under the care of a doctor, secured medicalisation of childbirth and the demise of midwifery as an autonomous profession (Douché, 2007; New Zealand College of Midwives, 2004). The passing of the 1971 Nurses Act resulted in midwives being classified as nurses and it became necessary for a doctor to be present when a woman gave birth under a midwife's care (Stojanovic, 2009).

The Home Birth Association was established in the 1970s, spurred by the medicalisation of childbirth, which was seen as contributing to the demise of the midwifery profession. This group took legal action when the 1983 Nurses Amendment Act saw midwifery education become a sub-speciality of nursing. The Save the Midwife consumer campaign, the 1987 Cartwright Report supporting women's choice and informed consent, the work of dedicated midwives, and the political situation at the time eventually saw the rebirth of independent midwifery when, in 1990, there was an amendment to the 1977 Nurses Act, enabling midwives to work autonomously as a publically funded profession (Douché, 2007; New Zealand College of Midwives, 2004). This autonomy and subsequent changes in the method of funding have resulted in midwives being the predominant care provider for pregnant women in New Zealand (Ministry of Health, 2012d). The amendment to the Nurses Act 1991 has subsequently been superseded by the

Health Practitioners Competence Assurance Act 2003, which enacted the Midwifery Council of New Zealand as the regulator of midwifery¹.

History of Midwifery in Canada—an overview

Midwifery has a long history in Canada and, until the late 18th century, it was practiced without legislation (Plummer, 2000), usually in the form of neighbour networks—women helping women (Eberts et al., 1987). As in New Zealand, European midwives came to Canada as immigrants, while the First Peoples communities (First Nations, Inuit and Métis) had a long tradition of women supporting women in birth and the transition to parenting (Native Women's Association of Canada, 2007; van Wagner, Epoo, Nastapoka, & Harney, 2007). There is also evidence that First Nations men sometimes supported their wife during childbirth (Eberts et al., 1987). For the European settlers in New France (now Quebec), the government established three autonomous branches of medicine, one being midwifery, in 1691 (Herbert, nd; Plummer, 2000), with the earliest mention of midwives documented in 1713 (Eberts et al., 1987). In 1788, the Medical Act in Quebec required that midwifery education be six months in a university (Plummer, 2000). The regulation or recognition of midwifery continued in Nova Scotia, with records showing that from 1755 to 1764 the British government paid midwives (Herbert, nd). From 1872 to 1881, under the new federation of Canada, there was compulsory certification for midwives in Nova Scotia, New Brunswick, and Quebec (Plummer, 2000). In Newfoundland and Labrador, which was still a colony of Britain at the time, the Midwives Act legislating midwifery education and practice was implemented in 1920 (Herbert, 2008a).

In 1912 in Canada, the Medical Council was formed and midwifery practice was eliminated in most areas. At this time nursing was establishing itself as having close ties with the medical profession (Plummer, 2000). The rise in public health

¹ Prior to the 2003 establishment of the Midwifery Council of New Zealand, midwifery was regulated by the Nursing Council of New Zealand.

concerns, the promotion of birth under a doctor, and the stories about dirty, untrained midwives saw the demise of the profession until the late 1980s (Relyea, 1992; Stahl, 1991).

Although many Canadian provinces had legislation governing midwifery, it was very difficult to practice during the mid-20th century because of medical restrictions and the growth of science and obstetric practice. In Canada, midwifery became, rather than illegal, virtually impossible to practice (Plummer, 2000). Midwifery remained outside the law, apart from in Newfoundland and Labrador, until 1986 with the opening of the first birth centre in an Inuit community in northern Quebec.

In colonial Ontario, as in the rest of Canada at the time, women provided childbirth help to their community. However, the first law passed in 1795 to regulate medicine resulted in handy women (lay midwives) being unable to practice legally. This law was repealed in 1806 when problems, associated with an insufficient number of doctors and the poor being unable to pay the doctor's fees, were identified in colonial Ontario (Biggs, 1990). A later amendment to the 1795 law enabled midwives to practice by stating that the law restricting the role of handy women in supporting childbirth did not extend to females who practiced midwifery (Biggs, 1990). There are records of women offering midwifery services in York (Toronto) with the earliest advertisement in 1810 (Young, 2010). By the middle of the 1800s Toronto had grown, and immigrant women, often widows, from Ireland and England made up those who practiced as midwives (Young, 2010). Midwives continued to practice, in small numbers without licensure, until 1865 when the earlier act exempting midwives was repealed (Biggs, 1990). However, in 1869 midwives were prohibited from working for gain or hire and that law was strengthened in 1874 (Eberts et al., 1987). A powerful medical lobby (Biggs, 1990; Eberts et al., 1987) coupled with the Victorian ambivalence toward midwives, changes in cultural norms, and the lack of midwifery training and organisation, saw the profession decline (Young, 2010). Unlike the New Zealand situation, where the Midwives Act in 1904 saw Midwifery practice and education regulated, by the beginning of the 20th century regulated midwives were all but eliminated from

Ontario (Biggs, 1990; Young, 2010). Non-regulated midwives in Ontario did practice during the 20th century, with numbers increasing during the time of the women's movement.

In the 1980s, there were approximately 50 midwives in private practice outside the legal system in Ontario, as well as midwives employed by the federal government in the far north (Eberts et al., 1987). In 1973, the Ontario Association of Nurse-Midwives (OANM) was formed as an interest group, and, in 1979, the Ontario Association of Midwives (OAM) was formed by a group of midwives whose aim was to work towards midwifery autonomy. In 1983, in response to the death of a baby at a home birth in Ontario in 1982, the College of Physicians and Surgeons put out a statement disapproving of its members attending home births. As a result, midwives continued home birth practice without doctor attendance. Lobbying by community groups and the Association of Ontario Midwives (OANM+OAM), plus the recommendations from the inquest into the baby's death, led to the setting up of a Task Force on the Implementation of Midwifery in Ontario in 1986, with the aim of investigating how to integrate midwifery into the health system (Eberts et al., 1987; Relyea, 1992). By January 1994, midwives in Ontario were regulated by the Regulated Health Professions Act and the Midwifery Act 1993 (College of Midwives of Ontario, 2012a).

The midwives in both countries work with women to ensure they have sufficient information on which to base choices and decisions. One area in which there is contestable evidence is the third stage of labour. This is discussed as part of the birth plan for which women make some decisions about how the placenta is to be born.

Context—Birth of the Placenta

The birth of the placenta is one of the many decision points in a woman's pregnancy and is an area that is fraught with controversy. It is a time of birth that

has been constructed as risky within the obstetric literature and, as evidence shows, for women in the third world birth and the third stage are risky due to nutritional deficits and deficiencies in health services (Davies, 2009; Fahy, 2009). A number of research projects comparing active management with physiological birth of the placenta have been undertaken (Begley, 1990; Kashanian, Fekrat, Masoomi, & Sheikh, 2010; Khan, John, Wani, Doherty, & Sibai, 1997; Prendiville, Harding, Elbourne, & Stirrat, 1988; Rogers et al., 1998; Thilaganathan, Cutner, Latimer, & Beard, 1993). Their findings have resulted in almost universal routine use of active management for the delivery of the placenta for women in the developed and developing worlds. Evidence for the best method of birth of the placenta, whether physiological or active, is changing, and the previously routine practice of active management for third stage of labour for healthy, low risk women is now being questioned (Buckley, 2006; Guilliland, 2007; Odent, 2003).

Difficulties with birth of the placenta can result in postpartum haemorrhage, a major killer in the developing world (UNDP, UNFPA, UNICEF, WHO, & World Bank, 2012). Stojanovic (2012) indicates that the medicalisation and nursification of birth has led to increased rates of postpartum haemorrhage (PPH). In the western world the high rates of PPH were often a result of manipulation of the placenta, sedation during the birth process, poor health (Tew, 1995), and possibly the high birth numbers per woman before the late 20th century (Graham, 2002). As with other advances in health, as public health initiatives developed and women's lot in western society improved, complications during pregnancy declined, including deaths from haemorrhage. Statistics from Scotland indicated that the death rates from other puerperal haemorrhage went from a total of 35/100,000 live births in 1931-33 to 7/100,00 live births in 1949-51 (Douglas, 1955), a fall of about 85% (Tew, 1995). Although early statistics from Canada and New Zealand are not easily available, maternal mortality in the western world was remarkably similar and remained relatively unchanged until the late 1930's, with declines in maternal deaths from all causes happening sharply after that (Loudon, 1991; Watson, 1955). This was before the routine use of oxytocic drugs.

Concerns were raised in the 1980s, first about the use of Ergometrine® or the ergometrine/oxytocin combination, Syntometrine®, for third stage management, its side effects, and obstetric routines in general. Consequently, the Bristol trial (Prendiville, Harding, Elbourne, & Stirrat, 1988) was undertaken to compare active management with physiological management. The Bristol trial found that active management for third stage reduced the amount of blood loss in the immediate postnatal period. Since that early Bristol study, there have been five separate trials that have investigated management of third stage, comparing active management with physiological birth of the placenta (Begley, 1990; Kashanian et al., 2010; Khan et al., 1997; Rogers et al., 1998; Thilaganathan et al., 1993). There have also been numerous other trials investigating various aspects of active management, including timing of administering the oxytocic drug (Jackson et al., 2001), which drug to use (Gülmezoglu et al., 2001; Kundodyiwa, Majoko, & Rusakaniko, 2001; McDonald, Prendiville, & Blair, 1993; Orji, Agwu, Loto, & Olaleye, 2007), IV oxytocin (Nordström, Fogelstam, Fridman, Larsson, & Rydstroem, 1997), timing of clamping and cutting of the umbilical cord (Cernadas et al., 2006; Mercer, McGrath, Hensman, Silver, & Oh, 2003; Mercer, Vohr, Erickson-Owens, Padbury, & Oh, 2010), and techniques of cord traction (Giacalone, Vignal, Daures, Hedon, & Laffargue, 2000; Khan et al., 1997).

The three trials that compared active management with physiological or minimal intervention for birth of the placenta (Begley, 1990; Khan et al., 1997; Rogers et al., 1998) supported the findings of the Bristol study and indicated that active management or the use of drugs plus practice techniques is the best way to reduce blood loss in the immediate postpartum period. The Khan et al. (1997) study, although supporting active management over minimal intervention, did not use physiological birth of the placenta because all women had IV oxytocin after delivery of the placenta. The Thilaganathan et al. (1993) trial found physiological management to be safe, but, like the Begley (1990) trial, post randomization withdrawal may have affected the results. The Kashanian et al. (2010) trial found that there was no significant difference in blood loss between the expectantly

managed and actively managed groups. However, fourth stage² blood loss was higher in the actively managed group. Like the Khan et al. (1997) study, women in the expectant management group did have IV oxytocin after the birth of the placenta. Earlier Cochrane and other reviews of these trials have consistently found the evidence to support active management of delivery of the placenta and extended the recommendations to all births. Nevertheless, the latest Cochrane review indicates that further research is needed before a recommendation of active management in all cases is made (Begley et al., 2010).

The midwives' lack of skill with physiological birth of the placenta was one of the issues identified as a cause of concern in the studies. At the time of these studies, routine active management was the norm in both the UK (Garcia & Garforth, 1989; Gyte, 1994; McDonald et al., 1993) and Abu Dhabi (Khan et al., 1997), where the studies were undertaken. In the Hinchingsbrooke trial (Rogers et al., 1998), midwives were reported to be comfortable with both physiological/expectant and active management of third stage. However, it was found that, when surveyed prior to the beginning of the trial, 81% of midwives felt very confident with active management, while only 41% felt very confident with physiological third stage.

In all studies women were considered low risk for PPH. However, in the earlier Prendiville et al. (1988) study, not all women were of low risk, as women who had had epidurals, Ritodrine^{®3}, labour induction, and forceps delivery were included and later had to be excluded. The Hinchingsbrooke trial had tighter exclusion criteria. Nevertheless, Fahy (2009) found the study included women who had had complications in labour and 67% required sutures, pointing to perineal trauma as possibly contributing to blood loss. Fahy indicates that in the studies undertaken the risk factors for women ranged from 15% in the Khan et al. (1997) study to 75% in the Hinchingsbrooke trial (Rogers et al., 1998). The methods of accounting for blood loss were different across trials, with the Bristol trial using measured blood

² The first two to three hours after the birth of the placenta.

³ Ritodrine[®] is a uterine relaxant used to stop premature labour (Jordan, 2002).

loss while the others used estimation of blood loss (Begley, 2010). A number of critiques of these trials point to the difficulty in comparing physiological and active management when the definition and practice of both differ among trials and the subsequent reviews did not consider this (Fahy, 2009; Hastie & Fahy, 2009; Wagner, 2001).

The studies defined physiological third stage or expectant management only in terms such as hands off, upright position, maternal effort, and baby to the breast; these factors are more about not being actively managed rather than genuine physiological birth of the placenta (Fahy, 2009). In most cases, the definition of physiological management used in the research studies is inconsistent and unclear, as is the definition for active management (Barlow et al., 2002; Begley et al., 2010; Fahy, 2009). The definition for physiological management does not truly reflect physiological birth of the placenta as it does not take into consideration other contextual, biological, and physiological factors necessary for physiological birth of the placenta (Buckley, 2006; Odent, 2003; Stojanovic, 2012). Fahy also points out that the definition of active management used at the time of the studies cited above, differs from the technique that is now recommended by ICM and FIGO⁴ (Fahy, 2009). The differences in definition would raise questions about the relevance of both past and present studies to the current recommended practice around active management.

The results from the Hinchingsbrooke trial (Rogers et al., 1998) indicate that mixed management was used in both groups, with only 63.9% of women in the expectant management group receiving full expectant management. Results also indicated that the PPH rate for those who had mixed management was 21% (Rogers & Wood, 2003), which is of interest as it points to other factors about management that may be contributing to PPH rates. The results from this trial were based on intention to

⁴ Administration of 10 iu oxytocin or another uterotonic drug within one minute after the birth of the baby. Use controlled cord traction once pulsation of cord stops to remove the placenta, and follow with uterine massage after delivery of the placenta as appropriate.
http://www.pphprevention.org/files/ICM_FIGO_Joint_Statement.pdf

treat, so a percentage of women in the expectant management group had mixed or active management (Fahy, 2009). The results reported that the PPH rate, based on intention to treat, was 16.5% for the expectant management group compared to 6.8% in the actively managed group (Rogers & Wood, 2003; Rogers et al., 1998). It was reported that, for those who had received full expectant management, the PPH rate was 11%. Other concerns relate to the estimation of haemorrhage and the time period used to estimate the PPH (Wickham, 2003). Wickham reported that, in her experience, women who had active management of third stage commonly had a large loss of lochia when in the postnatal ward. This finding has been partly confirmed in the study in Iran (Kashanian et al., 2010) which found a significant difference between the groups when the postpartum blood loss was recorded during the first hour post third stage.

In addition to the concerns about definitions and data collection techniques, the question has been raised about the relevance of these past studies to the midwifery context seen in Lead Maternity Carer (LMC) midwifery in New Zealand (Barlow et al., 2002) and within midwifery in Canada. The studies under question took place within hospitals in which medical staff supervised care (Barlow et al., 2002), and, as Wagner (2001) says, practitioners who work within the medical paradigm can only see birth and third stage as something that needs to be managed. Therefore, the studies applicability to home birth or midwifery facilitated birth is unclear (Harris, 2001).

To add to the controversy, recent statistics from caseload midwifery practice in New Zealand (Dixon, Fletcher, Tracy, Guilliland, & Pairman, 2009; Midwifery and Maternity Providers Organisation Ltd, 2009) indicate that higher rates of postpartum haemorrhage are associated with active management. Other cogent arguments are that the continued move, by international organisations, to recommend active management risks endangering women in countries that do not have access to oxytocic drugs (Guilliland, 2007). In addition, treating healthy women unnecessarily may not be advisable when the long term results of the

practice are unknown and could mean losing sight of midwifery's efforts to support natural birth (Guilliland, 2007).

The debate around management of third stage for low risk western women has been ongoing for thirty years or more. The controversy impacts midwifery practice, as recommendations are for active management for all women and many practitioners routinely use active management. Anecdotal evidence indicates that women are often not given the choice. There have been different methods of active management and the understanding of physiological birth of the placenta is variable. These factors can impact decision-making within this context and can be a challenge for both the woman and the health professional. It is for this reason that birth of the placenta has been chosen as the vehicle for the exploration of the decision-making process in the midwife-woman relationship.

The Impetus for this Study

My interest in carrying out this research came from my personal experience as a midwifery lecturer for twelve years and a practicing midwife for twenty years. I have practiced midwifery in the UK and New Zealand and have worked as a nurse in maternity in Canada. I have been a midwife in a medical model of care where active management of the birth of the placenta was the routine and have supported that approach. The unquestioned acceptance of active management for third stage persisted until I moved into midwifery education and independent practice with a midwifery group that supported a non-interventionist approach to childbirth. My practice, knowledge, and experience grew and the constraints I had felt in my employed role as a midwife disappeared. I began teaching, and through the years I have been party to students' stories from clinical practice. Between 2001 and 2010, I was a professional reviewer for midwives in the region in which I worked and practiced. I had an opportunity to see how midwives in the region practice and have discussed their practice with them. The experiences indicated to me that women may not be making fully informed decisions about various procedures that have

become routine in maternity care, in particular the practices around the birth of the placenta. It is these experiences that have sparked my interest in this research.

I have chosen to carry out the research in both New Zealand and Canada, firstly, because their midwifery systems have similarities in relation to philosophies, and methods of practice, but there are also differences relating to midwifery capacity and constraints against practice. Secondly, I am a Canadian who has resided in and practiced as a midwife New Zealand. I therefore I have an interest in midwifery in both of my countries. It was also hoped that locating the thesis in two countries would enable the taken-for-grantedness of context to be disrupted, facilitating a more nuanced exploration of the topic than locating the thesis in one country would allow.

The province that was eventually chosen for the Canadian aspect of my study, Ontario, was selected for practical reasons. I have personal connections there, and thus accommodation was convenient. Because I returned home from New Zealand to live in eastern Canada part way through this study, flying to the study area was feasible. Furthermore, Ontario has one of the largest populations of registered midwives in Canada, at around 584 (College of Midwives of Ontario, 2012b), and I had the opportunity to build midwifery networks in Ontario, as I am a member of the Canadian Association of Midwives Board, currently representing my home province of Newfoundland and Labrador.

Objectives and Methodology

This study aimed to explore influences upon the decision-making process in the woman-midwife dyad in New Zealand and Ontario, Canada, and to identify an effective model for decision-making within midwifery practice. I draw on social constructionist ideas and a qualitative relational methodology which developed during the study to explore decision-making within the woman-midwife relationship.

The evolving relational methodology developed and used during this project draws on social theory, midwifery theoretical principles, and various research methodologies. The methodology developed as a result of my professional experience and the challenges faced during the research process. The research design came about through consultation with midwives. Eight woman-midwife pairs in New Zealand and six women and their primary and birth midwives in Ontario were recruited through my social and professional networks. The women's and midwives' decision-making were explored through audio recording of a decision-making discussion followed by three way discussions with me. The collaborative research approach recognises that, while the audio-recorded discussion of decision-making and the birth belong to both the woman and the midwife, the knowledge on which this thesis is based is co-constructed by the participants and the researcher. Sociological theories about embeddedness (Granovetter, 1985), relationality (Sherwin, 1998), and decision-making were incorporated into the methodology, necessitating consultation with midwives, changes in research design, and recruitment of participants. Notions of embeddedness and relationality influenced by concepts of narrative identity (Somers, 1994), positioning (Davies & Harré, 1990, 1999; van Langenhove & Harré, 1999), power (Foucault, 1973, 1980, 1982, 1988), and the politics of location (Massey, 1992) also underpin the analysis of women's and midwives' contributions. The thesis does not attempt a comprehensive review of a particular theorist's work within a particular chapter but instead draws upon a range of theories to illustrate themes at work in this field, identified in extracts from conversations with the people who contributed to the research. This evolving relational methodology that is embedded in context, both personal and socio-political, and underpinned by multi-disciplinary theory, including those from midwifery, adds to professional theory. It may be seen as a suitable methodology for midwifery research that has potential application to other professions where continuity of care exists.

The Structure of the Thesis

In this chapter I have provided the background to the study, justifying the decision to investigate the decision-making process in the woman-midwife relationship. The historical context of informed consent and decision-making was presented. The chapter outlined the history of midwifery in, Canada with more detail of Ontario, and New Zealand as a means of highlighting the historical context for practice in both countries. The decision point of the birth of the placenta was chosen as the vehicle for this study and the research evidence around this aspect of care critically explored. The objectives and methodology of the study were outlined.

Chapter Two situates decision-making in a socio-political context and explores the underlying assumptions of the autonomous decision-maker. The chapter reviews the literature on contemporary decision-making and the decision-making models that are found in current health care. The paternalistic, the informed, and the shared decision-making models are explored. These models are critiqued particularly in the context of the woman-midwife relationship. It is argued that the models used do not fully acknowledge the complexity of decision-making for women nor in the woman-midwife relationship. The chapter also critically explores the literature on women's experiences of decision-making in the childbearing year. The chapter concludes by positing that there is a need for a new understanding of decision-making within the woman-midwife relationship.

Chapter Three presents the journey undertaken to achieve the research goals and describes methods that led to the findings, including an evolving methodology that is presented in Chapter Four. The challenges of participant recruitment are discussed along with the techniques used to overcome those challenges. The process of consultation with midwifery colleagues and the adaptation of the research project are presented. The method of data collection is outlined. The analysis of the talk using an adaptation of the thematic analysis method discussed by Braun and Clarke (2006) with aspects of conversation analysis (CA) used in the transcription, is presented. The voices of women and midwives are used to

illuminate the choice of themes identified from the discussions and facilitated interviews.

The study is situated within a social constructionist framework (Berger & Luckmann, 1966), with an influence from participatory epistemology (Heron & Reason, 1997), and reflective conversations (Feldman, 1995). Chapter Four, the first of the findings chapters, presents an evolving relational methodology that was developed and trialled during this research. The research methodology is a bricolage that borrows from a number of world views to construct a methodology that fits within a midwifery world view. Chapter Four also provides the rationale for this developing methodology, demonstrating how it fits with the nature and reality of the woman/family-midwife relationship and midwifery practice in general. The model is presented in visual form, and a critical discussion is undertaken, explaining the underlying principles and theoretical underpinnings of the methodology. The chapter concludes with a discussion of the theoretical principles and concepts underlying the analysis used within the thesis.

Chapters Five and Six present a discussion of the substantive findings of the study and put forward a new understanding of decision-making in the woman-midwife relationship that is presented in Chapter Seven. This study demonstrates that decision-making in the woman-midwife dyad is relational in nature, influenced by social networks and the social, political, and economic context and location in which they are embedded.

Chapter Five explores aspects of the findings as they relate to identity projects and the personal relationships that influence decision-making. Using the theories of identity and positioning, with an underlying thread of relationality and embeddedness, the chapter posits that women and midwives identify themselves and each other through relational networks. The identity they have of themselves and each other determines how they make choices as well as the actions that they take to ensure a fit between the choices made and individual subjectivity. It is demonstrated that the desire for a meaningful relationship with the midwife was of

importance to the women in this study, and to achieve that goal women made use of and were influenced by social networks. The importance of relationships is further highlighted when labour and birth become complex and vulnerability impacts the woman's ability to make decisions.

Chapter Six continues with the themes of embeddedness and relationality and presents the socio-political influences on decision-making. In this chapter the current context of midwifery in Ontario and New Zealand is presented, including both the wider jurisdictional aspects as well as the more local aspects of the political and institutional systems that impact midwifery and thus decision-making. Through midwives' and women's voices, it was found that institutional policies, practices, and structural constraints impact women's choices directly and affect the practice decisions that midwives make. This chapter highlights the similarities and differences between New Zealand and Ontario and how location impacts choice and decision-making. Considering identity and positioning on an organisational level and Foucault's theories of power, I discuss how midwifery organisations, particularly in Canada, resist the dominant discourse of obstetrics and position themselves and midwives to increase access and choice for women in the area of maternity care.

Chapter Seven concludes by tying together all aspects of the thesis and includes a final review of the theoretical underpinnings and principles of the methodology developed and used during this study. The findings related to the aims of the study are woven together and a relational decision-making model that is relevant for midwifery research and practice is presented and explored. The limitations of the study, the implications of this research, and suggestions for future study are presented.

The new conceptualisation of decision-making and choice, as located within a broad social context, will provide midwives and other maternity providers a deeper understanding of decision-making for women than current models allow. An understanding of decision-making as relational and embedded will enable midwives

to critically reflect on how choices are facilitated and/or constrained, resulting in critical attention to the status quo and an increased ability to facilitate informed choice that is more reflective of women's contexts. The following chapter reviews the context of decision-making by exploring the history of its development and three models of decision-making. It also explores women's experience of choice and decision-making during the childbearing year.

Chapter 2: The Context of Decision-Making

Introduction

In general, health professions consider evidence informed care and evidence informed decision-making as critical to the provision of health care. In midwifery, evidence informed care is interpreted as providing optimal care, based on the best available evidence, clinical judgement and including the woman and her family's preferences in that process (Muir Gray, 2001; Page, 2000). Informed decision-making is held up as one of the most important illustrators of the strength of the working relationship between a woman and her midwife. Informed choice in health care, the end result of decision-making, is upheld in law in many western countries including Canada and New Zealand.

The overall question for this study was: What are the influences on decision-making by women and midwives with regard to third stage management? The study also aimed to identify an effective decision-making model within midwifery practice, through exploration of the decision-making process (using the third stage of labour as a vehicle) in the woman-midwife dyad in New Zealand and Ontario, Canada. This chapter critically considers the contemporary, neoliberal environment in which current ideas of autonomy and decision-making have developed. In addition, three models of decision-making used in health care and a review of women's experience of decision-making during the childbearing years are critically explored. The chapter concludes with an argument for another understanding of decision-making, one more fitting with the midwife-woman relationship and with any other health care relationship that develops over time.

Contemporary Decision-making

The evidence in evidence informed care is not only that which comes from randomized controlled trials or from basic science, but evidence also comes from

those studies that look at peoples' experiences, as well as the clinician's practice experience, clinical judgement, and expertise. Page (2000) lists five steps, developed from Sackett, Rosenberg, Muir Gray, Haynes and Richardson (1996), that are necessary to provide evidence informed midwifery care. These include: i) finding out the wishes of the woman and her family, ii) using information from the clinical examination(s), iii) seeking out and assessing the evidence, iv) combining this with professional judgement and discussion with the woman, and v) reflecting on feelings, outcomes, and consequences. Optimal decision-making is not about following a recipe but about weighing all evidence together. This requires using conscientious clinical expertise, available evidence, and client preferences; otherwise, "practice risks becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient" (Sackett et al., 1996, p. 71). Evidence informed care is about individualised care. The evidence must be looked at with a critical eye and applied only on an individual basis. It is in this way that informed decision-making occurs. However, this premise of evidence informed decision-making creates a tension between the individual and the system, as publicly funded health care tends to prioritize the needs of the many rather than the requirements of the individual.

Decision-making is a process that leads to the choosing of a course of action among alternatives. It is a process in which those making the decision use various types of evidence to make a choice (Sullivan, 2006). Decision-making is influenced by a range of things, including the perceived risks and benefits of the action, the information and how the information is communicated, the beliefs and values of the decision makers, and the socio-political environment. How the process occurs will differ from person to person. How much participation clients have and want in the process depends on a number of factors, such as how critical the situation is (Cooke, 2005; Douché, 2007; Harrison, Kushner, Benzies, Rempel, & Kimak, 2003; Sherwin, 1998; Sullivan, 2006) and the social, political, economic, and cultural environments (McGregor, 2001; Ruthjersen, 2007; Sherwin, 1998) in which the individual is embedded.

Embeddedness and Decision-making

Embeddedness assumes that all relations are located within economic and non economic social structures (Baum & Dutton, 1996; Granovetter, 1985), rather than situated in idealized, abstract social markets, as is often presented in traditional economic theory (Callon, 1999; Granovetter, 1985). Traditional views of decision-making in the market economy were based on either self-interested, rational behaviour, totally removed from social ties and dictated by price, or were so directed by social relations as to be constrained by them (Granovetter, 1985; Polanyi, 1944). Beliefs about abstracted decision-makers are still evident in contemporary neoliberal economic theory (Granovetter, 1985), whereby maximum efficiency is achieved when actors involved in a contract or dealing enter and leave the relationship as strangers (Callon, 1999).

In order to make a decision, all possible options need to be known, those options need to be ranked in order of importance, and all possible outcomes and actions required to meet those options must be identified (Callon, 1999). Callon (1999) also points out that this notion of the calculating decision-makers, with knowledge of all possible options and actions, is disrupted when there is uncertainty, which is often characteristic of decision-making in health care (McGregor, 2001). When looking at individual or group actions within the social situations and networks, decision-making becomes rational when understood within social context, rather than being rational when removed from social context (Granovetter, 1985). Zukin and DiMaggio (1990) extend the context of embeddedness to include not only social but cognitive, political, and cultural environments. Although these sociological ideas of embeddedness and the economic market have been around for some time, contemporary western culture is still driven by many of the earlier ideas of self-interested individuals and abstract economic markets that ignore the embeddedness of the individual in social and socio-political networks.

Neoliberalism and Health Care - a Critical Review

Neoliberalism is a set of political beliefs based on free trade, economic liberalization and open markets (Harvey, 2005; Thorsen & Lee, 2006) and much of the literature on the subject is from a critical standpoint (Thorsen & Lee, 2006). Neoliberalism supports privatization of state-owned enterprises and the encouragement of the social role of private enterprise (Brenner & Theodore, 2002). Government's role is to put in place legislative and infrastructure frameworks to ensure the support of privatization and the role of private enterprise (Harvey, 2005). Neoliberalism was advanced and taken on as socially acceptable through the discourse of freedom (Harvey, 2005) and choice (Benoit, 1999; Davis, 2003; Douché, 2007). It was seen as enabling the liberation of individual entrepreneurial skills (Harvey, 2005).

Neoliberal policies exist in key national and international organisations, such as the New Zealand and Canadian governments, the World Bank, universities, and "think tanks", and it is now the dominant economic discourse (Harvey, 2005). In the 1990s, in New Zealand and Canada, neoliberal policy saw the restructuring of various institutions, including the alteration of public services such as health, as a means of optimizing economic development, achieving efficiencies, and saving money (Brenner & Theodore, 2002; Fougere, 2001; Haworth-Brockman, Clow, & Beck, 2012; McGregor, 2001).

It is accepted in contemporary western cultures that consumers of health care are constructed as autonomous individuals who desire and are capable of participating in and taking responsibility for their health and health care decisions (Davis, 2005; Ruhl, 2002). Choice is seen as paramount and, as Douché (2007) found in her work, not having choice is considered by some women as being communist and, by inference, the antithesis of neoliberal ideology. In the neoliberal philosophy of today, where the market and competition are seen as the foundations for a healthy economy, consumers, theoretically, are treated equally with regard to access to services. The individual is seen as competitive and society is seen as comprised of individuals looking after their own self interest (Brenner & Theodore, 2002;

Granovetter, 1985). Individuals who do not succeed in achieving financial independence are deemed unproductive (McGregor, 2001). According to Ruthjersen (2007), in a neoliberal belief system the ideal society is one that fosters practices that satisfy the individual regardless of whether all start out on an equal footing. It is believed that, as wealth increases, it will trickle down to those less advantaged (Harvey, 2005; Niggle, 2003).

In the neoliberal belief system the individual becomes the consumer of health services. Consumers are assumed to have the “real” power as they know what is best for themselves and can make informed choices about their care. A decision is viewed as a rational process based on the calculation of benefit and risk (Granovetter, 1985), without social influences, rather than one where the individual or person may be vulnerable and uncertain (Ruthjersen, 2007). Within neo-liberal economic theory, optimal decision-making occurs when parties involved in the transaction remain removed from each other while any conflict is resolved by pricing (Callon, 1999) or, in the case of health care, cost-benefit analyses (Mechanic, 1995). Yet, in countries like Canada and New Zealand, with public health and other safety nets based on a philosophy of collectivism and social support, there is an obvious tension with this neoliberal philosophy (Fougere, 2001). Health reforms impact the health care system as budgets are rationalised and the call for efficiencies are made and, as a result, choice may be limited (Audrey, 2009; Segall, 2000). Compounding this is the increasing concern about risk (Davis, 2003; Tulloch & Lupton, 2005) and a health system which has a male view point on women’s health issues (Benoit, Zadoroznyj, Hallgrimsdottir, Treloar, & Taylor, 2010; Capen, 2005; Sherwin, 1998; Spoel, 2006). In this environment, choice may be limited.

In New Zealand and Canada, as in other western countries, the health system is dominated by the medical profession and a “techno-rational” approach to health care (Sherwin, 1998; Davis, 2003). This approach has led to an increasing concentration on risk and a system that is gender biased (Benoit, et al., 2010; Capen, 2005; Tulloch & Lupton, 2003; Davis, 2003). The increasing concentration on risk in health care occurs despite evidence that western populations are presently

the safest they have ever been in history (Symon, 2006). The focus has moved from risk as an integral part of ensuring safety for the women and practitioners to a pervasive anxiety about risk (Haworth-Brockman et al., 2012; Skinner, 2003). As society becomes more individually focused, the risk is seen as an individual responsibility, and thus the individual is accountable (Tulloch & Lupton, 2005). The result is the generation of risk averse policies and guidelines in maternity, as health systems try to mitigate all types of risk (Symon, 2006). In maternity this is evident in increasing rates of intervention and increasing pressure on women to ensure they make the right decision, as deemed by the dominant discourse of medicine (Benoit et al., 2010; Edwards, 2004; Haworth-Brockman et al., 2012).

With increased attempts to reduce risk, comes heightened scrutiny of midwives and a desire to apportion blame. Maternity has become a minefield, as midwives negotiate the zone between birth being normal and birth being risky (Skinner, 2003). At a time when maternal mortality rates in the developed countries are at their lowest, there is an increasing fear of childbirth (Symon, 2006). Yet, at the same time, while concern about and mitigation of risk grows there is an equally loud voice stressing the importance of and need for patient choice (Symon, 2006). Davis (2003) and Spoel (2006) contend that the medicalisation of childbirth and the increase in technology has been promoted as the norm. According to Davis (2003), with the culture of risk in the health system today, choices outside the medical technological discourses are considered risky. Although choice is encouraged, when that choice is outside the accepted medical practice, as is often the case in midwifery practice, the midwife and woman may be marginalised. It is in this environment that women and midwives make decisions about care during the childbearing experience and it is within this environment that decision-making must be understood and explained.

Women's Experience of Decision-Making during Childbearing

Women's experience of their pregnancy and birth are remembered for a lifetime (Simkin, 1991, 1992) and have been known to have an effect on the health of

women and their families (Ayers, Eagle, & Waring, 2006; Simkin, 1996). It has been recognized for some time that a woman's sense of control of what is being done, participation in decision-making, and having wishes listened to and respected is important to her satisfaction with her birth experience and subsequent enhanced feelings of self esteem (Green, Coupland, & Kitzinger, 1990; Simkin, 1996). There is also evidence that when the labour and or birth has been traumatic, loss of control and feelings of helplessness during labour and birth are factors that can contribute to Post Traumatic Stress Disorder after childbirth (Ayers et al., 2006; Beck, 2004; Zaers, Waschke, & Ehlert, 2008). This knowledge about the long term effects of the birthing experience indicates that communication and decision-making during pregnancy and childbirth are critical components of midwifery care.

A number of research projects have looked at women's experience of involvement in decision-making during aspects of midwifery care (Brown, 1996; Freeman, Timperley, & Adair, 2004; Green et al., 1990; Harrison et al., 2003; Kirkham & Stapleton, 2004; Kirkham, Stapleton, Curtis, & Thomas, 2002a, 2002b; Kirkham, Stapleton, Thomas, & Curtis, 2002a, 2002b; Lavender, Walkinshaw, & Walton, 1999; Levy, 1997, 1999d, 1999e; McCourt, 2006; O'Cathain, Thomas, Walters, Nicholl, & Kirkham, 2002; Spenceley, 2004; Stapleton, Kirkham, Curtis, & Thomas, 2002b; VandeVusse, 1999). All show that women are involved to varying degrees in decision-making during pregnancy, that involvement increases their feelings of control and their satisfaction with care, and that there is much room for improvement. These studies also identify a variety of influences on decision-making in the woman-midwife relationship.

A number of studies (Brown, 1996; Levy, 1997; McCourt, 2006; Olsson, Sandman, & Jansson, 1996; VandeVusse, 1999) found that communication patterns between midwife or other health professional and women during the initial antenatal booking visit demonstrated that the health professional often steers the conversation in a particular direction, depending on the accepted practice in the unit, so that a decision fits with the accepted practice (Levy, 1997). Studies also found that styles of communication of the health professional vary from those that

encourage discussion and questions to those that discourage questions (Brown, 1996; McCourt, 2006; Olsson et al., 1996), with a more relaxed, informal, and unrushed style facilitating greater information giving and participation by the woman (Biley, 1992; Brown, 1996; McCourt, 2006; Olsson & Jansson, 2001). Although some research indicates that not all people want to be involved in health decision-making (Waterworth & Luker, 1990), there is evidence that childbearing women's reduced desire for involvement in decision-making may be related to the level of criticalness of the situation (Douché, 2007; Freeman et al., 2004; Harrison et al., 2003), and that satisfaction with participation is higher when the woman is involved in the decision-making to the degree that she wishes (Harrison et al., 2003).

Communication skills or patterns are an important influence on the process of decision-making. The seminal midwifery research in the area of information giving and decision-making in maternity was conducted in the 1990s in England and looked at the communication interaction between midwife and woman in a hospital clinic setting during an antenatal booking, which was generally the first visit (Levy, 1997, 1999a, 1999b, 1999c, 1999d, 1999e). Levy's grounded theory study involved observed and video recorded interactions of clinic antenatal booking visits as well as follow-up interviews with the women two weeks after the visit. The study also included an observed and tape recorded home visit by a midwife in an independent practice and a follow up interview with the woman. Levy found that midwives used different techniques to keep control of the information given and the agenda of the exchange and that these techniques were used to protect the women from certain information as well as to steer the woman toward a particular topic or decision (Levy, 1997, 1999d). Levy also found that women used techniques to deal with information and information flow. Some sought information or avoided information if the time was not right. The partner or support person involvement in the decisions was important, and women trusted professionals who took the time to explain and seemed to care even in circumstances where the midwife did not know the information (Levy, 1997). Levy noted that women were hesitant to seek information and ask questions because of the power relationship and feeling that

they could not or were not encouraged to ask questions (Levy, 1999e). She explained this reluctance in part by the fact that, in some cases, midwives were constrained by unit policy and resources, which affected the ability to offer choice. This tightrope was negotiated by both midwives and women in a way that attempted to ensure that both participants were safe (Levy, 1997).

A study during the same period by Olsson, Sandman, and Jansson (1996), in Sweden, while looking at the communication relationship between midwife and prospective parents, confirms Levy's (1997, 1999a, 1999b, 1999c, 1999d, 1999e) findings. The Swedish study found that the midwife steered the consultation in five basic relationship patterns, similar to those found by Levy. More individually oriented ways of relating encouraged more active participation by expectant parents, while more generalised ways of relating discouraged participation. Although Olsson et al. (1996) study, like Levy's (1997), does not deal with decision-making specifically, it demonstrated that communication style had an influence on the response of the woman and/or her partner, and that the midwife's behaviour controlled the interview and exchange of information. This research on communication style corroborates a later analysis by Olsson and Jansson (2001), which found that midwives controlled the antenatal booking visit and clients were discouraged from participating. A study in the US found that the degree of participation was limited by a conflict of interest between provider agendas and women's needs (Brown, 1996). The Brown (1996) study also found that a more open, relaxed communication style was more conducive to women's participation.

Some difficulties with Levy's (1997), Olsson et al., (1996) and Brown's (1996) research are that they dealt with only one clinic visit and focused on the booking visit, where often much information is discussed. The authors also did not look at decision-making per se but on the exchange of information and the power relations which affect the woman's ability to be involved in decision-making. Neither study indicated any specific information regarding management of third stage of labour, although one can assume that the same finding would apply; midwives/care providers would direct information and questioning toward eliciting responses that

would meet with what they felt was the appropriate answer. It must be noted that, at time of Levy's research routine, active management of the third stage of labour was the norm in hospitals within the UK (Garcia & Garforth, 1989). Having worked in the system at the time, I know that midwives were employed by the health boards, maternity services were run by obstetricians, and women received fragmented care during their childbirth experience. The studies discussed above are 15 + years old and circumstances and some beliefs have changed since that time (Mander, 2005). The studies also took place in practice situations that did not involve continuity of carer, unlike the current situations in midwifery practice in New Zealand and Ontario. In both Ontario and New Zealand, in caseload care, most women meet with their midwives several times over the course of the pregnancy. The assumption is that this continuity facilitates the building of a relationship, which in turn facilitates the exchange and discussion of information and decision-making (Guilliland & Pairman, 1995; Harding, 2000)

The ongoing relationship between woman and midwife is presumed to facilitate decision-making (Guilliland & Pairman, 1995). Continuity was found to have a positive influence on decision-making in a study in physicians' practices (Kaplan, Gandek, Greenfield, Rogers, & Ware, 1995); the longer the tenure of the relationship the more participatory the decision-making style. Studies in midwifery continuity of care models also show an increase in women's satisfaction with care when there is continuity (Biró, Waldenström, Brown, & Pannifex, 2003; Flint, Poulengeris, & Grant, 1989; Turnbull et al., 1996). Two studies have reported that choice and decision-making was a component of satisfaction (McCourt, Page, Hewison, & Vail, 1998; Waldenström & Rudman, 2008) and that the interactions between women and midwives in caseload practice demonstrated flexible, informal, and friendly behaviours that were conducive to discussion and questions (McCourt, 2006). An open flow of information during interactions was also found to facilitate freedom of choice in the previous Brown (1996) and the Olsson et al. studies (1996, 2001). Although not all studies of one to one or team midwifery specified that choices and decision-making were a components of satisfaction, other studies have identified involvement in decision-making as a component of

women's satisfaction with care (Blix-Lindström, Christensson, & Johansson, 2004; Green et al., 1990; McKay & Smith, 1993; VandeVusse, 1999).

Several studies in New Zealand and Canada have looked at aspects of decision-making between women and midwives (Freeman et al., 2004; Harding, 2000; Harvey, Rach, Stainton, Jarrell, & Brant, 2002; Spenceley, 2004). In New Zealand, Freeman, Timperley, and Adair (2004) investigated midwives' decision-making during labour and birth, women's experiences of partnership and equality, as well as their satisfaction with care. The Freeman et al., (2004) study followed, in real time, the care of women during their labour and birth by having the midwives record the episode of care. She found that decisions ranged from low risk, which the woman made by herself or with the midwife, to high risk, where the midwife made the decision based on her professional judgement. In a small study with midwives in British Columbia, Harding (2000) found midwives talked of shared decision-making as being the basis of a midwife-woman relationship and midwifery.

Most of the studies on women's experiences of decision-making in childbirth or childbirth experiences do not follow a decision point and most did not consider the decision point of third stage, possibly because active management of third stage has been the norm. However, two studies were found that contained reference to decision-making for birth of the placenta. Part of the Green, Coupland, and Kitzinger (1998) study found that, when women were asked about what they knew about third stage management, 11% knew *a great deal*, 53% of women reported *quite a bit*, 33% felt they knew *very little*, and three percent knew *nothing*. There appeared to be a correlation with education, with more educated women claiming to know more. Green and colleagues speculated that this may be related to educated women reading on their own and being more able to discuss issues with staff. However, it may also be related to staff making more effort to give the educated women more information or educated women being more confident in their knowledge. In this study, 59% of respondents indicated that they did not discuss information about third stage with a midwife or doctor in the antenatal period. Interestingly, in this study, approximately 13% of the women reported not

having the injection of oxytocin (Green et al., 1998), yet it is known that active management was routine in the units at the time of the study (Garcia & Garforth, 1989; Green et al., 1998).

The second study, done in New Zealand, looked at choice and used birth of the placenta as the vehicle. Spenceley's (2004) study involved semi structured interviews with six 'independent' midwives and four women who had had vaginal births within the preceding year. The aim of the research was to examine the decision-making around the birth of the placenta and the information used to assist that decision. Spenceley found that overall choice is important to women and midwives but it is not without limits. Choice was tempered with clinical judgement that appeared to allow the practitioner to override the woman's choice. Women talked of handing over decisions to the practitioner who had greater knowledge. Within the study, Spenceley found that pregnancy had a discourse of risk in the data of mothers and midwives. In addition, there was a discourse of surveillance in the midwives' data which related to risk, something which Stapleton, Kirkham, Curtis, and Thomas also found in their 2002 study and which Levy (1999e) reports in her study. Despite the discourse of choice in Spenceley's study, midwives "preserved the final decision on care for themselves." (p. 147).

Various studies support involvement in decision-making as important to women's satisfaction with their care during the childbirth experience (Brown & Lumley, 1998; Green et al., 1990; Waldenström, Borg, Olsson, Sköld, & Wall, 1996; Waldenström & Rudman, 2008). There is evidence that, in contrast with other models of maternity care, satisfaction is increased with continuity models of midwifery care, and that this is in part related to involvement in decision-making (Berg, Lundgren, Hermansson, & Wahlberg, 1996; Biró et al., 2003; Page, Beake, Vail, McCourt, & Hewison, 2001; Waldenström, Brown, McLachlan, Forster, & Brennecke, 2000). Some of these studies have proposed models to represent the communication exchange that occurs (Levy, 1999d; VandeVusse, 1999). A number of the studies (Freeman et al., 2004; Harding, 2000) also suggest that shared decision-making is the model that best describes the decision-making process in caseloading

midwifery. In the following section three models of decision-making used within healthcare will be explored.

Theoretical Models of Decision-Making within Health Care

The process of decision-making has evolved from its paternalistic roots to the more informed decision-making that came about after legislation in various countries made it a requirement. However, there continue to be concerns about the models of decision-making in health care in relation to clients' power within the relationship, cultural fit, and the perception of the health care provider as objective other (Charles, Gafni, Whelan, & O'Brien, 2006; Spoel, 2004). Due to these concerns, I had a desire to develop a model that takes into consideration the social aspects of decision-making and one that best reflects what occurs in midwifery practice. Shortcomings associated with each existing decision-making model suggest that there is a need for a model that ensures that both patient and practitioner are involved in making the decision. The following section critically explores three models of decision-making, the paternalistic model, the informed model, and shared decision-making. This critical examination suggests that a different understanding of decision-making is needed to fit with midwifery ways of practice.

Paternalistic Model

The paternalistic model is based on an older functionalist model of professionalism where the doctor, by virtue of his exclusive knowledge, education, and ethos of care, lays claim to superior knowledge over that of the patient and, therefore, is best suited to make health decisions for the patient (Tully & Mortlock, 2004) or has the ability to do what is in the best interest of the patient (Charles, Gafni, & Whelan, 1997; Emanuel & Emanuel, 1992). The patient assumes a sick role and with that role comes the patient's right to health care and the obligation to comply with the health professional's recommendations regarding treatment by giving consent to the treatment (Parsons, 1951). In less extreme cases, the health professional will

give some information to the patient and encourage the patient to agree to the suggested treatment (Emanuel & Emanuel, 1992).

The paternalistic model of decision-making was not designed to, nor does it, elicit the client's preferences and may limit the client's involvement to that of consent only. The paternalistic model is now deemed inappropriate by most health care providers, especially as clients become more informed, medical technology and treatments become more sophisticated, and there is protection of patient rights. This form of decision-making violates the client's right to be fully informed and have treatment decisions respected (Government of British Columbia, 1996; Health and Disability Commissioner, 1996; Legal Information Society of Nova Scotia, 2001). By having signed consent, the responsibility of the decision is placed on the client when it could be said that they have, for all intents and purposes, not been involved in the decision-making. The paternalistic model can also put the health professional in a vulnerable position should the outcome not meet the client's expectations and there ensues, rightly, a claim of lack of information. Aspects of the paternalistic model may still be identified in emergency situations where decisions have to be made quickly or the client, without family support, is unable to communicate with health professionals. However, from a feminist perspective, the paternalistic model totally disempowers the client, disregards women's autonomy, and historically it has not served women well (Sherwin, 1998).

Informed Model

A more recent model, in common use today, is one in which information about the treatment or intervention options with their various risks and benefits is given. The client is then required to make the decision from the options. This model is referred to as the informed model (Charles et al., 1997). In this model, the key principle is that of unbiased, non-threatening information from the health professional, with the client making the decision without the direction of or coercion from the health professional. Clients weigh up the information received and choose the option that

best fits with their beliefs, expectations and preferences (Gafni, Charles, & Whelan, 1998). The health professional may provide the client with a decision aid⁵ to clarify values and priorities (not generally seen in New Zealand) and or an information leaflet to help in the process. The practitioner should remain unbiased, although in New Zealand there is provision, according to Right 6(3)b of the Health and Disability Commissioner's Consumer Code of Rights (the Code), for the consumer to ask for a recommendation of the provider (Health and Disability Commissioner, 1996). The practitioner's advice could influence or change a decision if inappropriate recommendations are made, for instance, if the health professional used a qualifier such as, "Well, if you were my daughter I would..." However, if based on evidence, it would assist those who may not have a strong preference either way or are having difficulty with the decision-making.

There are several problems with the informed model of decision-making. To begin with, in many situations the client may be stressed or frightened, which will interfere with their ability to assimilate the information and lessen their desire to participate in decision-making (Charles et al., 1997; Douché, 2007; Harrison et al., 2003). There is also concern that, with the ever increasing amount of information available about some treatments, ensuring all information is made available is quite daunting or, alternatively, there is conflicting or little supporting evidence for a particular treatment. Another concern with the informed choice model, although it is not confined to this model, is the expectation that the practitioner provides unbiased information that is easily understood and that the client is left to make the decision, the assumption being that the client is capable of doing just that. In addition, there is the expectation that there is no influence on the part of the practitioner (Spoel, 2004), which has the potential of placing the client in a difficult situation as they may lack the knowledge and/or cognitive capacity to make such a

⁵ A standardized evidence-based tool to assist the patient to participate in decision-making, that contains information about the condition/treatment and how to personalise the information, raise their awareness of their ability to participate in decision-making, increase awareness of scientific uncertainties, help them clarify the personal value of treatment, communicate those values and wishes, and participate in decision-making (O'Connor, Llewellyn-Thomas, & Flood, 2004).

decision. These expectations are also at odds with the ethos of a caring profession. The practitioner becomes the objective agent who stands apart from the client and is only a vehicle for information giving.

The assumption under the informed model is of dispassionate, free thinking participants; however, it ignores the socio-political influences such as gender, social class, ethnicity, education (level and type), and culture of the participants (Spoel, 2006). Charles, Gafni, and Whelan (1997) point out that in this model the patient could find information on the internet or elsewhere, make a decision without the practitioner's input and be said to have made an informed decision. So, in fact, it could remove the practitioner from any involvement in the decision. While Gadow (1990, p. 43) contends that the informed model is in fact still paternalistic because it "insists, in the interest of the individual's autonomy, they be forced to make important decisions alone, with only technical assistance". In the case of midwifery, the informed model is also at odds with the philosophy of partnership and empowerment (Cooke, 2005; Spoel, 2004). The assumption that the practitioner comes to the decision-making objectively, without preferences or biases, can also be called into question.

In both the paternalistic and informed models, the health professional is depicted as the perfect agent. The paternalistic model assumes that the health professional has the knowledge and empathy to make the best choice for the client. In the informed model the health professional provides sufficient information and has the knowledge to ensure an informed choice (Gafni, Charles & Whelan, 1998). In both models informed consent is supposedly upheld, as in the paternalistic model the client has presumably consented to the health professional making the best choice, and in the informed model the client makes a choice based on unbiased, clear, and full disclosure of information, with their preference in mind. In the paternalistic model, the preference of the health professional takes precedence over the client's, while, in the informed model, the preference of the client takes precedence over that of the health professional (Charles, Gafni & Whelan, 1997). In either situation,

the health professional is expected to ensure that the information is complete and unbiased and that it is understood.

A difficulty with implementing the informed decision-making model is that, although clients want to be informed about their care and treatments (Green et al., 1998), not all want to make treatment decisions, especially when treatment decisions may be critical or they may lack the framework to assist with the decision-making (Charles et al., 1997; Freeman et al., 2004). Furthermore, there is personal and research evidence that clients want advice from the health professional, especially if there is a partnership relationship between client and health professional (Edwards, 2003; Freeman et al., 2004). As Harding (2000), in her research with midwives in western Canada, and Edwards (2003), in her research talking about choice with women in Scotland, found, decision-making for women is ideally care oriented and based on information gathering and discussion in an environment of mutuality. Further concern with the informed model is that the emphasis is on the duty of the practitioner to inform and uphold women's decisions, rather than the need to reach a decision that is in the best interests of the client.

There is little focus on the responsibility of the woman within this decision-making. Midwives may feel that they must uphold women's wishes at all cost, a situation that can place the midwife and woman and her baby at risk if things should go wrong. Without the woman being aware of the consequences of her decision-making or discussing this with the midwife, how can she make an informed decision? If women's and midwives' roles and responsibilities with regard to decision-making are not clear, the relationship becomes one sided and a decision made could put both the woman and practitioner at risk (Skinner, 1999). For example, if a woman has a history of postpartum haemorrhage (PPH) but withholds that information from the midwife, the midwife may support the woman's preference for a physiological birth of the placenta; the practice at present is that, with a history of PPH, active management is advised. There could be a large postpartum haemorrhage, resulting in long term consequences for the woman, and

a complaint against the midwife could be laid by the woman and her family. Even if the non disclosure of the health history is revealed, the midwife's practice in this case will have gone through an investigation and the lives of the woman, her family, and the midwife will have been affected (Calvert, 2012).

Shared Decision-making

A third model, shared decision-making (Charles et al., 1997; Freeman et al., 2004; Murray, Charles, & Gafni, 2006), aims to bring together the professional judgement of practitioners and the client's right to make an informed choice. This model addresses the shortcomings of the paternalistic and informed models. In shared decision-making, evidence based information is interpreted and discussed among all parties involved. It has been offered as a more client centred approach and is suggested as an ideal model of decision-making for medicine and maternity care (Charles, Gafni, & Whelan, 1999; Ford, Schofield, & Hope, 2003; Freeman et al., 2004; O'Cathain et al., 2002).

In New Zealand and Canada, statements by midwifery professional and regulatory authorities indicate that decision-making within the woman-midwife relationship involves support, negotiation, the fostering of self-determination, and shared decision-making (Canadian Association of Midwives/Association Canadienne des Sages-Femmes, 2010; Midwifery Council of New Zealand, 2004; New Zealand College of Midwives, 2007). This is to be carried out in an environment of open interactive communication (Canadian Association of Midwives/Association Canadienne des Sages-Femmes, 2010). The Shared Decision-Making Model proposed by Charles, Gafni, and Whelan (1997), and later adapted by Murray, Charles, and Gafni (2006), is a model that has been discussed for over three decades. Participants in the decision-making share the role and are partners in the flow of information, deliberations, and decisions. This model is considered woman centred for both the childbearing woman and midwife; it recognises the autonomy of the participants and the client's right to challenge the authority of the health professional (Charles, Gafni & Whelan, 1997). A prerequisite for health

professionals is to ascertain the patient's preferences with regard to participation in the decision-making (Charles et.al., 1997).

To be successfully implemented, the shared decision-making model requires clarity of the expectations of all parties involved and a commitment on all sides to the model working. The health practitioner must be willing to provide an atmosphere conducive to discussion and embrace the model. Information about the treatment options, risks, benefits, and costs have to be imparted to clients in a manner they can understand (Government of British Columbia, 1996; Health and Disability Commissioner, 1996; Legal Information Society of Nova Scotia, 2001) and must be evidence informed and evaluated critically. Personal considerations, such as the values and wishes of the client, must be considered. In this model, health care provider and client work together to come to consensus and agreement on the treatment option, so decision-making is shared with equal responsibility. This does not necessarily mean that they are both convinced that this is the best possible treatment but that they agree on this being the treatment to implement (Charles, et al., 1997). This agreement on treatment is a feature that distinguishes this model from the paternalistic model, in which the health professional makes the decision, and the informed model, in which the client takes full responsibility for the decision.

A relationship between practitioner and client, as a modification of this shared decision-making model, is partly discussed by Freeman and colleagues (2004), within the framework of a partnership model for midwifery in New Zealand. The models of midwifery in Canada and caseload midwifery in New Zealand entail continuity of care. The developing relationship between woman and midwife adds a dimension to the shared decision-making model that may be absent in a medical situation. Continuity not only enables longer time for consideration and negotiation, but the developing relationship may also support a more open environment for discussion (Edwards, 2003). Decision-making for the birth of the placenta requires time to discuss and put plans in place for the 'what if' scenarios. For example, although a decision for physiological birth of the placenta may have

been made, events within labour and birth may make this initial plan inadvisable. In a shared decision-making model that encompasses continuity of care, the midwife and woman would have discussed situations where physiological birth of the placenta may not be wise and an agreement would have been reached about what to do if such a case should arise. Decisions made in forming the birth plan could be revisited during labour and in times of high risk, such as the occurrence of a PPH; a previously agreed plan would only have to be reconfirmed or a unilateral decision made.

Freeman discusses on-going negotiation as levels of decision-making within a shared decision-making framework (Freeman et al., 2004). The role that each person in the relationship takes in the decision-making is based on previous agreement and changes in the risk level, determined at the time. A low risk decision, such as management of the birth of the placenta, can be made entirely by the woman after information sharing and discussion. A medium risk decision would be made by woman and midwife jointly, again, after discussion and negotiation. This may include a change in management of the birth of the placenta or a decision about management based on previous history. A high risk decision such as treatment of a PPH, may involve the midwife making the decision based on professional judgement and may include consultation with a doctor.

An advantage in the shared decision-making model is that the practitioner and client come to an agreement about the decision made and clients can be supported in making more difficult decisions where advice and guidance may be required. What is also of importance is that the preference of both practitioner and client is made evident within the model (Charles, Gafni & Whelan, 1997). The model is flexible so that the decision-making dynamic is able to change when a third party is involved, such as a family member or other support person. Multiple stakeholders in a care decision enable coalitions to be formed and to fluctuate in the health care encounter. The context within which the decision is made determines the number of coalitions that can be made. An example from personal experience involves a decision to intervene in a labour, when, despite all efforts, progress was poor; the

decision was influenced by the woman, her support person, and me, as the midwife, forming a coalition to achieve the particular outcome. The coalition can be stronger and decisions enhanced in a continuity relationship, such as is the case in midwifery care, which differs from a more medical consultation where an ongoing relationship may be lacking.

In Freeman's (2004) discussions of the shared decision-making model in New Zealand midwifery practice, she points out that the honest exchange of information, expectations, and the building of a relationship is possible. This allows the articulation of values and beliefs as well as plans for the pregnancy and birth within each person's philosophical framework or value system. In this aspect, the Freeman et al. (2004) model differs from the shared decision-making model proposed by Charles et al., (1999) where there is no expectation that those involved will discuss philosophical beliefs and values related to the issue. If, however, this is a long term relationship, such as with chronic illness, there is the likelihood that values and philosophy of the practitioner will be known to the client (Murray et al., 2006). Moreover, in the shared decision-making model proposed by Charles et al. (1997) there is no expectation that the relationship between health professional and client has a continuity aspect, other than possibly a follow up visit. Continuity is probable within a general practitioner-client relationship (Murray et al., 2006) but not to the extent inherent in the woman-midwife relationship. Over the childbearing period, a woman and midwife in New Zealand can see each other more than ten times during the pregnancy to the period of the labour and birth, and at least 7 times in the postnatal period (Ministry of Health, 2007c, 2012b), with experience indicating that each antenatal and postnatal visit lasts a half hour or more. In the Freeman et al. (2004) model, there is an implication that sharing of relevant information about themselves helps each participant in the decision-making to understand each other's perspectives as well as the constraints each operates under (Freeman, et al., 2004).

Care must be taken, however, that the discussion of philosophies, beliefs, and plans within the context of labour and birth do not influence or limit the client's choices

and decisions, and practice beliefs must be honest and evidence informed. According to research undertaken by Consedine and Moskowitz (2007) and Slovic, Peters, Finucane, and MacGregor (2005), emotion plays a part in the decisions made, and this influence needs to be made explicit. In addition, practices are often not evidence informed (Edwards, 2003). In some instances, the woman or midwife may choose a particular mode of care regarding birth of the placenta based on previous events. For example, a woman may have experienced extreme pain after active management of third stage. Alternatively, the practitioner may indicate a preference for active management of third stage based on a previous bad experience with physiological birth of the placenta or because she has always practiced that way. The shared decision-making comes when options can be offered and discussed, despite these issues. Nevertheless, some argue that the possibility of shared power and responsibility is an unrealistic concept (Sherwin, 1998; Edwards, 2003). As Douché (2007) points out, it is the professional who is held responsible should things go wrong.

Cultural and Feminist Critiques of Decision-Making

A concern with any decision-making model is its fit within different gendered and cultural contexts. The three models discussed have predominantly been developed according to western cultural values that privilege masculine characteristics – such as autonomy and independence. Charles, Gafni, Whelan, and O’Brien (2006) express concern that the underlying assumption, particularly with the shared decision-making model, is that it will work for all people in all situations.

Cultural values can influence the decision-making process whichever model is used. Participants may have different understandings of decision-making and the processes involved. For instance, the assumption that the key decision makers are the patient and the health practitioner may be incorrect, as in some cultures decision-making is made within the family and/or by an elder. This is certainly a strong value within Māori and Pacific cultures (Capstick, Norris, Sopoaga, & Tobata, 2009; Durie, 1994). Even within western cultures, it may be incorrect to assume

that clients want to make decisions on their own. Within the woman-midwife relationship, experience shows that partners and or family are involved in many of the decisions.

The assumption, from a neoliberal perspective, that the individual can make decisions autonomously, without the need for consideration of other people's opinions, does not represent the complex nature of social relationships (Spoel, 2004). Indeed, Sherwin (1998) argues from a feminist point of view that the western assumption about autonomy and informed consent disregards the intricate and complex social nature of health care decisions. Individual and cultural values may differ; the practitioner's view of why a particular way of managing the placenta is important may not be of importance to the woman. The assumption that a model can fit all may create a barrier to effective decision-making.

Other aspects of culture can also be misinterpreted or affect clients' apparent ability or desire to participate in discussions. For example, amongst some elderly people and in some cultures a health professionals' knowledge and the place they hold in society is highly regarded; hence, questioning the health professional is unacceptable (Browne, Fiske, & Thomas, 2000; McGregor, 2006). For others, it would be assumed that health professionals know best because of their greater knowledge, a status that has been conferred through discourses about professional competence (Foucault, 1973) and encouraged by the medical profession (Sherwin, 1998; Tully & Mortlock, 2005).

Culture impacts health care decisions as well as access to modern health care. It has been discussed in aboriginal populations, and well demonstrated by health disparities between aboriginal and non-aboriginal populations, that there is inequality in access to health services, resulting in poorer health for aboriginal populations (Anderson et al., 2006; Bramley, Herbert, Jackson, & Chassin, 2004; Durie, 2004; Frohlich, Ross, & Richmond, 2006; Native Women's Association of Canada, 2007; Robson, 2007). This inequality in access has long been attributed to, although not confined to, historical (colonial) events and political developments

that disenfranchised aboriginal populations (Anderson et al., 2006; Browne et al., 2000; Durie, 2004). Disenfranchisement may be perpetuated through the neoliberal world view in health care, which can and has been weakening the social paradigm of health care (Benoit et al., 2010; McGregor, 2001) and communitarian indigenous cultures (Robson, 2007). Compounding these issues are misunderstandings and stereotyping which interfere with the interaction that takes place between health provider and client (Browne, et al., 2000).

There are prerequisites or unacknowledged aspects to decision-making that are absent from current models and so bring into question the existence of choice. Sherwin (1998) points out the necessity for an ethos of respect for patient autonomy within health care where differences in power and vulnerabilities of patients would otherwise put them at risk. However, she questions the current concept of autonomy in health care which is based on the individual as an autonomous decision maker (able to make decisions without the influence of others). The very issues that make respect for autonomy necessary, illness, vulnerability, and fiscal restraint, calls into question the control the client has within the health care system. Systems put in place to ensure informed choice can be inadequate due to various pressures and influences. Time pressures, caseload pressures, workforce issues, inadequate communication skills, and the cultural and linguistic diversity within the community can all constrain informed decision-making. However, there are deeper ethical concerns with the western concept of autonomy and informed decisions. Sherwin (1998, 2004) and Secker (1999) point out that the understanding of autonomy that the models of informed choice and decision-making are built on is one of an articulate, well informed individual who has a range of options to choose from and who is used to making life decisions; conditions that are afforded only to the privileged.

The current understanding of decision-making is viewed by feminists as being based on masculine characteristics of the rational individual (MacKenzie & Stoljar, 1999). Decision-making itself is seen as an unemotional, rational weighing up of readily available, easily understood, evidence based information; these conditions are very

rarely met and are inadequate to describe the complex nature of human existence or meet the needs of health consumers (Sherwin, 2004; Spoel, 2004). Secker (1999) also points out that this concept of autonomy requires that the health professional be able to judge the patient's autonomy and choices, something which they are not equipped to do. Secker (1999) further posits that the result of this judging could be that many patients would not meet the strict standard and powerful institutions would treat these patients in a paternalistic manner, which would not promote patient autonomy.

Gadow (1990) suggests that what is important in health care decision-making is to uphold the individual's right to self-determination rather than a person's autonomy. She discusses *existential advocacy* as a part of the decision-making process whereby the health professional assists the individual in clarifying their values and what is important for them. Helping them to "become clear about what they want to do" (p. 44). These characteristics are absent in the paternalistic or informed (consumerist) models (Gadow, 1990) and are not clearly articulated in the shared decision making model. Although decision aids can be used by the individual to clarify values and priorities (O'Connor et al., 2003), using them without the support of the practitioner does not fit with a caring profession and Gadow's (1990) idea of advocacy.

Granovetter (1985), in discussing economic markets, and Sherwin (1998, 2004), in discussing autonomy, both contend that it is erroneous to characterise decisions as being made autonomously, as individuals are enmeshed or embedded in broad socio-political networks and decision-making is shaped by those networks. Sherwin (1998, 2004) contends that autonomy is shaped by political structures and relationships and further holds that individuals take part in activities and make decisions that are congruent with their idea of self.

Models of decision-making where values are clarified and power, responsibility and choice are shared may help to make the process balanced and address the concerns

with older as well as current models. The consideration of socio-politico-cultural contexts will further address concerns identified.

Conclusion

This chapter has explored decision-making within the current context of western society and midwifery. It has briefly reviewed the more relevant literature on women's experience of decision-making during their childbirth experience. The evidence demonstrates that women value information and being involved in decision-making during their childbirth experience. The evidence also suggests that women's experience of being involved in decision-making varies. Some of this variability is related to practitioner communication styles. The evidence also shows that caseload midwifery care, as seen in New Zealand and Ontario, Canada, provides greater satisfaction, possibly because it provides a longer time period in which to build a relationship and discuss issues and decisions. Although there have been studies in Canada, New Zealand, and elsewhere looking at decision-making in the woman-midwife relationship, they have looked at a discrete episode, have often looked only at situations that do not reflect caseload midwifery, and have only indirectly looked at the influences on decision-making.

The three models of decision-making seen in health care today were critically explored. Freeman et al., (2004) found that each model exists during the course of labour and birth care, while Harding (2000) found that midwives in western Canada perceive that shared decision-making is one of the foundations of their practice. It has been suggested in this chapter that these current models, paternalistic, informed, and shared decision-making, do not fully explain the complexity of the decision-making between women and midwives. The informed model, and to a lesser extent the shared decision-making model, are premised on an erroneous concept of the decision-maker as someone who acts independently, without others influence, has the skills to make choices, is free to make any choice, and will have that choice respected. In the shared decision-making model the presumption that negotiation between client and health professional can occur equitably is

misleading, as the differences in power between health consumer and health care provider can make such negotiations inequitable. Although some of the influences on decision-making have been highlighted by other research, none of these decision-making models reflects the complex social, political, and cultural factors that impact decision-making. The following chapter presents the research design and methods and sets the foundation for the relational methodology, presented in Chapter Four that developed from this research.

Chapter 3: Research Design and Methods

Introduction

The previous chapter reviewed the literature on decision-making in western health care and included exploring women's experience of decision-making during their childbirth experience. A review of the literature on autonomy was undertaken and it was concluded that current neoliberal ideas of the autonomous decision-maker do not fit with health care in general and within midwifery philosophy specifically. The paternalistic, informed, and shared decision-making models were critically explored. The chapter concluded that these models do not fully reflect the kind of decision-making that takes place in the woman-midwife relationship, nor do they take into consideration the complexity of decision-making and the embeddedness of decision-makers in the wider socio-political context. It is usual for chapter three to present the methodology used in the study. However, because the methodology developed over the course of the study, it is included as one of the substantive chapters of the thesis and covered in Chapter Four.

This chapter explores the research design, the methods of data collection, and analysis used in the current study, which was carried out in New Zealand and Canada. The chapter also outlines the challenges faced and the efforts undertaken to address the challenges. The chapter begins with the original design of the research project and early challenges associated with research design and recruitment.

Original Research Design and Challenges

Interest in the topic area and the research design used in this research study came from my experience as a midwife working with women and other midwives in my various roles as midwife, midwifery educator, and peer reviewer. The first research design underwent changes due to difficulties in recruiting midwives, and thus

women, into the study and in response to feedback from midwives and the women they talked to about the study.

The original research project (Figure 3.1) involved three interview sessions, one antenatal and two postnatal. Each session was to involve a midwife and one of her clients, along with me. The antenatal session was to begin with audio recording the decision-making discussion, between the woman and her midwife only, regarding the plan for birth of the placenta. Birth of the placenta was chosen as a vehicle for the study as it is a key decision point during pregnancy. The decision-making discussion was to be followed immediately by an informal interview between me, the woman (and her support person where available and if the woman agreed), and the midwife. A postnatal interview involving those same participants was to occur within two following the baby's birth, where events at the birth and, specifically, the decision regarding birth of the placenta were to be discussed. A final reflective interview that would have entailed reflection on the events of the birth, the decision-making process, and the research project itself was to occur between four to six weeks following the birth. The two postnatal interviews were to involve the woman, the midwife, and me. The two and four to six week periods were selected to avoid the criticism of interviewing in the immediate post birth period because it may colour recall of events (Waldenström et al., 1996). This time lapse also gave sufficient time to arrange visits, especially in Canada where travel was a consideration. The women and midwives were to be asked to keep a journal during this time to consider any further observations or comments they wished to make. The schematic below represents the original planned process.

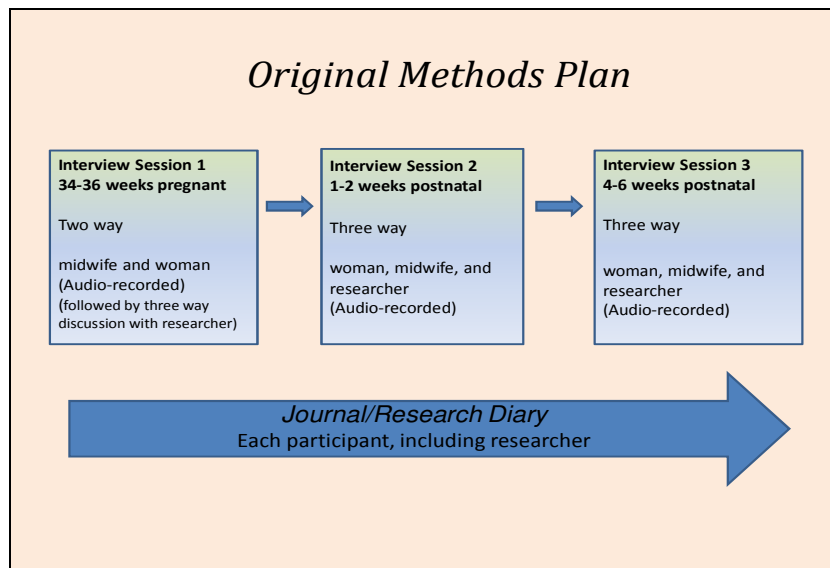


Figure 3.1: Original Methods Plan

My professional activities at the time in New Zealand as a Midwifery Standards Reviewer (MSR)⁶, meant that participants had to be recruited from outside the New Zealand College of Midwives region in which I worked and lived, which was the Greater Wellington Region, including the Wairarapa.

Ethical Considerations and Approval

In New Zealand and Canada, human ethics approval requires that if First Peoples individuals (Māori, First Nations, Métis and Inuit) are to be involved in the study, cultural safety is important and counsel would have to be sought from appropriate individuals (Canadian Institutes of Health Research, 2007; Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2010; Massey University/Te Kunenga ki Pūrehuroa, 2010, 2005). If Māori women were to be participants in the study, the proposal indicated that consultation with two Māori colleagues, one of whom was a midwife, would be undertaken. No women in the

⁶ Midwifery Standards Review (MSR) is a professional peer review/professional development process that is a required part of maintaining ongoing registration as a midwife in New Zealand. It involves the midwife reflecting on the professional Standards for Practice in relation to her practice, including her practice statistics, since her previous review. The midwife submits this paperwork and also presents herself to reflect on her practice with a midwife and consumer reviewer.

study who had Māori connections expressed concerns. No midwives identified as Māori. The Massey University Human Ethics Committee (MUHEC) had questions about Canadian ethical requirements and processes should women who were Canadian First Peoples be involved in the research. Ethical requirements were confirmed with the Canadian Institutes of Health Research (CIHR) (Appendix 1). No further ethics applications were required in Canada. I reviewed the CIHR guidelines for research with aboriginal (First Nations, Inuit, or Métis) people (Canadian Institutes of Health Research, 2007) as well as the Tri-Council policy document on Human Research (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2005; Canadian Institutes of Health Research et al., 2010). MUHEC was informed of this information and made no further requirements. With regard to First Nations, Inuit, or Métis women, the research did not investigate issues related to their cultures specifically. However, it was expected that if First Nations, Inuit, or Métis women were involved their values and beliefs may well be part of the discussions when dealing with decision-making during childbirth. Should this situation have arisen, guidance would have been sought from an appropriate cultural advisor of the appropriate band authority in the region. No First Nations, Inuit or Métis women were a part of this study.

Ethical approval was sought and granted by the Massey University Human Ethics Committee (Appendix 2) for the study to be carried out in New Zealand and Canada. Participant recruitment began, in New Zealand, in a district outside the area in which I worked and practiced.

Participant Recruitment—New Zealand

Recruitment of participants proved to be a challenge in New Zealand, where the first stage of data collection was carried out, and to a certain extent in Canada. Because this research was carried out in two countries, the challenges in and processes used for recruitment of the midwife and woman participants will be discussed in two parts, as they relate to New Zealand and then Ontario.

Once approval for the study was granted, recruitment of participants in New Zealand began. A letter of introduction explaining the project (Appendix 3) and information sheets for the woman (Appendix 4) and midwife (Appendix 5) were sent by email and post, to midwives and midwifery practices in the selected region. The letter invited midwives to participate in the study and to extend the invitation to clients. The aim was to recruit eight midwives and one client of each midwife as participants. The midwives and women were to be recruited from different midwifery practices in the region of the study. Combined with the projected number of participants to be recruited in Canada, this number was felt to provide a manageable amount of recorded data. Emails were sent to individual midwives and midwifery practices twice over a number of weeks. In addition, I attended a regional professional meeting and an advertisement (Appendix 6) inviting midwives to participate was sent electronically, by the regional chairperson of the New Zealand College of Midwives, to all members in the region. There was no response to my invitations over the following months. Recognizing the influence of the concerns expressed by the midwives at the regional meeting about research burnout and the issue of discussion of birth of the placenta taking place prior to the 35th week, consideration was given to changing the study location. Approval was sought from the MUHEC for a change in the region from which participants were selected (Appendix 7) to the Greater Wellington, Hutt Valley, and Wairarapa regions (Figure 3.2), where I was better known to the midwives.

This amendment was approved with a proviso that required not involving any midwife I, as a reviewer, had undertaken a Midwifery Standards Review on in the last two years or would review within the following two years (Appendix 8). The information sheet for midwives was redesigned accordingly (Appendix 9). The introduction letter and information sheets were put in the midwives' pigeon holes at the hospitals. At a regional professional meeting, the project was presented, information sheets made available, and midwives were invited to participate and to disperse the information sheets to other midwives in their practice; there was no response to my invitation.



Figure 3.2: Map of New Zealand. The research area included Wellington, Porirua, Hutt Valley (just north of Wellington), and Wairarapa. One midwife-woman dyad lived in the Manawatu. (source: mfe.govt.nz)

One midwife who had taken the information sheets provided feedback related to clarity around the research aim and the time commitment. Amendments were made to the woman's information sheet to make it clear that the research was about the decision-making process rather than the decision made. In addition, the project was changed to include two audio-recorded sessions only and the removal of the participant's journal. The information sheets (Appendix 9 & 10) were given to a number of midwives to obtain feedback from the midwives and women prior to finalising the information sheet to be circulated. Verbal feedback indicated that the project was seen in a more favourable light.

Final Research Design

Due to perceived obstacles to recruitment and issues brought forth during the original recruitment period, the original research design was adjusted. The final research design (Figure 3.3) included the audio-recording of the antenatal decision-making discussion regarding birth of the placenta, between woman and midwife only. This was to occur between 34 to 36 weeks gestation. This would be followed immediately by an audio-taped informal interview between the woman, midwife and me. A final audio-taped informal postnatal interview was to take place between the woman, the midwife and me, between 10 days and 6 weeks after birth.

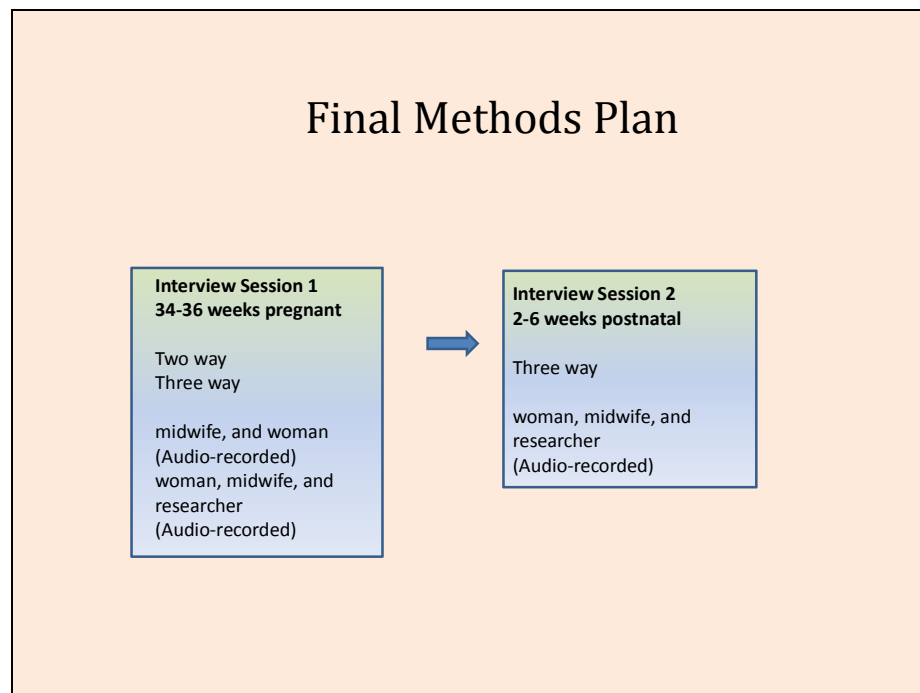


Figure 3.3: Final Methods Plan

There was still little interest in participating in the study with only two midwife-woman pairs participating, so, using professional/social networks, telephone calls were made to individual midwives in the region extending a personal invitation to participate in the study. This resulted in a further 6 positive responses. Interviews began in late December 2009, approximately 11 months after the initial ethics approval.

The Participants and Research Setting—New Zealand

In New Zealand eight midwives participated alongside one of each of their clients, whom they had invited to participate (see page vii). In two cases the LMC midwife was not the midwife at the birth and, in this situation, I was able to make contact with one of the backup midwives by telephone to fill in some information the woman could not recall at the postnatal interview. Three of the women had had babies previously, five women were in their first pregnancy, and four of those five women ended up with an unplanned caesarean section. All women and midwives were English speakers. The midwives recruited into the study provided care to the women throughout their childbirth experience from six weeks prenatally to six weeks postpartum. They were, therefore, the practitioners involved with the woman in the initial decision-making for the birth of the placenta. Each of the midwives who participated in the study had at least two years of practice experience. In situations where the primary midwife was not at the birth, the backup/birth midwife was known to the woman. In all cases, the birth midwife was aware of the plan for care.

All antenatal interviews took place when the woman was around 35 to 37 weeks gestation. All postnatal interviews took place within 6 weeks of baby's birth, apart from one which occurred at eleven weeks, as I had failed to keep track of the woman's due date, the midwife did not contact me when the baby was born, and the woman had been away. In this case, a convenient time for me, the woman, and the midwife was arranged for the postnatal interview. To avoid inconvenience to the women and midwives, all interviews were attached to a regular antenatal or postnatal visit, apart from the one mentioned above, and participants were made aware of the approximate time commitment for each 'interview' prior to consenting to participate.

The interviews took place wherever the woman and midwives normally met for the antenatal or postnatal visit. Antenatally, this was in the privacy of the midwives' clinic, apart from one session, which occurred in the woman's home. All postnatal

interviews took place in the woman's home. Only family members and support persons the woman agreed to have present were in attendance.

Participant Recruitment—Ontario

During the course of the study, I left New Zealand and returned home to the island of Newfoundland, off the east coast of Canada. This necessitated a change in the region of Canada in which the study was to be carried out. The original province, British Columbia, was no longer feasible because of distance and transportation costs, and Newfoundland and Labrador was not an option as it does not have regulated midwifery. With this in mind, approval was requested and gained from the MUHEC to undertake the study in whichever Canadian province was reasonable (Appendix 11, 12). The province selected was Ontario (Figure 3.4), with the region in and around Toronto chosen because it has the densest population. Ontario is the closest province to my home province with sufficient numbers of practicing midwives to make recruitment feasible.



Figure 3.4: Women in the study all lived an hour's drive from Toronto, or in Toronto, Ontario. My home is the island of Newfoundland in the province of Newfoundland and Labrador off the east coast.

Participant recruitment commenced with an email request which included an information sheet and cover letter amended for Ontario (Appendix 13), first to the Canadian Association of Midwives for their support; there was no reply. A similar email was sent to the Association of Ontario Midwives (AOM). Their reply indicated that individual midwives should be approached directly (Appendix 14).

Email requests were sent to the various midwife practices in the chosen region. The requests included the letter to midwives, separate information sheets for participants, and a leaflet introducing me as the researcher (Appendix 15). The initial email request was followed up at intervals by further emails and telephone calls to practice managers.

Using professional networks, I made contact with one Ontario midwife because we were both members of the Association of Midwives of Newfoundland and Labrador. During the period until the second interviews, participant recruitment continued with email and telephone calls or messages to midwifery practices. Two participants were recruited when I spoke to two midwives from Ontario at the International Confederation of Midwives (ICM) conference in Durban, South Africa in June of 2011. An additional two participants were recruited after I had visited a practice in Ontario and spoke to a midwife there.

The Participants and Research Setting-Ontario

In Ontario, six midwife-woman pairs took part in the study. All six woman-midwife dyads took part in the antenatal interviews, and in one case the woman's partner was present. The postnatal sessions involved the birth midwife, and in one case the primary midwife, and the student midwife who was present during the labour care. In four of the six cases the primary midwife was not at the birth (see page vii). At one postnatal interview, the birth midwife was unable to attend, as is explained below.

Four of the women had had babies previously. Two were in their first pregnancy, one of whom ended up with an unplanned caesarean section. Five women were 35-37 weeks pregnant at the first interview and one woman was at 29 weeks gestation, she was asked by the midwife when she came to the clinic if she wanted to participate, and she agreed to an interview at that time, while I was in the clinic. The six women came from five practices. All midwives recruited into the study had two plus years in practice. All participants were English speakers. The midwives were those who provided care to the women throughout their childbirth experience from six weeks prenatally to six weeks postpartum. They were, therefore, the practitioners involved with the woman in the initial decision-making for the birth of the placenta. In situations where the primary midwife was not at the birth, the backup/birth midwife was known to the woman. In all cases the birth midwife was aware of the plan for care.

In Ontario most interviews were carried out in the privacy of an office in the midwives' clinic, apart from two postnatal visits which took place in the privacy of the woman's home. As in New Zealand, to avoid inconvenience to the woman and midwives, all interviews, except one, were attached to a regular antenatal or postnatal visit, and participants were aware of the approximate time commitment for the interview prior to consenting.

In one postnatal interview, the midwife had to cancel at the last minute because she was attending another client who was in labour. The woman consented to having the interview in her home without the midwife being present; the timing was convenient for both the woman and me. The birth midwife for this woman was subsequently interviewed by email. Although the data collected from the midwife was valuable, email contact restricted exploration of issues and did not enable the exchange that is undertaken when the woman and midwife are interviewed together. Communication through email also prevented the use of encouragers in the conversation and an exchange that would have prompted reflection. With permission, the transcripts of this midwife and woman were exchanged so each could read the other's conversation; however, neither the midwife nor woman

made further comment, which would likely have occurred in face to face interviews.

To reduce the cost of travel, one postnatal interview in Ontario took place by Skype, with the woman and midwife in the woman's home and the researcher in a private office. This was a more effective method of communication than email contact; however, it involved voice only and so the body language and more intimate aspects of face to face interaction were missing. Because of the digital format of Skype, there was also a brief interruption in transmission if one of the participants and I spoke at the same time. This meant that encouragers, acknowledgers and other conversation facilitators were missing.

The Interviews—Ontario and New Zealand

The first data collection session in the research process consisted of the woman and midwife discussing the care options for the birth of the placenta and making a decision or not about which method to use. This discussion was digitally recorded. Before recording, written consent was gained from all participants, after ensuring that all information about the study was clear and any questions were addressed. After they were given instructions, the participants were asked to operate the digital recorder. To avoid any influencing effect of my presence, I left the room and returned when the midwife called me in, after the decision-making discussion. As the influences on the decision-making and the decision-making process were the main focus of the study, it was not necessary that a decision on method for the birth of the placenta be made during the first discussion.

The woman, midwife, and I proceeded immediately into a digitally recorded, informal, semi-structured interview/discussion. The support person, if present and from whom consent was obtained, also took part in this interview. The interview was to elicit information about what knowledge influenced the discussion and was guided by questions in Tables 1 and 2 below. The woman was asked to respond to the questions first. Following the discussion the women and midwives were given

the opportunity to ask questions and make any further comments related to the topic under discussion. In the early part of the study, women and midwives had been given a copy of the interview schedule to guide their reflections. As the project progressed, some women and midwives did not want the questions prior to or during the interviews, as they felt they would like to discuss things spontaneously. Following this feedback, I used the questions as a prompt only to ensure we had covered the topics of interest.

Table 1: Questions to facilitate reflection for the woman, prior to the birth
<ul style="list-style-type: none"> • When thinking about the discussion you had with your midwife regarding the birth of the placenta, what other thoughts and feelings do you have? • What knowledge and life experience influenced your decision-making for this aspect of care? • What information from family or friends influenced your decision-making? This question also related to discussion about birth of the placenta and choice of midwife. • What did you learn in antenatal classes about birth of the placenta? • How do you feel about the discussion? • Why? • Do you feel your knowledge and preferences were respected? • What would you like to do/ have done differently if you could <p style="text-align: right;">Adapted from Woodall (2000)</p>

Table 2: Questions to facilitate reflection for the midwife, prior to the birth.
<ul style="list-style-type: none"> • When thinking about the discussion you had with the woman regarding the birth of the placenta, what other thoughts and feelings do you have? • What knowledge and personal or practice experience influenced your decision-making around third stage? • What policies or protocols influence your decision-making? • How do you feel about the discussion? • Why? • Do you feel your knowledge and preferences were respected? <p style="text-align: right;">Adapted from Woodall (2000)</p>

Questions were also asked when clarification or elaboration of a point was desired and when comments arose that pointed to unexpected influences on the decision-making for midwives or women. Issues relating to unexpected influences, such as initial choice of midwife or the midwife's practice philosophy, were incorporated into subsequent interviews.

For example, in New Zealand a comment by a midwife about her philosophy of practice resulted in my subsequently asking midwives about what they tell women regarding their practice and asking women why they had chosen the particular midwife or the midwifery option in Ontario. Also, in Ontario, one midwife brought up issues with barriers to midwives practicing in some hospitals, and this was explored further in the interviews that followed.

As the analysis of the data began, themes identified from the initial interviews generated questions that were explored in subsequent interviews. Additional questions (Tables 3 and 4) explored more fully the influences on the women's choice of health professional and the midwife's choice of client, as research conversations suggested that these factors also influenced decision-making around birth of the placenta.

Table 3 Subsequent additional questions to facilitate reflection
<p>For the woman in New Zealand</p> <hr/> <ul style="list-style-type: none"> • What made you choose (the particular midwife)? • How did you find out about the midwife or midwifery practice? • (If friend or family) what did they say about the midwife/midwifery practice? • What did you know about how the midwife practiced prior to choosing her? <p>For the women in Ontario</p> <hr/> <ul style="list-style-type: none"> • Why did you choose Midwifery care? • How did you find out about midwifery care? And this midwifery practice? • (If friend or family) what did they say about the midwife/midwifery practice? • What ideas did you have about what you wanted for your pregnancy and birth?

Table 4: Subsequent additional questions to facilitate reflection
<p>For the midwife</p> <hr/> <ul style="list-style-type: none"> • What do you tell women about yourself as a midwife and your practice? • Are you comfortable with both methods of birth of the placenta? • In your practice would you say one type of management, physiological or active, predominates? <p>Additionally, in Ontario</p> <ul style="list-style-type: none"> • Given that you cannot meet the needs of all women, how do you and or your practice decide on which women to provide service to? • I hear that some hospital cap the number of births the practice can do in the hospital or the number of midwives with privileges. Is this the case here?

If available, the website or practice leaflet of the midwifery practice was reviewed for an indication of philosophy or practice principles. Where available, copies of information leaflets, booklets, or information sheets on birth of the placenta, used by the midwives and women, were also obtained.

A second interview took place after the birth and involved the woman and partner or other support person, if present, the midwife, and the researcher. Its purpose was to discuss what had happened with regard to the management of the birth of the placenta, what influenced that decision and the feelings about the event.

This conversation was guided by the questions in Table 5.

Table 5: Description of the event – birth and birth of the placenta from both the women and the midwives.
<ul style="list-style-type: none"> • Tell me to the best of your recollection the events of the birth and birth of the placenta. • What discussions took place, at the time, regarding the birth of the placenta? • Did the management of the birth of the placenta match what you had decided prior to the birth? • What policies/protocols or procedures at the local hospital influenced your decision? • What other people were involved in the decision to manage the birth of the placenta? • On reflection are you satisfied with the decision made at the time? • Are there any other comments/thoughts you have about this event and the decision-making?

Questions and discussion developed as the conversations progressed and comments were clarified. The conversation began with the woman telling of the events of her labour and birth experience.

With the exception of one interview, which took place eleven weeks postnatally, all interviews occurred within 10 days to 6 weeks after birth. Minimal research notes were made during the interviews, as it distracted me from being able to listen attentively to the talk (Clifford, 1990) and to encourage reflection. Notes were made just before or after the interviews and included information on the midwife and years of practice, whether other children were present during the interview, and relevant observations of the location and layout of the room. During the interview, a brief note was written, if not intrusive, (Montgomery & Bailey, 2007) to act as a reminder of comments for follow-up. There was continued email communication with midwives in Ontario during the writing up period to clarify some aspects of the data collected, such as the situation regarding transfer of care.

Ethical Considerations

In the design and implementation of this research project, a number of ethical issues were considered, and measures were taken to ensure ethical standards were met. These considerations are discussed below.

Informed Consent

Each midwife who agreed to participate in the study was sent, via email, information sheets for themselves and for women. Any questions the midwife had were answered prior to her agreeing to be a part of the study and recruiting a woman client. Information was sent in the email outlining, as closely as possible, the time commitment involved and briefly outlining the research project. At the interview, an overview of the research was given and an information sheet was handed out if requested or if either participant had not previously received one; any questions were answered. The information sheets also included assurances that the researcher would safeguard participants' privacy and confidentiality. It

specified that the data would be held for five years and that participants could withdraw from the study at any time during the research process. All participants then signed an appropriate consent form (Appendix 16).

Privacy, Security and Confidentiality

Privacy of interviews was ensured as discussed above. All consent forms were kept in a secure, locked office in New Zealand and, on the move to Canada, in an office in my home. All digital recordings are kept in a password protected computer. In all writing and publication, the confidentiality of all participants has been and will be adhered to. In all writing, participants have been given a pseudonym and any other people named in the recordings have been identified by initials or professional designation only. All identifying information was removed from all transcriptions. There are no identifiers within the transcribed interview material as to district or regional health board, hospital, region, or city/town of residence or the birth. Transcriptions were shared with study supervisors only. Digital recordings were heard only by the researcher who personally transcribed the interviews.

Potential Harm to Participants

Concerns were raised by MUHEC that the close relationship that develops between midwife and woman and the nature of the discussions about the women's childbirth experiences and the midwives' practice may make distinguishing personal confidence from legitimate "data" difficult. This was addressed by upholding confidentiality of all information discussed in the sessions, only transcribing and using discussions relevant to the research, sending transcripts to the participants for review, and disclosing only information that had been acknowledged as public or confirmed by the women and midwives as relevant and acceptable for release. Protection from harm is also maintained by upholding confidentiality as discussed above.

No concerns related to clinical care arose; nevertheless, plans had been put in place were this to happen. In New Zealand, this would have involved referral to the New Zealand College of Midwives Resolution Committee of the region or to the

Advocates of the Health and Disability Commission, for the woman. In Ontario referral to the Association of Ontario Midwives or the College of Midwives of Ontario would have been undertaken. If professional practice issues regarding the midwives' safety to practice during the process of the research had arisen, the concerns would have been referred to the Midwifery Council of New Zealand or the College of Midwives of Ontario, as appropriate and as the law requires, and to a midwifery support network in the relevant region.

Researcher Potential Difficulties and Safety Considerations

For personal security reasons, all visits were conducted during the day time and the midwife, woman and support person(s) were present, whether in the woman's home or the midwife's office. All midwives who participated in the study in New Zealand were known to me prior to the research. In Ontario, all interviews but one were carried out in the midwife's clinic, and other people were present in the outside office. As discussed previously, in one instance I carried out an interview in a woman's home with just myself, the woman and her husband. In that case communication with the woman was arranged via the midwifery practice secretary, and the midwife was aware I was visiting the woman at home.

Transcription Accuracy

Because the nuances of talk are important for understanding, I transcribed all the digital recordings from the antenatal discussion and antenatal and postnatal informal interviews word for word as close to the time of the interview as practical. Both Poland (1995) and Bird (2005) suggest that this practice may add to the trustworthiness of the work.

Particulars of the transcribing code from Conversation analysis (CA) such as overlapping speech, speeded up speech, loudness of speech, and features that express emotion, such as laughter (Appendix 17) were included when transcribing. While CA itself was not used in the analysis the transcribing technique was used to help focus attention on the voices of participants and take note of all nuances of speech that may convey the meaning of the conversations (Lapadat & Lindsay,

1999). For example, Helen, when speaking to midwife Candice, says, “What I can gather with the jab [injection of oxytocin] it’s not actually ↑essential >I mean there are times when it is obviously< **BUT** it is not one of those things >I know they do it< most of the time but it is not (.1) one of the (.) most essential things it still comes out naturally and it will come out its not gonna stay in there or anything so.” The various symbols help the researcher note the emphasis on the talk. Speeded up speech, indicated by the arrows < >, is used to defer interruption from the listener. The notion (.1) is used to indicate a pause in the conversation with the numerical value suggesting length of pause, and the bold **BUT** designates increased emphasis. These transcription codes were not included in the quotes in Chapters Five and Six, so as to not detract from the participants voices. Digital recordings were revisited if the written transcriptions were unclear.

The timely transcribing, transcribing by the researcher, and following, to some degree, the transcription techniques of CA increased the researcher’s familiarity with the participants’ talk and strengthened accuracy. According to Hammersley (2010), these factors may help with understanding the intent of aspects of the interview conversations.

Data Analysis

Analysis of the participants’ talk began with the first interviews, as I considered the overall question of the study: What are the influences on decision-making in the woman-midwife relationship? Early in the data collection and analysis, it became evident that identity and relationships were a pivotal part of decision-making. In discussion with my supervisors, it also became evident that embeddedness and relationality were key concepts arising from the participants’ remarks and discussions. As will be discussed in Chapter Four, a broad definition of relationality was used, one that considered not only personal relationships but the wider socio-political and cultural contexts. During the discussions and conversations participants shared their stories. These discussions and contributions were subsequently analysed with the notions of embeddedness and relationality in mind.

Narratives as a whole (Frank, 2010a; Phibbs, 2008; Plummer, 2003), as well as in part, were analysed for what they revealed about identity and for themes that illustrated relationality and embeddedness. This approach was combined with analysis of themes within the the actual stories and talk of the participants (Braun & Clarke, 2006). Both methods of analysis were looking for personal influences as well as wider influences on decision-making.

Thematic analysis as discussed by Braun and Clarke (2006) was used. This is a flexible method (Braun & Clarke, 2006) that enables the researcher to work across methodologies. This less structured approach to thematic analysis than the more traditional methods, as discussed by Boyatzis (1998), is used in this thesis⁷.

Analysis commenced as each interaction unfolded and I began to think about what was being said (Braun & Clarke, 2006). Thematic analysis is not a linear process of data collection, transcription and studying of the transcripts. Analysis is a complex and dynamic process that begins from the first 'interview' (Blaikie, 2009; Mauthner & Doucet, 1998); its dynamic nature is indicated by inclusion of additional questions in later interviews. Analysis required a familiarity with the data, and thus careful attention was paid to listening and transcribing as well as reading of the transcriptions. Undertaking transcribing of audio recordings in a timely fashion, as close to the interactions with participants as possible, facilitated a familiarity with the data. Furthermore, discussion of the data with supervisors was an important element in firming up ideas and confirming emerging themes. As themes were identified they were explored further in the interviews that followed a process that enabled participants to be included in the development of the themes.

⁷ Thematic analysis as described by Boyatzis involves the development of themes and codes. Themes are based on dependent and anchor variables. Transcripts would be studied for instances of high representation and low representation in order to develop a criterion reference for the theme. Transcripts are then studied for aspects of conversation that fits within each theme.

Recordings were listened to and transcripts read for overlap and differences in the woman and midwives' talk, across the conversations related to influences on decision-making. This included themes or overall plot (Mauthner & Doucet, 1998) from the talk and narratives as a whole as well as differences and commonalities within the talk and narratives of participants. In the analysis for the thesis, sub-themes were not used to identify patterns of thought across some of the data sets. This is because the focus of analysis was on ideas that illustrated themes at work within the field rather than distinguishing high or low representation of themes. For example, the themes of vulnerability and trust, presented in Chapter Five, appeared in four of the women's descriptions of the birth event. Other themes occurred in nearly all of the data sets. For example, social networks informing choice was found in 12 of the 14 contributions from the women. Themes that related to influences on decision-making in the woman-midwife relationship were chosen for closer analysis.

The main themes identified and discussed in Chapter Five demonstrated the embeddedness and relationality of decision-making and included ontological and philosophical influences on decision-making, social network influences on decision-making, relationships, vulnerability, and relational trust (Figure 3.5). Within the broader theme of ontological and philosophical influences were ideas relating to choice, natural birth, continuity, and identity, particularly in relation to how the women and midwives positioned themselves, each other, and other providers.

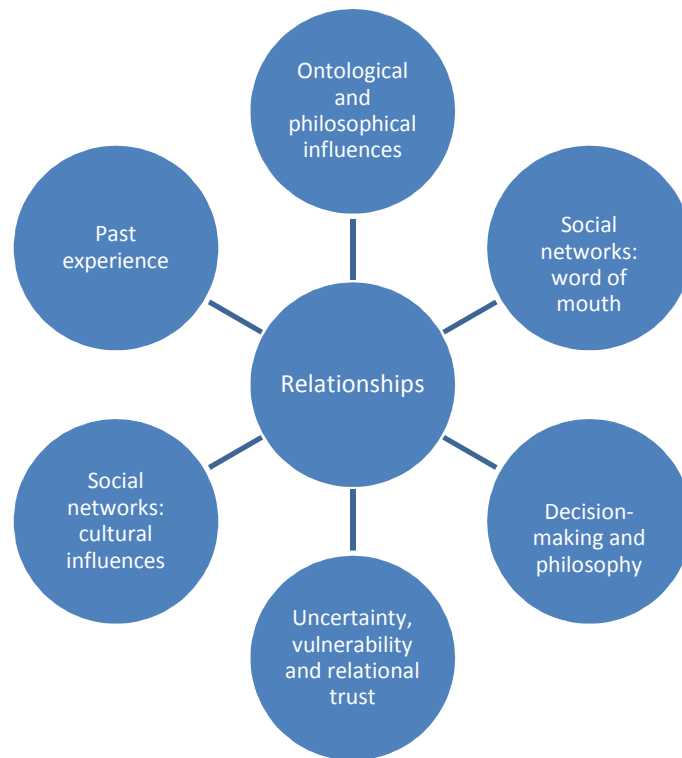


Figure 3.5: Themes of Relationship

Using a cut and paste method, the transcripts were reviewed for comments and remarks that illustrated these themes. For example, in some cases talk and descriptions from the midwives and women supported or illustrated their identity with regard to childbirth. Midwife Cindy, in the antenatal discussion with me and the woman, said, “When I first meet people, I actually, I tell them I am quite a holistic midwife and this is my views on birth and right at the beginning, didn’t I, Jane? I said I’m into natural birthing.” Identities and relationality were also called upon in the language used during discussions. For instance, in discussing physiological labour and birth, expressions such as “you’ve had a lovely birth,” were used, in which the midwife’s client is drawn in to support the narrative through the use of the word *you’ve*. Themes within the discussions and in responses to questions about how women chose their midwife illustrated the importance of social networks for the women. An unintended but significant advantage of interviewing both the midwife and the woman together was that it

enabled language that reflected the relational nature of midwifery to be recorded and presented in the thesis, interactions such as “you’ve had a lovely birth,” and “didn’t I, Jane? I said I’m into natural birthing” illustrate this point.

Discussions with the midwives and women and reading around the contexts of midwifery in Ontario and New Zealand enabled wider socio-political influences on decision-making to be identified, and these brought in ideas from Foucault on power/knowledge as well as the theories of professional projects (Tully & Mortlock, 2004). The importance of context within the thesis was highlighted when midwives talked about the environment in which they worked. For example, Ontario midwife, Erin, mentioned that the hospital in which they have admitting privileges caps the number of hospital births the practice can do per year or the number of midwives with privileges. Erin’s casual comment drew my attention to the way in which the capping of midwives and/or births would have significant implications for decision-making and choices around child birth in the Ontario context. For this reason, it was decided to explore in more detail themes around how context influences choice. The main themes relating to context (Figure 3.6), which eventually made their way into Chapter Six, include consultation and choice, politics of location-access and choice, professional culture and choice around birth of the placenta, workforce issues, decision-making and place of birth, and infrastructure, regulation, and decision-making. The recording and transcripts were studied for further comments and description and remarks that illustrated these themes.

A key theme identified in the New Zealand interviews related to how initial choice of midwife shaped subsequent discussions and choices around childbirth. It was, therefore, decided to explore this theme further through looking at the practice literature and websites of both Ontario and New Zealand midwives who participated in this study.

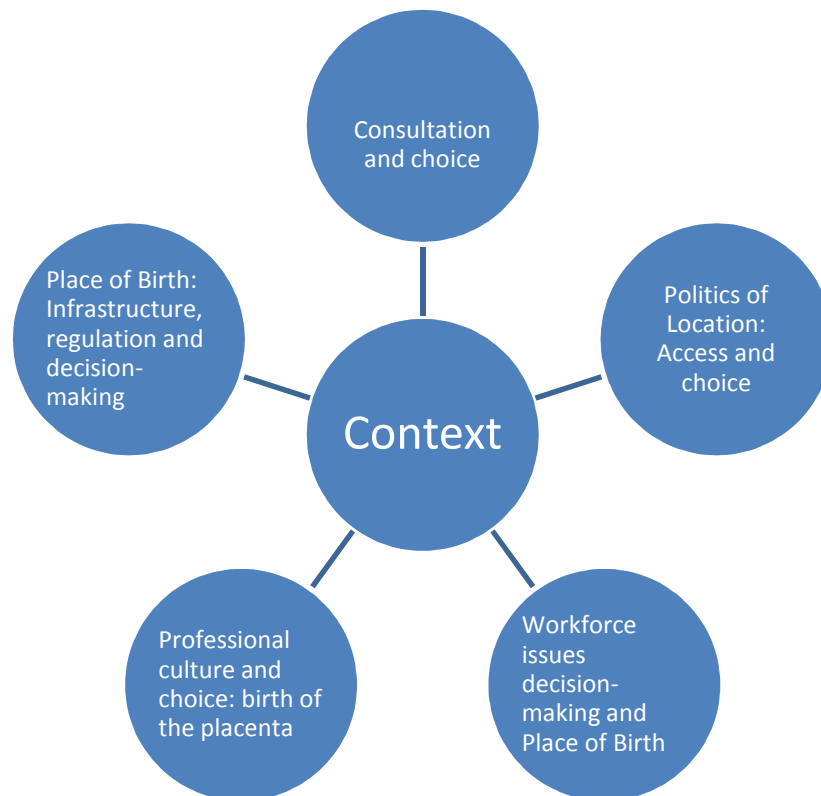


Figure 3.6: Themes of Context

When available, printed material on birth of the placenta used by the women and midwives was collected and reviewed for the fit with practice identity and how it related to the decision-making. Practice websites and information leaflets were reviewed for practice philosophy or practice principles that indicated midwifery identity and philosophy.

Trustworthiness

Trustworthiness refers to the openness of the research process and the degree to which the process was followed and documented such that others can readily confirm the trustworthiness of the work. Trustworthiness implies that the analysis and results of the research are true to the participants and that the findings reported accurately reflect what the participants meant and what the research found (Streubert, 2011).

There are a number of ways to determine trustworthiness in qualitative research. Triangulation is one such method used in this study to strengthen trustworthiness (Patton, 2002). Using Denzin's (1978) classification of methods for triangulation this study used multiple data sources by confirming initial themes in following interviews and by using document sources, including the academic literature, to confirm some of the wider contextual issues that came up in the women's and midwives' talk. Participants from two countries and from a number of different midwifery practices can also be considered a form of triangulation (Shenton, 2004)

Other methods to uphold trustworthiness in this research included methods previously discussed, such as recorded interviews and timely, accurate, and detailed transcription (Bird, 2005; Hammersley, 2010; Poland, 1995) Audio recordings were transcribed word for word (Bird, 2005; Poland, 1995). Moreover, participants were given the opportunity to add any further comments and reflection at the end of each interview as well as when they were sent the transcripts and the research summary for their perusal (Cooney, 2011). Additionally, women and midwives were contacted electronically to provide them an opportunity to clarify any questions I had as the writing progressed (Cooney, 2011). Participants' words were used in the thesis and publications. To confirm trustworthiness of the themes, the full transcripts were reviewed by my PhD supervisors (Shenton, 2004). All recordings were digitally identified with date and time, and all recordings, transcripts and digital audio recordings filed with a midwife and woman identifier. All transcripts and material will be kept for five years.

Credibility and Fittingness

Credibility deals with the authenticity and clarity of the description of the experience so that the participants and others in a similar situation recognise the experience as being similar to their own (Beck, 1993; Cooney, 2011; Streubert, 2011). Fittingness attests to how the findings fit with the understanding of the wider audience (Beck, 1993; Streubert, 2011).

Credibility was achieved by using participant's stories and experience to guide the research and by having participants review and verify their transcripts. Participant selection criteria were clearly explicated and every effort was made to give a "picture" of the women and midwives who participated. Recruiting midwives from multiple practices and in two countries gives credibility to the conclusions drawn, and the likelihood that the findings fit with what others experience. Moreover, the acceptance of an article for publication, based on the New Zealand aspect of the study (Noseworthy, Phibbs, & Benn, in Press), further indicates that the findings were credible as publication required peer review (Patton, 2002). Participant midwives were sent the details needed to access the published article from the New Zealand aspect of the study and asked for feedback; at the time of writing, none of the midwives have provided any.

Feedback from several sources helped to confirm the credibility and fittingness of the results. At presentations at a sociology conference in New Zealand, at PhD school, and in a midwives' conference in Canada, listeners provided positive feedback. Also, a summary of the research findings (Appendix 18) was sent to participants and feedback requested. One midwife from each country responded via email; the New Zealand respondent did not comment on credibility issues. However, the Ontario midwife, Erin, wrote, "...your findings are as I expected! In Canada, clients seek out midwives for continuity and informed choice. Midwives are mandated to provide informed choice in order to support women's participation in their care." Women commented as well, with Hattie writing, "As to the summary, you really nailed it so to say. I agree 100% with everything you stated there". Also, Catherine commented, "I was very happy with your research. I felt that you really understood why women in Canada choose midwifery". These comments by both women and midwives attest to the fittingness of the findings.

The study settings have been made clear so that context for the findings can be understood. The findings in Chapters Five and Six coincide with and support other research in the field of health care and midwifery in particular.

Auditability

Auditability refers to the audit trail that supports the detail of the study and enables others to follow the path and reasoning of the researcher, but which also makes clear the researcher's stance with regard to beliefs, values and assumptions (Cooney, 2011; Liehr, Marcus, & Cameron, 2005; Mays & Pope, 1995). Auditability was demonstrated in the beginning chapter where I made clear my position as a midwife who has practiced as caseloading self-employed midwife, as a midwifery educator, and as a peer reviewer in New Zealand. The midwives in the area of the study in New Zealand knew of that position. In Canada an introduction letter was sent when recruitment was undertaken. The details contained in the methods chapter, including an explanation of the method of data analysis, support the claim of auditability. Documents enclosed in the various appendices provide a clear trail for audit purposes.

Safety

The relational methodology developed during this study (discussed in Chapter Four) requires that safety, both physical and spiritual, be respected. No physical harm was caused by this study. Furthermore, in email feedback from some of the midwives all indicated that they felt respected and safe to talk about their practice around third stage. Midwife Penny, in New Zealand, wrote, "I found you very safe and easy to talk with, listened to, respected, and interested. You absolutely gave me time and opportunity to say what I wanted to say in relation to your questions." Midwife Barb, in Ontario, wrote, "[Y]es I felt comfortable to talk to my clients in your presence and communications were done in a very respectful manner and clients were comfortable too." Midwife Erin, in Ontario, also found the process safe:

My experience participating in the research process itself was very positive. It has been a real pleasure getting to know you Ann as well as learning about midwifery in NZ & N[L] [Newfoundland and Labrador]. I felt totally comfortable sharing my personal process of informed choice regarding the 3rd stage of labour. I hope it was helpful to you and will provide valuable information to the profession.

Two women provided email feedback on the research process that indicated their sense of safety, with Catherine saying, “I felt very safe talking to you and with my midwives present.” I also sensed during the discussions that those who participated felt safe and respected. The feedback from midwives, Erin, Barb, and Penny indicates that a safe research relationship had been developed and that the midwives felt free to talk about the issues of the research. This feedback enhances the credibility and trustworthiness of the research. The comments from participant midwives also points to the importance of relationship building to ensure the midwives, and thus women, felt safe to discuss their experiences with me.

Conclusion

In this chapter the research design and methods used to collect and analyse the data in a way that fits within a midwifery paradigm have been reviewed and the relationality of the research process was highlighted. The challenges with recruitment of participants demonstrated the importance of recognizing the wider influences and demands on midwives and researchers and how these impact decision-making and actions. After consultation with and listening to midwives’ and women’s concerns and suggestions, alteration of the research design was undertaken. The technique used to recruit midwives and their clients into the study in New Zealand also demonstrated how my embeddedness in social and professional networks and relationships played an important part in the process. By using my social and professional connections and by building relationships with midwives in Ontario, I was able to recruit midwives who subsequently recruited women to participate in the study. Data collection techniques of using an informal conversational style and involving woman and midwife together, along with

support people and toddlers, helped to enrich the conversations and ensure that they were woman-centred. This style, plus techniques of checking themes with participants during the research, sending a summary for feedback, and seeking feedback on a published article, bolsters credibility and also fits with an ethos of relationality. Being attentive and responsive to participants' talk and feedback enabled a wider exploration of issues and demonstrated a flexibility as the design was adjusted to accommodate that feedback and talk. These challenges of recruitment, design changes in response to feedback, and research techniques resulted in critical reflection on the process of this research. That reflection and discussion with supervisors sparked the realisation that this was a relational research methodology, and it is this that is discussed in Chapter Four.

Chapter 4: Building a Relational Methodology

Introduction

I began this research project from a humanist qualitative stance and a research design influenced by the ideas of a participatory epistemology as discussed by Heron and Reason (1997) and with an interest in reflective conversations (Feldman, 1995) that reflected my identity as a midwife and educator and as a midwife who takes part in and appreciates reflective conversations with peers during Midwifery Standards Reviews (MSR)⁸. The research began with a descriptive interpretive approach informed by thematic analysis as described by Braun & Clarke (2006) but as the research went proceeded this was combined with a more critical approach in the analysis. The understanding of this methodology continued to develop over the time of this research. The final methodological framework comes out of the research journey from the blending together of the philosophical principles of partnership and woman centeredness from midwifery with a number of concepts in research, such as participant centeredness and social theories, including ideas about embeddedness (Granovetter, 1985) and relational autonomy (Sherwin, 1998).

This chapter presents the evolving relational methodology that developed as a consequence of this research project, a methodology in which decisions are made and actions taken in relation to participants as well as the wider context of the research itself. In this chapter, the methodology is discussed, a model is presented,

⁸ Midwifery Standards Review (MSR) is a professional peer review/professional development process that is a required part of maintaining ongoing registration as a midwife in New Zealand. It involves the midwife reflecting on the professional Standards for Practice in relation to her practice, including her practice statistics, since her previous review. The midwife submits this paperwork and also reflects on her practice with a midwife and a consumer reviewer, who are a part of the MSR committee in the region.

and the principles and theoretical underpinnings that construct this methodology are explored. The discussion of the theoretical principles underpinning the methodology also relates to the concepts that construct the lens through which the analysis was undertaken.

Why a Relational Methodology?

The woman-midwife interaction in caseloading practice⁹ is about relationships. Caseloading midwives, whether they work in Canada or New Zealand, follow principles of partnership, informed choice, and continuity, as required by their regulatory authorities (College of Midwives of Ontario, 1994a; Midwifery Council of New Zealand, 2004). Consequently, this methodology has been developed and carried out within a framework of partnership, where the research is participant-centred and focused on participants' needs and wishes as well as those of the researcher. Many of the qualitative methodologies used in midwifery, such as phenomenology, feminist, and participatory approaches, share with a relational methodology characteristics of a naturalistic and participant centred approach to the world and the consideration of how to best represent human experience and locate the researcher within the research and text (Denzin & Lincoln, 2011a). The methodology used in this study also shares some features with other qualitative methodologies in the way the approach evolved. In addition the methodology has in common characteristics of action research, which follows a participatory paradigm that is participant-centred and responsive to context and thus the evolving methodology could be considered to be a special type of participatory research. The methodology shares principles with some indigenous approaches such as narrative inquiry within an aboriginal epistemology as discussed by Barton (2004), flexibility and aspects of relationality in an indigenous, non-western

⁹ In Canada the model of midwifery practice is a community based case load practice where a midwife provides pregnancy, birth, and postnatal care to a number of women in her case load. She is backed up by another midwife in her practice group. In addition to case load practice, New Zealand midwives also work rostering and rotating within a hospital, providing episodes of care to women when admitted to hospital in the antenatal or postnatal period.

methodology as discussed by Weber-Pillwax (2001) and Steinhauer (2002), and a bicultural methodology, Te Whakamāramatanga, as developed by Kenney (2009), all of which acknowledge the importance of relationships and a world view other than a western view. There is no one research approach that includes the principles that are incorporated into this evolving methodology, principles that recognise the embeddedness of the researcher in social networks and the influence of context on the research journey, from research design to writing, and which came from carrying out this study. Relational and participant-centred, this methodology encompasses principles that acknowledge the social nature of people, the importance of participants in the research process, and the requirement to be responsive to participants' voices and needs. It also acknowledges that the researcher is placed as both a participant and facilitator of the participants' stories and that both participant and researcher are embedded in a broad socio-political context which directs action. Important to this research methodology is that it is carried out in a manner that is ethical in its broadest sense, embraces the principles that underlie the profession, and is contextually relevant and appropriate.

The methods used to develop the research project, carry out the study, and analyse the women's and midwives' contributions demonstrate that this research followed principles that have been presented in this methodological framework. It is also demonstrated that this methodology has been found by both women and midwives to be safe and relevant to midwifery research.

A Relational Methodology

People are relational beings; our concept of ourselves and how we understand the world is constructed through the networks in which we are embedded. These relationships are intimate, socio-political, context driven, and multiple. Who we are and how we position ourselves in the social world is evident in our talk and actions. A relational methodology recognises the complexity of influences on researchers and participants, but, foremost, this methodology acknowledges the importance of the participants in the process, and, unlike positivist and early qualitative

methodologies, the researcher is not the objective observer but is a participant, co-creating knowledge and facilitating reflection. A relational methodology recognises that the researcher and research itself are embedded in a wide social, economic, geographic, and political network that influences research decisions and actions. The contexts in this research include, but are not confined to, the following: the research itself; the woman-midwife relationship in New Zealand and Ontario, Canada; family and friends; pregnancy and childbirth; culture; regulatory and professional organisations; institutional and governmental controls; discourse, and discursive practices, including professional, midwifery, medical, and popular. Recognising the complex influences, this methodology makes use of and works around the contexts of participants, including the location in which the research is carried out.

Sherwin's (1998) definition of relationality as the wider personal, socio-political influence on human actions and Granovetter's (1973, 1985) concepts of social ties and embeddedness within social networks reinforce the relational methodology's recognition that the research relationship is contextual. Like other human activity, it is impacted and constructed by social, cultural, political, and economic circumstances and belief systems at the time and location in which it is situated. Using concepts of participation and partnership, like other qualitative methodologies this methodology puts a human and realistic face to the research undertaking, an approach that is fitting for midwifery research of this kind.

Elements of identity (Mishler, 1999; White, 1992) and Harré's theories of positioning of selves through various practices fit with ideas of narrative identity (Somers, 1992, 1994). It is through our talk and other discursive practices that we express our identity, reveal our perceptions about others' identities, position ourselves, and are positioned by others. Granovetter's (1973, 1985) discussions of embeddedness support the construction of identity through social interaction and, as is the case with narrative identity, suggest the possibility of change and avenues for action. Sherwin's (1998, 2004) expanded view of relational autonomy blends well with Granovetter's (1985) theories, as factors outside the personal

relationships, factors not under our control, also impact autonomy and decision-making and are the context which makes up the discourses and from which we draw our identity. Sherwin's claim that relationality affects autonomy is in keeping with Foucault's notions of dominant discourses and how they influence decision-making by creating conditions that impact choice and by ignoring factors that play a part in controlling the ability to make decisions by limiting choices. Harré's theory of positioning (Davies & Harré, 1990; van Langenhove & Harré, 1999) and Twigg's (2004, 2007) discussion of resistance in the elderly demonstrate that we can use social technologies to effect change and resist dominant discourses. Democratisations of knowledge as well as non-local forms of relationality have become more evident with electronic media that enables networking throughout the world. Reflective conversations/interviews become a site for talk that identifies characteristics of human nature such as identity, positioning and resistance.

Underlying principles

The Radial Cycle in Water

I have represented the principles of this methodology as a radial cycle with the participant then the researcher in the centre and with a background of water (Figure 4.1). This image places the participants at the centre of the research relationship, which is fitting with midwifery's stance on woman/family centred care. The connected circle of the principles of the methodology acknowledges that all principles are linked and are necessary to carry out this research in an ethical and safe manner. These key principles of partnership, participation, protection and communication are supported by explanatory concepts. The water indicates that participants and researcher are immersed or embedded in relationships as well as wider socio-political and cultural environments that affect decisions made and actions taken by the participants and researcher. Furthermore, those influences are

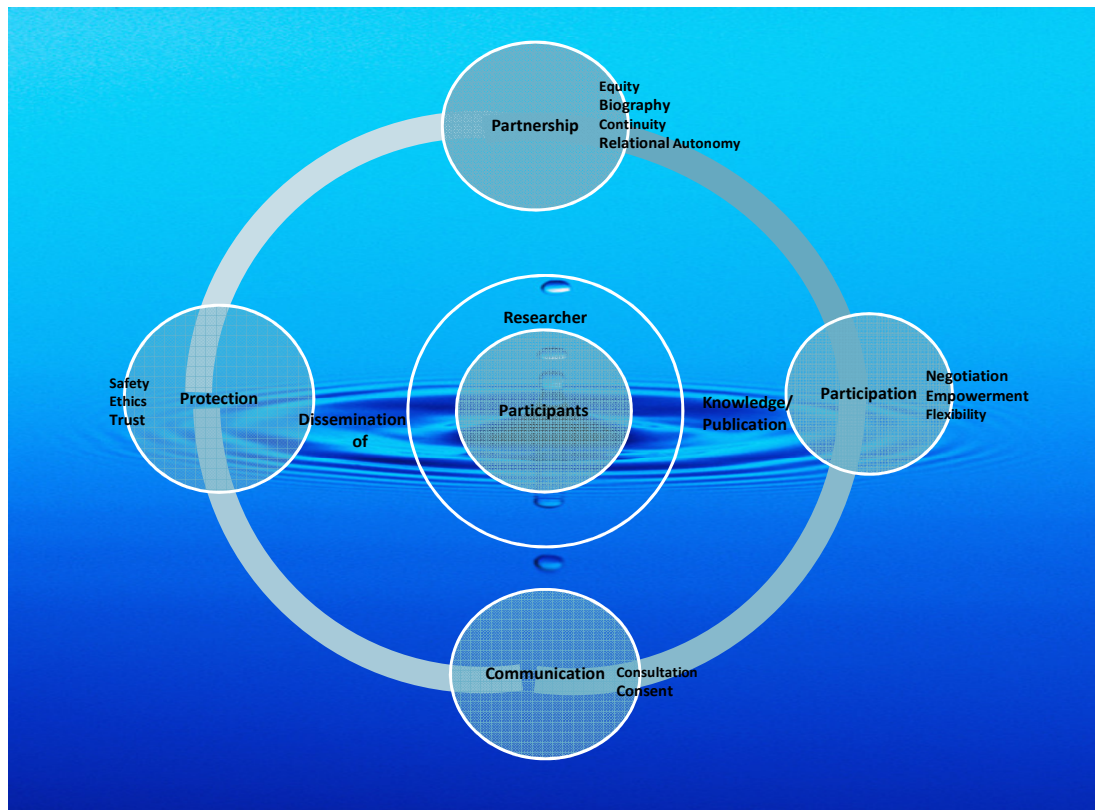


Figure 4.1: Relational Methodology Framework

fluid; context can change and research must be responsive to the situation and to the participants' voices. The ripples represent dissemination of knowledge from the research and the responsibility that the researcher has to the participants to ensure that their stories are ethically represented. The following is a brief explanation of each component of the framework, some aspects of which will be discussed further under theoretical influences. Each component in the outer cycle is of equal importance and is needed to support each other concept within the methodology.

Participant Centred

One of the central principles of midwifery professional practice is that care is woman/family centred (Canadian Association of Midwives/Association Canadienne des Sages-Femmes, 2009; Guilliland & Pairman, 1995). Participant centred research holds personhood central to the research process (McCormack, 2003). Principles taken from midwifery, which place the person at the centre in interactions, are applicable to this relational methodology that has been designed for research with

childbearing women and midwives. Participant centredness requires that the researcher considers and works with the individual's beliefs and values and requires respect. Moreover, in this methodology the researcher is also a participant, and, as such, consideration of the researcher's values and needs is also important. The principles of this methodology acknowledge the co-participants as integral to the research undertaking with the process being responsive to their needs and comments. Participant centredness requires mutual respect, responsibility, and flexibility.

Partnership

In keeping with the underlying principles of midwifery practice, in this relational methodology the research relationship requires that the researcher and other participants work together to achieve the goals of the study, whatever they may be. The results of any research depend on its participants and their willingness to share their knowledge. Each participant, including the researcher, contributes unique knowledge to the process and each has responsibility within that research relationship. Like the woman/family–midwife relationship, power may fluctuate depending on the context, but the stories belong to the participants.

Equity is about fairness, justice, and treating people without prejudice. Equity in research acknowledges differences in power and position and undertakes to ensure participants have equal opportunity to contribute to the research. Equity is also demonstrated when participants are supported to participate in the study and their contributions and meaning are given equal value, rather than the researcher's interpretation taking precedence. Equity is demonstrated in midwifery research when each participant is given the opportunity to speak and when the woman and her support person and midwife are involved together in the research conversations.

It has been proposed that the researcher holds a power that can dictate the subsequent research relationship, especially when that research may be undertaken with Māori (Wilson, 2008) or aboriginal people. Research has not

served aboriginal people (Steinhauer, 2002; Wilson, 2008) nor others (Coney, 1988) well in the past. Equity is more likely to be achieved when researchers give up power and control over the research process and facilitate collaboration with participants with regard to the research design and its implementation. This involves, among other things, facilitating the equal contribution of each woman and midwife participant, and checking that the transcripts and findings agree with the women's and midwives' interpretations of their stories.

A research partnership acknowledges that research is embedded in the social networks through which ontologies, in the form of interests, preferences, and expectations are configured (Stewart, 2001). Biography and identity shape choices about what is researched and may provide resources that guide the research process. A relational methodology in this midwifery research also involves sharing of accounts and experiences of life events, and in doing so participants share themselves. These biographies are not confined to current events but include past experiences. The sharing of biographies includes the appropriate and relevant aspects of the researcher's biography as this assists in building a relationship, establishes the researcher's credibility, and is part of creating a safe environment.

In midwifery practice continuity is necessary to build a relationship and to work in partnership (Guilliland & Pairman, 1995). Continuity as a means of building a relationship applies to midwifery research and may be facilitated by using a relational methodology. Continuity implies a time commitment for all co-participants, who signal that they would like to be involved in the research from start to finish. Continuity necessitates the researcher being involved from research proposal to publication and carrying out the transcription of participants' talk. In this study continuity was also facilitated through repeat interviews and involvement of the midwife or her back up at the birth. Continuity in the research process ensures a thorough understanding of the data, enables the participants to have continuity in their contributions to the research, and facilitates the building of a relationship.

A partnership that is supported by continuity implies that autonomy is then recognised as relational. Relational autonomy recognises that a person's autonomy is relational, that it is influenced by relationships as well as the wider socio-political environment. This is contrary to the current western idea of autonomy equated with independence and individualism (Sherwin, 1998). In this research relational autonomy recognises the importance of relationships and context on agency and action within research. Building relationships, existing relationship networks, and context were important in designing the research, in recruiting midwives and women to participate, and in carrying out the research in two countries.

Participation

Any partnership requires the participation of all involved in the relationship and this methodology recognizes the human need to take part and interact, as it is through interaction that we learn about and construct the world. In fitting with the woman-midwife relationship in this methodology, the researcher, woman, and midwife are co-participants. The researcher is not the objective other as may be seen in positivistic research (Lincoln & Guba, 2000). Participation also refers to the encouragement and facilitation of co-participants' involvement in the research process, including the research design, as they wish, as it is through participation as partners that knowledge is co-constructed.

Negotiation is a process of discussion to reach a goal or decision agreeable to all parties involved and is an important aspect of participation and partnership in a relational methodology. Negotiation is undertaken, for example, to decide how the research is conducted, what is explored, and when, where, and how the research discussions take place. A type of negotiation is undertaken in the process of recruitment of participants and gaining consent for participation (Kenney, 2009).

Empowerment comes from feeling safe and respected and is an important part of enabling participants to contribute to the research. Empowerment is fostered by encouragement of participation, thus it entails the researcher having skills to nurture that involvement. Empowerment can also come from the act of

participation in the research itself. Part of facilitating empowerment is ensuring participant safety and protection, but it also requires good as well as consistent communication.

Because this methodology takes into consideration relationships in context it requires flexibility and an openness to change. Flexibility allows the research to meet the needs of both researcher and participants. It facilitates participation as flexibility enables change to meet participants' needs. In this research, it enabled the change of the research design and the adaptation to participant context when it came to data collection. Flexibility also extends to openness to ideas when writing.

Protection

A necessary part of any research relationship is that it follows ethical principles. Protection implies the need to shield those who may hold less power in a relationship (Kenney, 2009). In this methodology protection also refers to the need to protect an individual's privacy as well as confidentiality in relation to the information that is shared. In a relational methodology protection refers not only to following ethics guidelines but also protection of the participant-researcher relationship and the ethical principles. Generally, knowledge that is specific to a Māori tribe is kept within the hapū (family) or iwi (tribe) (Tinirau, 2008). Collective ownership of knowledge may mean that some information shared by individual Māori may not be able to be included in the findings from the research. If working with Inuit, First Nations, Métis or Māori people, it will involve discussion of the mechanisms whereby possession of research data can be determined and protected (First Nations Information Governance Centre, 1997; Massey University/Te Kunenga ki Pūrehuroa, 2010). For all participants it is ensuring an understanding of how research data is to be safeguarded, used, and disseminated.

Protection also extends to ensuring spiritual, physical, emotional and cultural safety (Chilisa, 2012; Kenney, 2011). It is the assurance, for the woman and midwife participants, that their opinions and talk will be listened to, respected, and in publication, reflect their meaning. Safety requires that participants' views are

respected even when they may conflict with others. For the researcher, this involves being aware of her own beliefs and values and ensuring that her position as a researcher does not impact the safety of co-participants. This requires creating an environment of interest and respect in which participants feel safe to share their stories and selves (Kenney, 2009).

Ensuring safety in research may be particularly challenging when cultural issues arise during the course of the research. For example, although a piece of research may not target a minority group or indigenous knowledge, there is the chance that cultural issues could arise during discussions with participants who are not members of that cultural community. If, for example, participants speak negatively about a particular cultural group, the researcher needs to be cognisant of how these discourses may impact the targeted cultural group in presenting findings from the research. Safety, therefore, also requires that the researcher seek guidance in situations where participants may have cultural understandings that are different from those of the researcher and/or enact stereotypes in discussion of a minority ethnic group.

Ethics in research and practice entails following principles that ensure the safety and prevent the exploitation of co-participants in the relationship. All research follows ethical codes as laid down by various relevant bodies. The ethical codes followed and read in this research deal with human research in both Canada and New Zealand (Canadian Institutes of Health Research, 2007; Canadian Institutes of Health Research et al., 2005, 2010; Massey University/Te Kunenga ki Pūrehuroa, 2010, 2005). In this research, ethical practice also embraces the requirement of following the other principles of this relational model/methodology. Relational ethics requires going beyond the surface and recognizing and valuing the uniqueness of the individual (Gadow, 1999). Ethics in health care research also implies an obligation to report unsafe practice if disclosed by participants who are health professionals, as well as the courage to challenge unethical research if encountered in the research setting.

Trust is being able to rely on another and relational trust is embedded in relationships. In research that involves a relational methodology, it is more than a trust based on the researcher's knowledge and perceived responsibilities. Trust is the result of a relationship in which participants feel safe to tell their accounts, share their experiences and are assured that their privacy and confidentiality are respected. Trust is revealed in a research relationship when the conversations with the researcher are honest and have integrity (Goldberg, 2008). Trust is engendered when the researcher builds relationships, shares her story with participants (Weber-Pillwax, 2001) and demonstrates adherence to ethical principles that indicate her reliability. In research that uses a relational methodology, trust is imperative; otherwise, trustworthiness of the research cannot be assured.

Communication

Communication is an important principle of this model; without good communication skills and good communication the research cannot be undertaken. In midwifery research, this involves attentive listening, clear questioning, following through participants' talk, and keeping participants not only abreast of the findings but ensuring they have the opportunity to have their say. Communication involves consent and consultation but also extends to sending transcripts and research findings to the participants for further comment, and the dissemination of the findings.

The continued confirmation of participants' consent to participate is a necessary part of communication in health care research. Within a context-driven methodology consent must be freely given but must be able to be freely withdrawn (Smythe & Murray, 2000). Prospective co-participants must be fully informed of the research process, outcomes, time commitments, and any possible risks, when giving consent. Consent is not confined to the signed consent at the beginning of the study but also applies to the approval of individual transcripts and consent to release the transcripts for analysis. Ongoing consensus on or approval of research findings by participants in qualitative research is referred to as process consent (Munhall, 1994). Process consent ensures consent is ongoing even when the

research project has changed. It is important when working with vulnerable people but also with all co-participants (Usher & Arthur, 1998).

Process consent is necessary because in a relational methodology the project is context dependent and subject to change, as demonstrated in this study. To ensure co-participants ongoing safety and protection, consent must also be ongoing especially when unexpected events occur causing a change in plans. Ensuring that co-participants are informed and give ongoing permission also ensures that a relationship of trust is established and maintained. However, when dealing with consent, legal and regulatory requirements that override the right to privacy must be revealed and adhered to. For example, if concerns regarding safety to/of practice arise the researcher is obligated to report an incident to the relevant regulatory body.

An important part of a relational methodology and which came out of this research is the role of consultation in developing the research design. Consultation is part of ensuring equity and participation and takes into consideration the context that influences participants' decision-making. Consultation also involves seeking counsel at times when a situation may be outside the researcher's knowledge, for example, ensuring cultural safety when participants may be from a culture that is different from that of the researcher. Although consultation with midwives in this project began after ethical approval was granted, it may begin during the proposal stage as ideas are shared with colleagues and others with a stake in the research.

The principles underlying the relational methodology developed in this study which reflects the relationships that develop the woman/family-midwife partnership fit with research that involves continuity of care relationships. This methodology acknowledges the embeddedness of researcher and participants in wider socio-political contexts and the sometimes messy undertaking that research of the human condition involves. The following section further explores the theoretical underpinnings of partnership, participation, protection, and relational autonomy introduced in the methodology framework.

Theoretical influences

Social Constructionism

Midwives in New Zealand and Canada, who work in the framework of caseloading practice, develop a relationship with women which can grow over the family's childbearing years. Together the woman/family and midwife build a relationship and knowledge of each other. Using their knowledge, and influenced by the wider social and political environment, they construct an understanding of the childbirth experience that is unique to that family. This knowledge shares understandings that are common to that culture but also to the wider childbirth culture that embraces midwifery and has developed over time, influenced by historical events (Donley, 1998; Weinberg, 2008). Following the midwifery principle of a relationship, research also entails a relationship in which participants and researcher together construct an understanding of the research goal. This understanding takes place within a context that is shared and yet unique to each person.

Social constructionism is a theoretical framework which holds that understandings of the world around us is not a given fact or inevitable but rather constructed by people through available ideas and practices which help them make sense of both the event and themselves (Burr, 1995; Gubrium & Holstein, 2008). Socially constructed understandings are passed on through social interactions and co-operative undertakings between people. Our identity and the things we know are formed and maintained by the social processes, social networks, and discourses in which we are culturally embedded (Berger & Luckmann, 1966; Burr, 1995; Shweder & Miller, 1985), both locally and globally (Massey, 1991). The aim of social constructionism is to make evident the social, political, cultural, moral, and economic institutions, both local and global, that sustain and are sustained by assumptions and understandings (Gergen, 1985; Weinberg, 2008). Identifying these assumptions and understandings opens up avenues for change (Foucault, 1989).

Social constructionists do not deny that individuals make choices and are involved in decision-making; however, our general understanding of choice and how it

happens is constructed from and impacted by the various discourses that exist within our society (Hacking, 1999) and have developed over time. Concern has been expressed that the implication of social constructionism would be that discourses would have more agency than humans, making humans blind followers of rules. Burr (1995) and Granovetter (1985) provide assurance that humans have the capacity for reflection and that the participation in relationships and interaction with social structures can change and shape social processes, and it is this capacity that gives us agency (Berger & Luckmann, 1966).

Participation

Humans are relational beings. In midwifery care, the midwife, the woman, and her family work together in a professional friendship (Pairman, 1998). The midwife as the objective other does not fit with the midwifery value system (Hunter, Berg, Lundgren, Ólafsdóttir, & Kirkham, 2008; Spoel, 2004). The principle of relationality applies also to the midwifery research relationship. A relational methodology recognises that humans seek interaction but also holds that the notion of the objective researcher who carries out research on subjects is misleading. The understanding of participation as it applies to this research comes from two sources, as a part of midwifery practice theory, to be discussed, and from epistemological thought.

The epistemology of participation (Heron & Reason, 1997) embraces the belief that existence is participatory and knowledge comes from the experience of working together as humans. The emphasis on participation has had a resurgence in qualitative research circles as theorists such as (Heron & Reason, 1997) have felt the need to address the absence of a participatory ethos in qualitative methodologies at the time. The recent volume of Denzin and Lincoln's (2011b) *The Sage Handbook of Qualitative Research* contains multiple methodologies that are relational in nature. Similar to social constructionist thought, in the participatory paradigm everyday encounters with the living world are the basis of knowledge and being. The participatory paradigm recognises that constructed reality comes from social and language practices and is layered on top of participatory reality. In

research, participation realises the human desire for interaction and cooperation and is grounded in the everyday world; it realises that human existence is a relationship (Heron & Reason, 1997). In a participatory paradigm the researcher does not stand apart from the participants. The very fact that the researcher exists implies participation; the researcher has an influence and is influenced throughout the research project. A participatory epistemology in research means the researcher is part of the experience and the participants are involved in all aspects of the research project as they wish. Heron and Reason (1997) use action research as a vehicle for expression of this paradigm.

In this relational methodology it is the underlying principles of the researcher being a part of the research, not the objective other who carries out research on human interactions and behaviours, which is of importance. In a relational methodology the researcher encourages and facilitates participation in the research and is an integral part of the research. The woman and midwife not only share knowledge with me about the pregnancy experience but I share relevant knowledge about my experience and we are influenced by each other. Like action research, participation means consultation with potential participants in refining the research design.

New Zealand's Te Tiriti O Waitangi¹⁰, the founding document between the Crown and Maori, holds participation as a key principle. Moreover, participation is one of the principles of health legislation for New Zealand (Kenney, 2011). Community participation in health care policy and decision-making has also been fostered in Canada for some time and by the World Health Organization (WHO) (LaLonde, 1974; World Health Organisation, 1978), although with variable success both worldwide and in Canada (Chan, 2008; Mitton, Smith, Peacock, Evoy, & Abelson, 2009).

¹⁰ Te Tiriti O Waitangi- is New Zealand's founding document. It is an agreement between the Crown and Māori which lays down the principles of the political compact between the crown and Māori. It includes the tenets of partnership, participation and protection. (Ministry of Culture and Heritage, 2012)

Inherent in participation on a more personal level is partnership. Each person is encouraged and supported to work together as equals. Partnership cannot work without participation (Fox, 2000) and participation requires more than lip service; participation requires partnership. Midwifery models in New Zealand and Canada endorse partnership as a means of acknowledging the value, autonomy, and equality of all involved in the relationship (College of Midwives of Ontario, 1994f; Guilliland & Pairman, 1995). Within this relational methodology partnership is a key theme.

Partnership and Research

Partnership plays an important part in midwifery in both Canada and New Zealand. Its implication is that the woman, her family, and midwives work together in the relationship to achieve an outcome that is desired by the family as well as by the midwife. In its ideal, partnership is about working together as equals, each partner contributing unique knowledge and experience to the relationship, where power may fluctuate between participants but where there is an understanding that the childbirth and research experience is the woman's, and care is focused on her family's needs and wishes. In the current study, relationships built on partnership occurred when the knowledge of the participants was respected and equal weight given to their views/meanings as to my own. The expectations of the participants, which was to have their voices heard, and my own goal of understanding the influences on decision-making during their birth experiences were met.

An underlying principle of partnership is treating participants with respect, and this resulted in involvement of both midwife and woman together in the research dialogues. Partnership in this research also entailed participants being involved to the degree they wished and ensuring that the participants could include a support person in the research interactions, if they desired.

Partnership has been developed into a model for midwifery practice in New Zealand (Guilliland & Pairman, 1994, 1995), and although the model has not been

adopted by international midwifery professional organisations, the term *partnership* has been adopted internationally (Association of Ontario Midwives, nd-a; International Confederation of Midwives, 2005). *The Midwifery Partnership* (Guilliland & Pairman, 1994, 1995) a model for practice in New Zealand, provides a framework for the working relationship between woman and midwife. One of the philosophical underpinnings of the model is women-centred care. Its principles include negotiation, equity and empowerment, and informed choice and consent (Guilliland & Pairman, 1994, 1995). The methodology developed for this thesis draws upon the principles of partnership from New Zealand midwifery philosophy and practice. As such, the concepts of participant-centredness, consent, negotiation, equity, and empowerment are foundational to the relational methodology developed for midwifery research.

The International Confederation of Midwives (ICM) adopted partnership as a key principle in 1993 (Guilliland & Pairman, 1995) and continues to support partnership in its philosophical statement (International Confederation of Midwives, 2005). The Canadian Association of Midwives (CAM) also has partnership within its statement of values and beliefs (Canadian Association of Midwives/Association Canadienne des Sages-Femmes, 2009). Partnership between woman and midwife is part of the philosophy statement of the College of Midwives of Ontario (CMO) (College of Midwives of Ontario, 1994f). The International Confederation of Midwives, CAM and CMO documentation does not explicate the term partnership, possibly because leaving it open enables a dynamic and individual interpretation as is relevant to the context. However, woman centeredness, family centred care, and working together are part of the Canadian midwives' philosophy (Canadian Association of Midwives/Association Canadienne des Sages-Femmes, 2009). The lack of a full description of partnership in jurisdictions outside New Zealand may also be due to the fact that the partnership model is unique to New Zealand, so it may not be applicable to an international setting or reflect the woman-midwife relationship that exists in other countries. In New Zealand, the partnership model of practice developed during a time of discontent with the existing maternity system, at a point in history of socio-political change, and was influenced by Te Tiriti O Waitangi.

The Midwifery Partnership Model for Practice was developed by two New Zealand midwives, Guilliland and Pairman. The model was influenced by the women's movement of the 1970s and 1980s, the resistance of women and midwives to the medicalisation of childbirth, and the ensuing political action to regain autonomy for midwives and birthing women in New Zealand (Donley, 1998). It was further influenced by health care consumer surveys (Guilliland & Pairman, 1995). The socio-political and cultural context in New Zealand at the time also had a major impact on moving forward the principle of partnership (Skinner, 1999), with a Labour government in power and a female minister of health. There is also talk within the profession that a midwife involved in the movement used social networks, in which the then minister of health was a member, to further the goal of midwives.

Alongside women centeredness, continuity of care is a philosophical principle of the model (Guilliland & Pairman, 1995; Surtees, 2004) and is supported by Canadian Midwifery (Canadian Association of Midwives/Association Canadienne des Sages-Femmes, 2009). Continuity within practice or research enables a relationship to develop, thus facilitating the building of trust and empowerment, which leads to openness and sharing of information. Partnership has been embraced by the midwifery professional and regulatory bodies in New Zealand in both the professional standards for practice (New Zealand College of Midwives, 2007) and in the competencies for entry to the register for midwives (Midwifery Council of New Zealand, 2004). Although the model has become part of the identity of New Zealand midwifery (Kenney, 2011), there have been concerns expressed.

The New Zealand Midwifery Partnership model has been criticized as being un-researched (Lauchland, 1996), idealised and not working for all women, apart from those who are white and middle class (Kenney, 2009; Skinner, 1999). Both Kenney (2009, 2011) and Fox (2000) claim it does not work for Māori women and midwives. Fox (2000) attributes this to the fact that two of the principles of Te Tiriti O Waitangi, participation and protection, are excluded from the partnership model.

The model has been described as being Euro-centric, not paying service to Māori values and, therefore, not fitting within the Māori worldview of childbearing and partnership (Kenney, 2009, 2011). This may account for concerns expressed by Skinner (1999) who found that working in partnership with Māori women during the childbearing year was a challenge.

In the original documents discussing the model (Guilliland & Pairman, 1994, 1995), when referring to the woman, the baby and family/whanau are included. The contention was that the woman was the one determining who was to be involved in the relationship. Despite the inclusion of the need to recognize Māori as Tangata Whenua¹¹ in the competencies, the inclusive family/whanau statement is currently confined to a footnote in the legal competencies for entry to the register for midwives (Kenney, 2009; Midwifery Council of New Zealand, 2004). Most documentation from the profession talks only of the relationship between woman and midwife (Kenney, 2009, 2011). The individualized focus on the woman does not take into account the family and the embeddedness of women in immediate and wider social, cultural, and political contexts which impact the relationship. The women who developed the model were white, middle class, and there is no evidence that consultation with Māori was undertaken, nor does the model acknowledge or represent Māori values and understandings (Kenney, 2011). The model does, however, have some sound underlying principles, as outlined, and it is these principles that are embraced in the relational methodology.

Despite some well-founded concerns with the Midwifery Partnership model as discussed, its supporters contend that the concept of partnership can be open to interpretation (Daellenbach, 1999), while Benn (1999) sees it as an ideal to work toward that came at a time when the profession was struggling to be heard. The underlying principles of the model, especially if the values of protection and participation are considered along with Kenney's (2009, 2010) recommendation of

¹¹ Tangata Whenua is the Māori term for People of the Land, the aboriginal people of New Zealand.

a more contextually driven and thus more culturally appropriate model, are of value. Kenney developed a bicultural research model, Te Whakamāramatanga, which she suggests could be adapted to an international setting and could represent the woman/family-midwife relationship (Kenney, 2009). In the Te Whakamāramatanga model, Kenney contends that models of midwifery care and research should be contextually driven, involving consultation and taking on principles that encourage participation and protection as well as those principles that are relevant to the society and relationship in which it is used.

A contextually driven partnership in both midwifery practice and midwifery research requires consultation with participants to ensure the design is understood and meets participant's requirements. It also requires flexibility so that the participant's context is considered. In the current study partnership and flexibility are evident in the researcher's willingness to change design after consultation but also in the changes in data collection techniques, given circumstances as outlined in Chapter Three. A research partnership requires a flow of information between those involved, necessitating good communication skills on the part of the researcher. The researcher requires listening as well as questioning skills, so participants can be empowered to share their experiences. Partnership in research involves the facilitation of autonomy in all parties and realizing that that autonomy is relational. As Sherwin (1998, 2004) suggests, this requires support that fosters autonomous action because not all individuals have the skill or experience to act autonomously (Sherwin, 1998, 2004). The facilitation of participation is also an important aspect of any partnership, as it acknowledges that the research belongs to all involved. Partnership depends on continuity and allows the researcher to gain deeper engagement with the participants' contributions. These principles of a research partnership are contextually driven; this context includes the social as well as the political and economic environments.

Embeddedness and Research

Midwives and women are part of a complexity of social networks which impact their choices and actions. These networks also apply to researchers and range from

the political and economic to the intimate relations with partners, friends, and others. In this research my embeddedness in midwifery social networks played a significant role in participant recruitment and construction of the final research design as it was through ties with other midwives and midwifery networks that recruitment occurred in New Zealand and Ontario. It was also through these midwifery networks that consultation occurred, which resulted in changes to the research design. Moreover, embeddedness and social ties shaped the conceptual lens through which the participants' talk was analysed.

Embeddedness refers to the extent to which institutions and individuals are immersed in social networks (Granovetter, 1973, 1985) and how these networks influence behaviours and decision-making (Callon, 1999; Granovetter, 1985). Granovetter uses theories of embeddedness to critique the workings of decision-making in neoliberal economic markets, in which actors are portrayed as either overly controlled by social rules and their desire to fit within those rules or are totally removed from those social ties in their dealings as they are only interested in maximizing their self-interest. In either situation both groups of actors make decisions without reference to the social relationships and/or contexts in which they are embedded. Granovetter points out that human actions are firmly immersed in "ongoing systems of social relations" (Granovetter, 1985, p. 487). It is this aspect, the immersion of women and midwives in a complex network of political, historical, and social relationships that sees choices as entangled (Callon, 1999). Granovetter first introduced his theories on relationships in his discussion of dyadic ties or friendship networks of two individuals (Granovetter, 1973). In his 1973 work, he discusses the advantage of working with social networks because it is through these expanded social networks that information, influence and opportunity flows. Granovetter's theories on embeddedness are consistent with Sherwin's discussion of relational autonomy.

Relationality and Research

Relationality, which calls into question more traditional views of autonomy, and the researcher-participant relationship, and embeddedness are interconnected.

Relationality came to play in this research in the recruitment of midwives to participate in the study, and relationality, like embeddedness, influenced the lens through which the voices of women and midwives were analysed. Granovetter's idea of embeddedness is aligned with relationality (Bergum, 2013; Bergum & Dossetor, 2005; Gadow, 1999; Sherwin, 1998, 2004). Relationality deals with both the personal networks and relationships of ethical practice (Bergum, 2013; Bergum & Dossetor, 2005; Gadow, 1999) as well as wider social, political, and institutional relationships and their impact on autonomy (Sherwin, 1998, 2004). In health care, relationality goes beyond the more traditional ethical principles of duty or utilitarianism and acknowledges that humanity is needed in day to day work. Relational ethics deals with the one to one interaction that happens between people. It is when the health professional is "present" to the woman and in the moment (Beaudry, 1996). It also refers to the everyday relationships in which we are embedded that influences who we are and what we do (Mishler, 1999; Phibbs, 2008). In feminist social literature, Sherwin (1998) speaks of relational autonomy as an ethical stance that recognizes that individuals are influenced by the socio-political networks in which they are embedded and that these networks influence decision-making. In other words, people do not make decisions removed from the influences of family, culture, and the wider socio-political, economic environment (Bergum & Dossetor, 2005; Granovetter, 1985; Sherwin, 1998). Bergum and Dossetor (2005), in fact, argue that our autonomy is lived only in relation to others and Sherwin would add also in relation to the wider cultural, socio-political, and economic environments.

It was relationships with midwives that enabled recruitment in New Zealand and through the building of relationships recruitment occurred in Ontario. Also, due to relationships, networking with other professionals and friends led to consultation about and alteration of the research design. After receiving ethical approval for the research, I began participant recruitment in New Zealand via a number of methods, including attendance at professional meetings. It was at these regional meetings that reasons for midwives deciding not to participate were raised. The reasons were related to concerns about confidentiality, instances where discussion

regarding third stage happened earlier than the planned recorded discussion, and research burnout. There had been a number of research projects in the region and the midwives felt over researched. I acknowledged these concerns, addressed the issues and thanked the midwives for their attention. This challenge demonstrated how researchers need to take into consideration potential participants' decision-making in relation to events that impact their ability or desire to take part in research. It also makes evident the need for flexibility and a willingness to adapt research plans. A request for change in location of the research and the eventual use of professional networks resulted in recruitment of midwives into the study as well as consultation about and change to the design. In Canada, recruitment was also facilitated through professional networks, via a shared membership of a midwifery association and through building relationships with other midwives.

The role of relationality was important in this research in that I, as the researcher, was not removed from the participants or from participation in the data collection. By having a common ground and by being known to the participants, I was able to establish a comfortable relationship with them, a relationship in which the women and midwives felt safe to have discussions in which they shared their stories. In research, relationality goes beyond the traditional positivist practice of the researcher being "objective" and acknowledges that there is a relationship with the participants. By being present I was participating in the research relationship, and it was because of relationships I was able to carry out the research.

Relationality is also applied to this research in the way that I was mindful of the wider influences on the midwives and women and their ability to participate. The wider influences on this research were realised when the research design was reviewed in response to women's and midwives' comments about time commitment and by accommodating participants' wishes for time and venue of "interview" sessions.

Identity and Positioning

It is within relationships that ideas of ourselves and others are developed. Analysis of the women's and midwives' talk was influenced by the concepts of identity and positioning. Identity and positioning are relational concepts as both only have meaning through interaction with others (Mishler, 1999; Somers, 1994). Identity is any source of action that cannot be attributed to biophysical expressions and which has stability or continuity that observers recognise and can attach meaning to (White, 1992). For example, a person may have an identity as a particular kind of midwife or as a researcher, based on her actions, and talk. Positioning is defined through speaking, writing, and carrying out rights, duties, and obligations, but it is also the expectations of others of how those rights, duties, and obligations will be exercised (Davies & Harré, 1990; van Langenhove & Harré, 1999). Positioning is what people do through various discursive practices, including talk, to locate themselves and others as certain kinds of people, depending on context. Positioning can take the form of aligning oneself with another or, alternatively, contrasting oneself to another (Mishler, 1999).

Individuals can have various identities, such as sister, daughter, midwife, student, researcher, and teacher, and within those can be recognised a particular type of midwife or teacher (Mishler, 1999; Somers, 1994). Identity is context driven, meaning the identity assumed by an individual is appropriate for the context (Phibbs, 2001; Plummer, 1995) and is constructed from the various available discourses or narratives in the public domain (Phibbs, 2008; Somers, 1992, 1994). Organisations, professions, and groups also have identities, and these identities are bound up with the social environment in which they are embedded (White, 1992). Identity directs actions and decisions, which suggests that actions and decisions would be congruent with identity.

Viewing identity as narratively created (Somers, 1994) reflects the relational and dynamic aspects of identity (Phibbs, 2001). Narrativity encompasses time, space, and relationality, allowing for the shaping and reshaping of identity in action and in

response to not only discourse but location (Somers, 1994; Phibbs, 2001, 2008; Plummer, 1995). Narratives also reflect relationality in the telling of experiences that involve others and in the way that a narrative gains meaning in its transmission, as it is interpreted by the listener or reader.

A woman's identity is shaped and reshaped when she becomes pregnant, through discourses of pregnancy as well as by the physicality of pregnancy and the relationships encountered. The identities of both the midwife and woman shift and are shaped by the events and circumstances of that childbearing experience and their wider experiences. As a result, narratives can be studied for what they reveal about identity and their embeddedness in social networks (Phibbs, 2008). As an illustration, I, the researcher, have a particular identity of myself as a researcher, which I have constructed from the various ideas available in the general, as well as the research, community and my social and academic networks and history. My actions with regard to the research I carry out are directed by and consistent with my identity as a researcher. In this research project, potential participants may identify me as a researcher and/or a midwife, particularly in the research region of New Zealand where I have worked. As this research progressed, my ideas of myself as a researcher changed and developed. Moreover, my identity is context driven. During the carrying out of, reporting on, and talking about my research to colleagues and family, I am a researcher, sometimes a research student, and always a midwife. However, at my place of employment, I am a midwife-nurse educator. When I talk about my research I am narratively creating my identity of myself as a midwife researcher. This example of identity applies to all researchers, who will be embedded in their particular context, research community, and genre. Various practices undertaken by researchers, position them in a particular way. Actions I undertake, such as talking about my research, publication, and presentation of my research, position me as a midwife researcher. Those I present to and who read my work begin to identify and position me as a midwife researcher. If I am positioned as a competent researcher, that provides me certain rights afforded to that position (Harré & van Langenhove, 1999).

Positioning and identity enable narratives and other discursive practices to be explored within those relational networks (Phibbs, 2001). Identity and positioning of selves and others as identified in the participants' talk and how that influences decision-making in the woman-midwife relationship are presented in the findings from the analysis of the data collected for this project. Positioning and identity construction align well with Foucault's notions of power and resistance.

Power-knowledge-discourse

Foucault's theories dealt with power and knowledge and how groups and individuals came to be positioned as they were and afforded the privileges that they had (Fahy, 2002; Rouse, 2005). Midwives and women work within a health care system, in both Canada and New Zealand, in which the discourse of medicine is dominant. Pregnancy is constructed as risky, and women, midwives, and the maternity system are influenced by that discourse. However, through various discursive practices around midwifery care, New Zealand midwives have positioned themselves and have been positioned as major players in maternity care. As a result, the majority of families in New Zealand will now have a midwife as the Lead Maternity Carer or a midwife involved in their care at some stage. In Canada, midwives are gaining voice as provincially, territorially, and nationally women and midwives campaign for access and choice (www.canadianmidwives.org; www.born-pei.ca; www.yffm.ca) by positioning themselves and being positioned in ways that will raise the profile of midwifery care. Aspects of the analysis in this thesis drew on Foucault's theories of disciplinary power, resistance, and knowledge.

Michel Foucault's work was diverse, dealing with, among other things, a history of discourse, the development of a genealogy of power relations and the different ways that people are constructed or constituted as objects of power (Miller, 2008a). Foucault's thoughts on power and knowledge developed over the years of his work. In the examination of the various disciplines, such as medicine and psychiatry, his goal was to offer alternative views to the traditional understandings of power and knowledge, thus enabling avenues for change (Gutting, 2005; Martin, 1988). For Foucault, power is equated with influence rather than force (Foucault,

1980). He suggests that power is transmitted through social networks and is co-created by those in power and those who resist (Rouse, 2005), rather than being held within an organisation or institution (Foucault, 1973, 1977, 1989, 1990). In his early writing Foucault postulates knowledge, and thus power, is contingent on economic, social, and political conditions prevalent at the time. Hence, the accepted truth (the dominant discourse) is historically situated (Kenney, 2009). In the case of medicine, the introduction of medical technologies, coupled with the need to control citizens (Miller, 2008a), allowed medicine, in the 1800s to develop a “scientifically structured discourse about an individual” (Foucault, 1973, p. xiv); people became knowable. Having the public accept the knowledge claims of a discipline increases the power of the discipline (Fahy, 2008). This power enables the acquisition of knowledge. Therefore, the two are intimately linked, which is why Foucault referred to the concept as Power/Knowledge (Foucault, 1980, 1982). Foucault’s analysis of the power of the dominant discourse is further elaborated through concepts of disciplinary power (Foucault, 1973) and bio-power, in which he created a distinction between administrative power and technologies of the self (Foucault, 1990).

Foucault distinguishes disciplinary power from legal power in terms of the technologies it enacts to control its citizens and maintain its position. Legal power is visible having laws, power of arrest and imprisonments, for example. Disciplinary power does not become visible unless there is resistance (Foucault, 1982). Disciplinary power is found in professional disciplines and within the institutions in which they practice. It can operate alongside legal power and may also undermine it (Fahy, 2002). Disciplinary power includes the administrative state which deploys record keeping as a form of control that is enacted through technologies of power such as hierarchical observation, setting normalised standards, and examination/inspection (Ells, 2003; Miller, 2008a). When judged to be outside of normal standards that are established through record keeping, ‘patients’ are subject to medical interventions in order to normalise them. Disciplinary power includes what Foucault referred to as the ‘gaze’(Foucault, 1979). It is through the medical ‘gaze,’ that doctors gain knowledge (Fahy, 2002). The acceptance of

dominant discourses and the 'gaze' results in people taking on 'technologies of the self,' practices of self-surveillance that ensure they "attain a state of certain happiness, purity, wisdom, perfection or immortality" (Foucault, 1988, p. 18) and meet socially accepted standards that are associated with dominant discourses of the milieu in which they are embedded.

There are various discourses around any idea; the dominant discourse, the one that has power, is the one which has wide acceptance as the truth (Burr, 1995; Sawicki, 1991). Positioning by self and others gives those within the dominant discourse the most social power (Kenney, 2009). Fahy reminds us that power is associated with sets of understandings about what is valued within society, and thus it is society, via its representatives, that determines which knowledge will be accepted (2002). A current dominant discourse around decision-making is one of rationality, objectivity, and individualism (Ells, 2003). In maternity care it is the discourse of obstetrics (Downe & McCourt, 2004; Fahy, 2002).

A main concern with Foucault's discussions of discourse and power is that discourse appears to have power over the construction of identity since identity is constructed through available discourses (Burr, 1995; Miller, 2008a); therefore, autonomy is limited. However, others point out that Foucault also indicated that where there is power there is resistance because power cannot exist without resistance (Foucault, 1977; Rouse, 2005; Twigg, 2004, 2007). As well, enlightened and progressive discourse can be just as much an expression of power as repressive discourse (Twigg, 2004). Foucault himself, in his discussions of power and resistance, indicates that knowledge can open ways to resist, as those with less power can use available discourse to challenge the status quo (Foucault, 1989). For example, in her work with aging adults, Twigg found that the older adults in community care used social technologies and clothing to resist current discourses about the aged (2007).

Evidence of resistance extends to other groups. In the histories of midwifery of both New Zealand and Ontario women and midwives used discourses of choice and

autonomy, dominant in the neoliberal discourse at the time (Miller, 2008a), in their resistance to the medical dominance of childbirth. Resistance is an effect of power relations and can take many forms. Aspects of Foucault's power/resistance knowledge discourse and the influence on decision-making were used in the analysis of the accounts of women and midwives for this study. The notions of disciplinary power and resistance also came into play in the analysis of the influences on local and national midwifery organisations and their use of social networking, including the internet, to gain a foothold in the health scene, particularly in Canada.

Reflective Conversations/Interviews

The tools for data collection and analysis used in this research fit with the nature of midwifery, the theoretical beliefs of the researcher, as well as with the goals of the research. To that end, reflective conversations/interviews were chosen to encourage participation and the consideration of the influences on decision-making. This study takes the stance that the dialogues invoked by this research are conversations. Conversations imply reciprocity and interest. Women and midwives, and midwives themselves, undertake conversations to learn about each other, to reflect on and make sense of events and learn from practice. In the current study, dialogues among participants are reflective conversations in which participants use the discussion to exchange information, tell stories of their childbirth experiences, talk about their beliefs and choices during the childbirth experience, and reflect on those events and the focal points of the study. I am not only a participant in this methodology but a facilitator of the other participants' reflections and, along with the woman and midwife, a co-constructor of the research narratives.

Rom Harré contends that, "The fundamental human reality is a conversation," (1984, p. 20). Conversations are an integral part of everyday life. In conversation we relay ideas and tell stories. Conversation is a purposeful, directional, and thoughtful exchange among two or more people; in past studies it has been used as occasion

for informative and transformative processes (Augstein & Thomas, 1975; Candy, Harri-Augstein, & Thomas, 1985; Feldman, 1995, 1999a; Harri-Augstein & Thomas, 1991; Hollingsworth, 1992). Reflection is a process of thoughtfully examining an event, its content and process, in order to learn from or understand and make sense of that event (Dewey, 1933; Schön, 1987). Part of reflection is oral and or written recounting of events, the narrative (Somers, 1994). Reflective conversations are used as a women-centred way to assist the midwife to reflect on and learning from her practice (New Zealand College of Midwives, 2007). In midwifery practice in Ontario peer review, which entails reflection on practice with colleagues, is a requirement of continuing practice (College of Midwives of Ontario, 1999). In midwifery education students are encouraged to reflect on their learning and practice. Researchers and educators have introduced conversation as a participatory method where purposeful discussions and reflection develops new understandings and as a means of professional and personal development (Feldman, 1995, 1999a; Hollingsworth, 1992). The concept of conversations as sites for the co-construction of narratives carries with it the implication that humans are social beings. Reflective conversations were used in this study. Those conversations were analysed for influences on decision-making.

Method of Analysis

In fitting with the relational nature of this study and methodology, a method of analysis that could identify the various influences on decision-making, while being flexible and enabling analysis of all parts of the conversations, was needed. Analysis of the data involved exploration of themes.

For a developing methodology, such as this one, thematic analysis offers an accessible form of analysis as it is not embedded in a particular framework but can work across different theoretical frameworks (Braun & Clarke, 2006). It allows flexibility in use that more prescribed methods of analysis do not (Braun & Clarke, 2006). Thematic analysis enables examination of the ways in which the various research concepts of embeddedness, relationality, identity, positioning, power,

location and context, influence decision-making. Thematic analysis has been used in two ways in this research. First, the dialogues and the discussion and talk as a whole, were analysed for what they say about the participants' identity and place in society. Second, the dialogues were analysed for themes related to influences on decision-making.

The use of thematic analysis of the talk is fitting for this methodology because our lives are lived through stories, our talk; this is a natural part of being human (Frank, 2010b). In this research talk covers all dialogue including the accounts or narratives of events. As such, talk and narratives are ways of making sense of and giving meaning to events in our lives and are a way of dealing with unplanned occurrences (Frank, 1998; Polkinghorne, 1988). Narratives give form to everyday events and link these to time and action (Polkinghorne, 1988). The term narrative has many meanings from any oral or written presentation (Brockmeier & Harré, 1997; Polkinghorne, 1988) to literary forms that follow linguistic form and rules. For the purpose of this research, narratives are the accounts of events that participants give in order to explain and reflect on those events. Narratives and talk can be used not only to tell a story but can be analysed for what that story says about the individual within society (Frank, 2006; Mishler, 1999; Somers, 1992, 1994) and explored for the narrative's effect on society (Plummer, 1995). Our talk and stories have different meanings to different people (Frank, 2006) so can be interpreted by the listener from their particular viewpoint (Frank, 2010b; King, 2003).

Conclusion

This chapter has set out the principles for an evolving relational methodology/model and outlined the theoretical underpinnings for each of the tenets within the model. Epistemological and theoretical ideas coming from various western paradigms are blended to create a whole. Philosophical frameworks from midwifery were explored and relevant aspects incorporated into the methodology. A range of theoretical approaches was used in both data collection and analysis of the participants' talk, including conversation as a method. Concepts from theories

of identity, positioning, embeddedness, power/knowledge, and relationality have been discussed in relation to the research partnership and the methodology. Thematic analysis of talk and other dialogue used within the thesis such as email correspondence have been presented. The following chapter discusses the findings as they relate to the interpersonal influences on decision-making, in which identity plays an important role.

Chapter 5: Relationships and Decision-Making

...decisions around childbearing form part of a tapestry that weaves together the temporalities of a woman's past, present and future as well as her relationships with others. (Douché, 2007, p. 161)

Introduction

The previous chapters have outlined the background and justification for this study, highlighting the concerns with some of the theoretical models of decision-making seen in health care today and how these can impact women's choices during the childbearing years. Chapter Three described methods used for data collection and analysis that led to the methodology which developed from the research process and was discussed in Chapter Four. This chapter will discuss the themes identified from one aspect of the study, that of how decision-making is influenced by participants' embeddedness in relationships and how this contributes to women's and midwives' identities and to the choice of midwife or midwifery. All these factors influence decision-making in the woman-midwife partnership.

Embeddedness and Relationality

In this chapter relationality refers to personal relationships and how they influence decision-making. How decisions are made in relation to more intimate social relationships, whether that is with family and friends or a meaningful relationship with the midwife is explored. Granovetter, in his early work (1978), talks about how an individual's actions are influenced by social networks and the importance of those social connections, however strong, in disseminating information and influence. The strength of that tie is dependent on the length of time, the intimacy, and the reciprocal service that characterizes the tie. He suggests these micro level interactions influence wider macro level phenomena. This aspect of network analysis is connected to his later idea of embeddedness (1985), a social theory that

sees humans as social beings immersed in social networks, in relationships. In this chapter Granovetter's theories of social ties, the embeddedness of people in these social networks and their influence on decision-making, are used to demonstrate that the woman-midwife relationship is more than an objective exchange of service for recompense (Callon, 1999) where decisions are made based on the calculation of risk and benefit (Callon, 1999; Granovetter, 1985). Rather, the remarks and talk of the women and midwives in this study demonstrate that decision-making is not an individualistic undertaking. It is very much influenced by the women's and midwives' embeddedness in social networks and relationships.

The talk of the women and midwives in this research showed that there is a complex mix of factors which influence decision-making and that the current models of decision-making do not reflect this complexity. More significantly, these models do not reflect the relational influences on decision-making. Themes identified in the research suggest that the initial choice of midwife, the influence of family and friends as well as beliefs, values, past experiences, and cultural values have a strong influence on choice and decision-making for women and midwives.

Participants' choice of midwife was shaped by the degree of ontological fit between the midwife's philosophy of practice and the woman's desires around her childbirth experience or a fit between the woman's beliefs and desires for her pregnancy and what midwifery is seen to offer. Postnatal interviews with participants identified that the contingent nature of childbirth introduced vulnerability among some participants, creating a need for increased trust between the midwife, birthing woman, and her family. The following sections consider the influence of family, friends, past experience, and philosophy of childbirth on the choice of midwife. Although some themes are dealt with separately, the influences themselves form a complex network, where women and midwives' talk illustrates a number of themes.

Ontological and philosophical influences on decision-making

Congruency between ontology¹² and practice philosophy influenced the choice of midwife for the women interviewed in New Zealand and Ontario, and this shaped subsequent decision-making within the midwife-woman relationship. Both midwife and client come to the relationship with concepts of themselves and each other as part of a profession and wider social network (Beaudry, 1996; Douché, 2007) which directs action. Granovetter (1985) contends that decision-making is firmly immersed in those ongoing and dynamic social relationships.

Findings from the current study of decision-making between the woman and midwife indicate that women tend to choose their midwife based on the degree of fit between the midwife's philosophy of practice and the women's beliefs about and desires around her childbirth experience. The women felt the midwife would support them in the choices that they would make. Women interviewed for this project came to the relationship with ideas and beliefs about what they wanted in a midwife as well as knowledge about the midwife's way of practice. At the beginning of the discussion with the midwife regarding the birth of the placenta, four of the eight women in New Zealand indicated they wanted natural or normal birth of the placenta, a term used by a number of the women and which, in the following discussion with the midwife, was interpreted as physiological birth of the placenta. During the ensuing discussion between woman and midwife, three others indicated a choice for natural birth while one chose to wait and see, as suggested by the midwife. In Ontario two of the six women chose a physiological third stage of labour after the discussion with the midwife, while one woman opted to discuss it further with her husband and to see what she learned in antenatal classes, but she indicated a preference for a physiological third stage. Three of the six women chose active management after the recommendation of the midwife, based on their clinical history. Of these three, one chose to adapt the standard procedure by

¹²Ontology is the essential nature of a being in the form of identities, interests, preferences, expectations, and philosophy and its ties to other beings.

delaying cord clamping and cutting until it had stopped pulsing and ensuring skin to skin contact with the baby. In the preceding discussion about active management the midwife had talked about it in reference to how an obstetrician would do it, which included baby on the bed and immediate clamping and cutting of the cord. Most of the women in this study indicated their preference for natural birth of the placenta or as natural as possible, indicating a more natural belief/desire about birth. In the following section, decision-making around birth of the placenta is discussed first in relation to the New Zealand interviews and then in relation to Ontario.

New Zealand

When New Zealand midwife Cindy asked Jane what she wanted with regard to birth of the placenta, the following conversation ensued:

Jane: The normal way.

Cindy, confirming: The normal way, OK?

Jane: I've done it twice the normal way.

Cindy: The normal way. Now, which is the normal way for you?

Jane: Giving birth to it.

Cindy: OK, just letting it come out actually by itself?

Jane: If there is trouble look at it then but....

Jane's request, at the beginning of the conversation, for normal birth of the placenta indicates her leaning toward natural birth. She had come to this midwife with that expectation.

Cindy goes on to explain both methods, starting with physiological birth of the placenta. Cindy's preference for physiological birth of the placenta may be identified in the language used to introduce the topic in her conversation with Jane. "So physiological is when, what happens is the baby is taken up and basically put on your chest, and you're happy with skin to skin care?" Jane replied in the affirmative and Cindy continued, "Yeah, so that's really nice for the bonding and you know the baby just loves it as well."

The language used suggests that, for Cindy, physiological birth of the placenta is more 'relational' and baby centred than active management. Linguistic cues that indicate Jane is happy with skin to skin care implicitly provided Cindy with permission to continue with information about her usual way of practice. Cindy says:

Now what I usually do, usually is if you want to do physiological, that's the natural way, which I can't see why you wouldn't do. Personally, myself, if you had a lovely beautiful birth and why would you actually then um...[use active management].

For Cindy, active management is unnatural and inconsistent with her ideas about what constitutes 'a lovely beautiful birth'.

Conversation with Mania also revealed her leaning toward natural birth. Mania wanted a Māori midwife but could not find one in the region in which she lived. She explained, "I knew June specialized in water birth and acupuncture and so that was that." The researcher asked, "So you knew she had a natural [philosophy]?" Mania replied, "sort of alternative approach, yeah, so that is what [I wanted], yeah.

June, when asked what she told women about her practice, replied:

I general[ly], I don't dwell on that [her acupuncture practice] 'cause generally in [the] first meeting there's so much to get through. But I do usually basically say that I'm a non interventionalist rather than, you know, focusing particularly on alternatives or particular modes of birth or anything. I just sort of, I really emphasize that I, unless I see a reason to interfere, I don't interfere. Because I see pregnancy as normal and natural and your baby is, your body has made this baby and your body is gonna be able to birth this baby. And so really it's just making the point that I don't interfere unless absolutely needed; which is how I try to keep it.

Use of acupuncture and water birth indicated to Mania that June had a practice philosophy that complemented the holistic Māori world view and hence is stated as a key reason for Mania's choice of midwife. In her statement about her midwifery

philosophy, June positions herself as a natural midwife, confirming Mania's initial impression of June's practice.

The talk of participants suggests that both women and midwives are accepted on the basis of the philosophical fit between the midwife and woman. The information provided by the midwives indicated their beliefs around birth, and some indicated that if their approach did not meet with the woman's needs, the woman was free to choose another midwife. Cindy clearly indicated her philosophy, when talking about the influences on her practice:

When I first meet people I tell them I am quite a holistic midwife... I'm into natural birth. If you think you're one of these persons that come in and want an epidural within two minutes of you actually going into labour, then I'm probably not the best midwife for you.

Helen identified her philosophy around birth when she said that she knew that midwife Candice did homebirths and hospital births. Helen's choice of a natural birth of the placenta also indicated her philosophy. In the community, Candice and the practice she works with are identified as a group that supports natural birth. When asked about what she tells women about her midwifery practice, Candice talked about informing them that she worked in the local hospital and elsewhere. She also tells women about the midwifery group she works with and said, "...our little brochure indicates we try and encourage birthing naturally without unnecessary interventions."

Most of the women who participated in the study in New Zealand chose a midwife based on local knowledge in the public domain about the midwife's practice philosophy of pregnancy and birth.

Kate had found out about the midwifery group and midwife Fran via the group's website. The group has a long history in the region and is known for their support of natural birth, they do home as well as hospital births. The philosophy on the

group's website clearly indicates this and that they support physiological birth and the judicious use of intervention.

Most of the women who participated in the New Zealand part of the study chose a midwife they identified as a natural midwife. The midwife, by identifying her philosophy either on the website, as with Fran, or through networks in the community, signalled to the women that their beliefs around childbirth coincided.

Ontario

In Ontario, where midwifery care is the exception, the reason for woman choosing a midwife differs from the reasons for women in New Zealand. The congruence between women's wishes around childbirth and the midwives' philosophy also became apparent in the conversations with the women participants in Ontario. Women in Ontario did not specifically indicate that wanting a natural birth was an objective; however, their discussions with the midwife and with me indicated a natural view of birth. All of the woman participants in Ontario chose midwifery care because they equated midwives with giving choice and offering continuity.

For Gail, choice entailed having the option of a homebirth. She had all her three babies with midwife Ellie. Gail says:

I liked that the midwife can offer more choices regarding these issues. The care is in your control. And you have a lot more options and you are told about the decisions you're making. Whereas talking to other people who had OBs everything is kind of routine and I wanted to have a say in my care. And also the time they [the midwives] spend with you, [there is] lots of time for questions.

In her narrative, Gail clearly indicates that midwifery care is seen as being personalized, individualized, in the woman's control, and with choices provided. This is the public narrative, as Gail had no experience with any other type of care. Gail's comments bring time into the conversation as a very important factor in the developing relationship and on the ability to make choices, something that she

suggests does not happen with obstetric care. Gail's narrative also points to the importance of relationships in her care provision.

Offering informed choice was of high priority for the Ontario midwives in their practice. Midwives identify themselves and are identified by the women as offering choice and, in talking about it, positioned themselves in contrast to other maternity providers. As midwife Ellie said when asked about third stage management,

"I think I do it because we are probably the only people who offer that choice." This was backed up by midwife Erin, "...I mean the philosophy of midwifery is to give women choice."

This is congruent with the philosophy of the College of Midwives of Ontario [the regulatory authority of the jurisdiction] philosophy that includes a number of statements on supporting women's informed choice and decision-making (College of Midwives of Ontario, 1994b, 1994f). The professional organization for midwives in the jurisdiction also holds continuity of care and informed choice as two of the three principles that guide the profession (Association of Ontario Midwives, nd-a, nd-b). In this case, the midwife, the profession, and the regulatory body all position midwives as providers of choice and continuity.

Women identified midwives as offering choice and continuity in contrast to other care providers. This can be seen by Gail's comment above which implies that other practitioners do not provide the choices. The positioning of midwives in contrast to others was especially apparent with the women who had previously received maternity care from a doctor, as can be seen by Catherine's statement. Catherine, when asked about why she chose a midwife for her last three pregnancies, said:

So for me, he [the doctor] sort of said if I induce you today, then I'll be on call or else you're sort of at the hands of whoever, you know, you don't know them so. So that was a big factor for me. I felt over-managed with him [referring to her young son who was with her] and sort of wanted a lot more choice and, like I said, a better relationship with the care provider.

In this statement, Catherine is identifying midwives as providing choice, continuity and a caring relationship. Catherine also identifies midwives as being different from obstetricians, who she sees as health professionals who over manage, do not give choice, and cannot provide continuity of care.

Nancy, who had an obstetrician with her first pregnancy, said something very similar to Catherine and, when asked what she wanted for her pregnancy this time, said,

“Definitely more control over the situation, a better understanding of what was going on, ah, yeah, more compassion, just yeah, just some love you know.”

The identifying of obstetric care, in contrast to midwifery care, positions obstetric care as impersonal, where there is a lack of time and care is routinized. In contrast, midwives are seen to provide personalized, individualized care, where time is not an issue, where there is more choice, and where care is in the woman’s control. This positioning of the midwife and obstetrician as providing contrasting care highlights the importance to the women of establishing a relationship with the caregiver. This finding is congruent with the findings from a Quebec study by De Koninck, Blais, Joubert, Gagnon, & L’équipe d’évaluation des projets-pilotes (2001) in which a matched sets of midwifery clients and obstetric clients were evaluated regarding satisfaction with their maternity care. Although all women indicated satisfaction with care, the women under the care of midwives consistently indicated more positive responses than the woman under obstetric care. The positive responses included indicators of humanistic care, defined as care that was more personalized. De Koninck et al.’s (2001) finding supports the importance of a relationship with the caregiver and thus its influence on the decision to choose a midwife.

The Relationship

Combined with choice, continuity of care was an important reason for women in Canada choosing midwifery care; this enabled a relationship to develop, something

the women valued. Ester, who was experiencing her first pregnancy, indicates the factors that influenced her choice of midwife:

... so there's a couple of factors. I think that I like the ability to know whose going to be attending the birth. I think that, I think that's probably the number one reason, you get to meet everybody and you get to form somewhat [of] a relationship with them before giving birth because if you go the OBGYN route you might not necessarily have your doctor at [the] birth.

Nancy, who had her first baby under the care of an obstetrician, was asked if it was about shared beliefs or relationship that she chose midwives this time, she replied,

"More about the relationship 'cause I found my beliefs naturally coincided. After that if there was a good relationship, then things were just in place already.

A good relationship was so important to Nancy that she contacted five midwifery practices in the city and interviewed a couple of midwives before making the choice she did:

...I actually saw a couple of midwives cause I wasn't sure. I wanted to make sure I had a good rapport with the midwives in case. My first experience [with obstetric care] wasn't very good. We went to five different places [midwifery practices] before and then [found these midwives].

These findings not only show the importance of relationship in decision-making but they support international studies that indicate women and midwives value choice and a supportive relationship during childbirth (Berg et al., 1996; Halldorsdottir & Karlsdottir, 1996; Lavender et al., 1999; Lundgren & Berg, 2007; Walker, Hall, & Thomas, 1995).

In the talk of most of the women who participated in this study, the identity they have of a particular midwife or midwifery group in New Zealand is that of a natural

midwife, one who can provide them with the care they want to achieve a natural birth with as little intervention as possible. In Ontario, midwives are identified predominantly as offering choice and continuity of care, which enables a developing relationship, in contrast to what is possible with the other care providers. Both Catherine's and Nancy's comments also point to the desire to establish a relationship with the care provider. In New Zealand, only Jane referred to the relationship with the midwife when she said about Cindy, "*she was lovely.*" However, the relaxed relationship between the women and midwives, and the fact that the postnatal interviews were often interspersed with laughter, indicated that a close relationship had developed.

The talk of women who contributed to this research indicate that relational decision-making is embedded in social networks through which ontologies, in the form of identities, interests, preferences, and expectations are configured (Callon, 1999; Gadow, 1999). The ontological characteristics of decision-making suggest that the processes involved in forming and maintaining a partnership between the woman and midwife more closely fits with post-structuralist theories, in which narratives of the self direct behaviours, shape choices, and guide information giving (Sherwin, 1998; Gadow, 1999). Post-structuralist understandings of choice suggest that the way in which people position themselves and are positioned by others as certain kinds of subjects may also direct interactions and outcomes (Phibbs, 2008). The midwife comes to the relationship with an identity of "midwife" which embraces certain beliefs and practices. The woman comes to the relationship with an identity as a pregnant woman but also with certain beliefs and wishes around childbirth. Each player identifies each other in a particular way relevant to the relationship, past experiences and a desire to maintain a continuous or coherent narrative of the self, as a holistic midwife, a practitioner who offers choice or as a woman who believes in natural birth; this shapes their discussion and subsequent decisions (Davies & Harré, 1990; Phibbs, 2008) around care.

The development of a relationship is facilitated with continuity of care and this continuity enables the development of choice (Guilliland & Pairman, 1995), which

are two factors that have been identified by woman as providing a feeling of satisfaction with their birth experience (Berg et al., 1996; Edwards, 2005; Hodnett, 2002; Proctor, 1998). Relationship and choice were found to be reasons that women in Canada (Beaudry, 1996; Marion, 1999; Wilson & Sirois, 2010) chose midwifery care. Choice and the quality of the relationship were found by Fairbrother and her colleagues (2012) to be reasons young women would choose midwifery care in the future. Further, Wilson and Sirois (2009) found that women who chose a midwife value the relationship more and have a more natural birth philosophy than women who chose an obstetrician.

The findings from the Ontario participants are supported by other studies carried out in Canada. Marion's (1999) study with women in Nova Scotia found that women's experience of care with a midwife included the sense of empowerment, which was due to being supported in their choices and learning about maternity options. In both Beaudry's (1996) study in Newfoundland and Marion's (1999) study, women talked about concerns with interventions that happen in hospital birth care. The women in Marion's (1999) study positioned midwives as providing protection of normal birth, thus they made the choice to have homebirths. Beaudry's (1996) study found the midwife was positioned as acting as a buffer, in part against the negative practices of nurses and doctors in the hospital. These findings are congruent with findings from a study by Fairbrother, Stoll, Schummers and Carty (2012) with university students in Ontario. Fairbrother et al. found that, although a higher percentage of students would choose an obstetrician, for the female university students who would choose a midwife to provide their maternity care the most frequently mentioned reason given for this choice was the quality of the relationship that is developed. The study also found that those who would choose a midwife as their care provider had more confidence in vaginal birth.

The importance of the relationship in choice of midwife and the fit between woman and midwife is supported by a study carried out by Wilson and Sirois (2010) in four Canadian provinces. The study used an online survey that assessed a number of birth related beliefs and expectations of women who had a low risk pregnancy.

Among the variables studied were preferred relational style, birth philosophy and satisfaction with care. It was found that women's choice of health professional ensured a fit between woman and health professional and was related to beliefs and expectations with women who chose a midwife having a natural birth philosophy and a greater desire for a relationship that was more equal. Not only is there congruency between philosophy and ideas of self between health professional and woman, but the current study also found that these concepts influenced the decision-making process.

Decision-making and Philosophy

Findings from this study also suggest that practice philosophy and the woman's beliefs, as identified in her talk, powerfully influenced decision-making within the midwife-woman relationship. Information concerning both methods of birth of the placenta was given and discussed, and during these discussions the philosophies became apparent. In both Ontario and New Zealand, most of the women chose a natural birth of the placenta. The women either indicated their preference at the beginning of the discussion with the midwife or by the end of the discussion.

When asked by Candice what she was thinking, Helen in New Zealand said, near the beginning of the discussion:

...more naturally rather than having the jab [injection]. What I can gather with the jab it's not actually essential. I mean there are times when it is obviously but it is not one of those things... I know they do it most of the time, but it is not one of the most essential things. It [the placenta] still comes out naturally and it will come out, it's not gonna stay in there or anything so...

Helen's talk indicates her more natural approach to childbirth but at the same time acknowledges that if active management is needed then it is used, indicating her alliance with Candice's practice philosophy of "... encourage[ing] birthing naturally without unnecessary interventions".

Mania, in New Zealand, began the discussion with the midwife by indicating she wanted to keep the placenta and had been doing some research and wanted a lotus birth. Midwife June clarified that this meant a natural birth of the placenta with no injection, to which Mania replied:

“Pulling the placenta, I just think, that’s just not right.”

Kate, when talking to midwife Fran about birth of the placenta, discussed the care of the placenta afterwards. Kate and her partner had learned about this in antenatal classes. She talked about lotus birth and maybe that it was not quite for them but they wanted to keep the placenta. Fran explained that lotus birth was one end of the spectrum and that there is a middle ground. She then discussed active management as being at the other end of the spectrum. Kate said:

“I didn’t realize it [active management] was standard?” Fran replied, “No it’s not standard; it’s the other end of the spectrum.” Kate responded, “Ah, the other end. Oh cool, OK, great.”

When Fran then discussed physiological third stage she said:

...well you’ve had a lovely normal birth; ya know there’s usually not a whole lot of need to intervene, and if it’s fine with you allowing the placenta just to come out. If we are not concerned about baby, we’re not concerned about you bleeding heavily. Then that’s kind of standard within our practice here; that’s what we do, ya know.

Kate responded, “Yeah, oh good.” Her tone of voice indicated relief. Kate then went on to discuss a friend who had had acupuncture, done by Fran, to help birth the placenta.

Kate’s awareness of how the midwifery group practiced was obtained from the group’s website and from public narratives about the group. Kate’s participation in childbirth classes that support natural birth and her discussion with Fran indicated that she wanted a natural birth and this influenced the decision for physiological

birth of the placenta. Fran's way of discussing physiological birth, the language she used when discussing it and the philosophy of the group, indicated that she supported natural birth.

New Zealand midwife, Jess, discussed third stage with April and her partner, Ben. She told them about both methods and why active management is used, then said,

"So what I sort of do, this is my general practice, you guys can say yes or no, is basically I wait and see what the birth's like."

April acknowledged Jess's view that the unpredictable and contingent nature of childbirth influences the decision around the birth of the placenta; she indicated she was in agreement with Jess's suggestion and that she had no preference either way.

In Ontario the decision-making discussion reflected the philosophy of choice. The midwife provided a detailed description of the procedure of active management and the events of physiological birth of the placenta. The women and their partners, if present, asked questions and the women then made their decision or were given the opportunity for further consideration. Three of the women decided on active management after discussion of risk factors in their past history. In one of these cases the midwife indicated she would consult further with her colleagues as the woman had indicated initially she wanted a physiological birth of the placenta. At the postnatal interview, the woman and midwife indicated that the choice had been for active management. Two of the women chose to wait and see and one woman and her partner were going to think about it a bit more.

It became evident in the research that the midwife and woman's philosophies around childbirth shaped how information was discussed, determined how the midwife offered choices to women, and governed how she practiced. In each case in Ontario and New Zealand, philosophies were revealed in the discussion and through the decision-making process as women and midwives came to an agreement about the plan for birth of the placenta. Philosophies also directed how

the discussions were undertaken. In New Zealand, discussion reflected both the midwife's and the woman's philosophy of natural birth, while in Ontario the discussions reflected the philosophy of choice. Despite choice being a philosophical imperative for women in NZ and Canada, ontological narratives of self may be disrupted by an unfolding birth event in which complications and/or unexpected interventions occur.

Uncertainty, vulnerability and relational trust

Decision-making in childbirth is intensified when complications occur or unexpected events arise. In this section I consider how a form of decision-making that is based on relational trust becomes salient when difficulties arise that reduce a woman's autonomy and/or choices in childbirth. Sherwin (1998), although pointing out the necessity of an ethos of respect for patient autonomy within health, questions the current concept of autonomy which is based on the individual as an autonomous decision maker [able to make decisions without influence or consideration of others]. Personal health issues make respect for autonomy necessary; however, vulnerability and/or complications call into question the degree of control a patient may have within the health care system. The way in which loss of autonomy impacted decision-making is evident in the postnatal discussions with women, interviewed for this research, who underwent caesarean sections or had reached a stage of exhaustion during their labour. Mania suggests that in an emergency autonomy is reduced as decision-making is taken over by experts:

The decisions, it was an emergency [the need for the birth to happen the way it did] and in an ideal world that was my plan, the lotus and water birth and no pain relief. But in reality they [the doctors] are the experts. They need to take over and if that is what needs to happen...

While Tracey in New Zealand comments:

"Guess with having the C section there was really no decision as that was the only option, just being informed about it."

Tracey's response suggests that, in an emergency, decision-making resembles a hybrid of the paternalistic and informed consent models where the woman is informed of events and gives consent to the procedure required. The doctor is positioned as the best person to make health care decisions and information is given in order to elicit consent to treatment.

Exhaustion or deviation from the birth plan during labour also impacted on the choices that women were able to make. When asked about the decision-making during labour, Helen in New Zealand commented:

“...I had absolutely had it; I mean it's hard enough trying to push her out...”

Kate in New Zealand talks of the change in plans for the labour and birth and the third stage of labour once she had early rupture of membranes. She said:

“...Because there has been intervention [induction of labour], that's then mandatory [active management]. It took away any choice about it.”

When circumstances required that alternative decisions be made, trusting that the midwife or health professional would make the right decision was important. Although Kate would have liked more options, she comments on the need to trust the doctors; she said:

“...and obviously you trust them ... because they've got the skill.”

In Ontario, Hildy's story points to the woman's vulnerability when complications arise and illustrates how autonomy can be disrupted and choices reduced. Despite things happening quickly, Hildy indicated her trust in the doctor's decision.

Hildy had gone over her due date and the plan was that she would have an induction of labour at forty weeks and ten days. Her care had been handed over to the obstetric and nursing teams, as was the policy at that hospital. During the early

procedure, before labour commenced, complications arose with the baby's heart rate trace and Hildy was told that she would need a caesarean section. Hildy said that the time from decision to caesarean section was twenty-five minutes; her midwife was not there at the time. When asked how she felt about what ensued, she replied:

Yeah, at first when the doctor said you know we're going to, you're told you're going to have a C-section you don't have a choice. That at least [is] what I thought. My husband, you're kind of like a deer in the headlights, you don't go in planning to go into full blown major surgery so it was scary. The doctor left 'cause it was a really quick visit and then the nurses came in and we just kind of stopped and we thought, just a second here, are there any other options, like is this just it? So the doctor came and explained the situation with the heart monitor and how that was alarming and that was the best decision she thought for the baby, so it kinda felt a bit out of control. You know, you go in with a bit of a vision or a plan. We're very open minded, my husband and I. It turned out to be the best thing because, ya know, he [baby], because ya know he wasn't in a good situation what with the cord [he was entangled in his cord] and the pooh in utero, so out he came.

The midwife and student midwife arrived during the preparation process. Hildy's vulnerability and the importance of the relationship with a known caregiver was demonstrated when Hildy said:

It was nice 'cause Alison [the student midwife] and Cherie [the backup midwife] were there for it. So that was really nice for me emotionally to recognize some faces and say, come here I know you guys.

When asked to reflect on the events and how she felt about the decision Hildy replied:

I felt OK after the facts of knowing these other issues [meconium stained liquor and the cord wrapped around baby] and I think they made the right call, the doctor made the right call. Even though it wasn't what I had planned or envisioned. We were in good care and baby came out OK.

Helen in New Zealand had had a long and tiring labour and eventually had an epidural and active management of third stage. Helen's husband, when asked how things went overall, also acknowledged the importance of a trusting relationship:

But then, obviously, with the whole factor of if things turn to custard [went wrong] which, unfortunately, they did in some areas but that we actually had enough trust and we'd discussed with Candice that you know her decision at the end. If something particular needed to be done then we were quite happy to go with that.

When asked about the decision for birth of the placenta, Helen suggested that it is based on the relationship that had been built with Candice. She said,

"Having the trust with Candice, she would only recommend something like that if she absolutely had to."

Comments made by Helen and her husband regarding the way Candice provided information and offered choices in childbirth clearly illustrate the relational and collaborative nature of decision-making within midwifery care.

The unplanned birth experiences of Mania, Tracey, Helen, Hildy, and Kate enabled them to reflect on the decisions that were made prior to labour and to compare them with decision-making during labour. Women interviewed who had birth experiences that deviated from both their expectations and the birth plan that they had developed with their midwife suggested that unexpected events may increase vulnerability by limiting autonomy and choice.

In one of the Ontario interviews, Nancy demonstrated the relational trust she had in midwife Tilly during the discussion about the birth of the placenta. Nancy had had a postpartum haemorrhage after an induction of labour for her first baby. Although she and the midwife discussed both methods for birthing the placenta, Nancy said, toward the end, after they had discussed situations where active management would be needed:

“But then also Tilly in that situation, I would like **trust** that maybe if I am not in the best like situation you would totally...” Tilly interjected, “We take over, absolutely, in an emergency situation...”

Findings from this research suggest that choices are dependent on circumstances with prior decisions revisited through ongoing interaction and discussion during the unfolding birth event. The woman’s talk in these situations indicates a vulnerability and concern for the baby’s safety. The women’s reflections afterwards acknowledge the realization that choice may be limited and that trusting in the health professional to make the right decision is important. In these instances the trust in the midwife is based on a relationship, the midwife’s knowledge, and a shared philosophy. The trust in the doctor is based on acceptance of the doctor’s knowledge as expert knowledge and a sense of having no other choice, whether because of concern for the baby and or/no other choices being offered.

Social networks: Word-of-Mouth

Social ties play a significant role in finding midwifery care. Word-of-mouth and relying on social networks have a strong influence on choices of all kinds, including choices around health care (Huppertz & Carlson, 2010; Lupton, Donaldson, & Lloyd, 1991). Choice of midwife for most of the women in this study was influenced by social networks, specifically family and friends.

In both Ontario and New Zealand, social networks, such as family and other women who had used a midwife’s services, played an important role in finding a midwife, as well as opting for midwifery care in the case of Ontario. Social connections may be of more importance in Canada where midwifery service is not the norm. Beaudry (1996), in a phenomenological study with six women in Newfoundland, found that because midwifery wasn’t regulated at the time in the province, the midwife didn’t advertise but women found her through their social networks. Midwifery is now regulated in most of Canada but women still use word-of-mouth to find midwives, as there is a lack of general public awareness of the service.

In one of the Ontario interviews, Catherine indicated this was her sixth pregnancy and her third baby with midwife Erin; the first three babies had been with an obstetrician. When asked if she spoke to friends when looking for midwives for her fourth birth, she said:

“I [have] talked to them [women friends] since but no one that I had known prior had ever had a midwife birth.”

To find a midwife the first time, for her fourth pregnancy, Catherine looked on the midwifery professional association website.

In the current study twelve of the women chose their midwife after a recommendation from family, friends or colleagues. Lily, in New Zealand, had accessed information from the local hospital about the midwives in the area and knew that Midwife Jasmine supported natural birth; Lily talked to a friend who had used Jasmine’s services and said:

“Well she recommended her. She only had good stuff to say.”

Hildy, in Ontario, had a friend in another city who was a midwife and she had talked to her friend prior to becoming pregnant; her friend had recommended midwifery care. When Hildy became pregnant, some good friends who had recently had a baby recommended the practice and the midwife, Barb. She explained:

“Yep, I’ve heard just very positive things about midwifery as well as this particular clinic and practice, and about Barb.”

Nancy had found out about midwives through other couples:

“Through people who had had children. They were saying you should have a midwife. It’s amazing.”

Tracey, in New Zealand, when asked why she chose Penny as her midwife, said:

“She is related to my husband. She had also done another friend of mine and my partner’s sister, and then I found out through my auntie. You also did my auntie.”

Tracey also chose the midwife because she was from the same cultural group and could speak the language. This was important as Tracey’s mother was not fluent in English. Helen, in New Zealand, knew of Midwife Candice because they went to the same church. She also knew that Candice did both home and hospital births, which to her indicated a natural approach to birth. Hattie, in Ontario, who had also had an obstetrician previously for her first birth, chose a midwife this time on the recommendation of her sister, who had used the service. Jane, in New Zealand, had talked to mothers at her son’s school, while April had been referred to the midwifery group by her sister-in-law who had used their services and was a midwife herself. When asked how she found the midwives, Gail, in Ontario, replied:

“My partner went to school with the daughter of a midwife here.”

The way that women found midwives in both New Zealand and Ontario shows how complex and entangled social networks are (Granovetter, 1985). In this research friendship and family networks of the women intersect with networks of the midwives.

Social networks: cultural influences.

Apart from family and friends influencing the choice of midwife, social networks in the form of culture also play an important role in decision-making. Moreover, certain forms of family specific cultural knowledge may be needed in making decisions around childbearing. For example, in two cases in New Zealand the family had Māori members and care of the placenta after birth was an important consideration, evident in the woman’s discussions with the midwife. Within Māori

culture the *whenua*¹³ [placenta] is sacred as it provides nourishment for the baby and connects the baby to the *whenua* [land] of its people. Treatment of the placenta after birth is important. For many Māori, the placenta is buried at the family marae¹⁴ or wahi tapu¹⁵ site in the region in which the father or mother's Iwi¹⁶ is located. This ensures that the child will always have a connection to its ancestral land and a place to call home (Rickard, 1977). To do this requires knowledge of whakapapa¹⁷ and consultation with extended family members. It may include decisions around the creation of an ipu whenua¹⁸ and arrangements for the burial ceremony (Kenney, 2009; Kenney, C. personal communication 6/11/10).

Cultural context means that in New Zealand, questions about management of the birth of the placenta for all women, regardless of ethnicity, include wishes for the care of the placenta after birth. Mania, who had Māori heritage in her family, had discussed this with both her partner and her father. Kate also went home to discuss care of the placenta with her partner, who was Māori. Tracey, a member of a minority ethnic group that is not indigenous to New Zealand, asked her mother if there was any special care involving the placenta. Although there is no cultural practice around care of the placenta for many women in Ontario, midwife Tilly indicated that she asked all women after the birth whether they wanted to take home the placenta as she had done that herself.

It has been demonstrated that social networks play a significant role in decision-making and choices during childbirth. These relational networks influence the choice of midwifery or midwife but also play an important role, via cultural expectations, in aspects of care of the placenta as well as in choosing a midwife whose practice and belief system was congruent with those cultural expectations.

¹³ The Māori term for placenta but it also it the term to refer to the land.

¹⁴ Marae is the central communal meeting place of the tribe that serves both religious and social purposes.

¹⁵ Wahi Tapu a sacred site.

¹⁶ Iwi form the largest social unit in Māori society and can be translated as people.

¹⁷ Whakapapa –genealogy but also related to wider relational knowledge

¹⁸ Ipu Whenua is a vessel for storing the placenta which is typically made out of clay or a gourd

The complexity of relational influences on decision-making is further demonstrated when women talk about past experiences and their influence on present decisions.

Past Experience

The choice of midwife was also influenced by past experience, whether it was good or bad, and relationships played an important role in that. Kylie in New Zealand had midwife Andrea previously, while in Ontario Gail had midwife Ellie previously and Catherine had midwives Erin and Kathy for her last three births. When talking about how the practice decides which clients to take she indicated they always take repeat clients. Erin said,

“Yeah,[a] repeat [*client*] is always, it’s nice too, cause you already have that relationship.”

Catherine added:

It’s very comfortable. You don’t have to come back in and meet someone new and explain all over again every single one of your pregnancies, every single one of your births. ... you have that standing relationship, yeah.

For other women, their choice of midwife or midwifery was influenced by events at their previous birth(s) and how that highlighted the importance of relationships, shaped their beliefs about themselves as birthing women, and was an important influence on their decision-making. For the Ontario women who had had previous births with an obstetrician, midwives were identified as providing a more positive alternative.

Catherine who had had her first three babies with an obstetrician, when asked why she chose midwives said:

It was after the birth of my third son. He was, I was induced two days overdue for sort of not really any great reason other than, other than convenience, ...otherwise if you don’t go in on a certain day you don’t get who you want to deliver your baby. Which to me is an absolutely 100% huge, I have to have a relationship with [the person] who’s delivering the baby.”

When Nancy was asked why she chose midwives she replied,

“...because I had had a horrible experience the first time with a doctor.”

Both of those statements not only indicate the influence of past experience on choice but position doctors in contrast to midwives as discussed previously.

Jane's first birth had been induced early because of a complication. Her second birth had happened quickly and unexpectedly at home, without a midwife in attendance. Jane described the experience of pushing out the placenta, “And that's an amazing feeling pushing that out.” This influenced her desire for a subsequent natural birth, “... ya natural is good”, and her search for and choice of Cindy as her midwife.

Past experience for these women had a strong influence on their choice of midwife this time. It points to the importance of a good relationship in providing satisfaction with the birth experience and building trust. The past experiences influenced the identity the women had of themselves as birthing women, resulting in the choices they made to have a midwife in the current pregnancy.

Conclusion

In contemporary western cultures, consumers of health care are, for the most part, constructed as autonomous individuals who are capable of participating in and taking responsibility for their health and health care decisions (Davis, 2005; Rhul, 2002). In a neoliberal philosophy where the market and competition are prioritised health care decisions are viewed as a rational calculation of benefit and risk (Granovetter, 1985; Callon, 1999) in which consumers have the power to make informed choices that maximise their self interest (Granovetter, 1985). Efficient and cost effective consumer choices are associated with decontextualised, market based decision making in which reduced patient practitioner interactions are

emphasised (Baum, 2008). The voices of both the women and the midwives who participated in this research point to the desire for a relationship which is characterized by continuity of care and control. The talk of participants illustrates how choices are made through ongoing interaction and discussion. Conversations introduce uncertainty, relationality and time into the decision making process. Midwives and women in this instance are no longer strangers; they are entangled in a web of relations and connections through which identities are constructed (Callon, 1999). The narratives and talk of the women and midwives in this study have demonstrated that decision-making is not an individualistic undertaking but rather influenced by the women's and midwives' embeddedness in social networks and relationships.

This chapter demonstrates how ontologies are configured through interests, expectations, experiences, and preferences. It takes into account variabilities in knowledge that may arise from different understandings, protocols, procedures, or conversations, including uncertainties about the choices available and expected outcomes (Callon, 1999). There is a mutual philosophy about care and birth that has an important influence on the choice of midwife or woman, decisions and decision-making processes. A shared understanding of expectations is developed in which the extent to which the client desires involvement in decision-making is negotiated and the participation of significant others in decision-making facilitated. This chapter suggests that understandings of autonomy in this model shift from consideration of individualism to the recognition of the personal influences on decision-making.

In this chapter it is demonstrated that decision-makers do not make decisions without consideration of others, but rely on social networks, the relationship with the midwife, and the unfolding birth event. Findings from this research highlight that the understandings of choice within health care are complicated. As Granovetter (1985) argues, decision-making is a dynamic process that is relationship and values based. The following chapter considers decision-making in relation to factors such as the organization of maternity services, workforce issues,

and organizational practices. While considering these factors the chapter also highlights the similarities and differences between Ontario and New Zealand in relation to these larger contextual issues.

Chapter 6: Decision-Making in Context: birth space and decision-making

Introduction

The previous chapter explored the themes that were developed from the talk with women and midwives, positing that decision-making in the woman-midwife encounter is strongly influenced by identity projects and relationships. The images that the women have of midwives, and of themselves as childbearing women, impact their choice of a particular midwife in New Zealand or their decision to opt for midwifery care in Ontario. These identities have a strong influence on how discussion of choice is undertaken and the subsequent choices made. The professional identity the midwives have of themselves in both New Zealand and Ontario influenced their choice of clients and how they discussed the birth of the placenta. The previous chapter also pointed out the wider relationship aspect of decision-making by highlighting how family and friends influence the initial choice of midwife, midwifery practice, or midwifery care. The desire for a meaningful relationship with their caregiver was especially evident in the talk of the Ontario women. It was also demonstrated that cultural considerations in New Zealand influence decision-making, particularly for the birth of the placenta.

This chapter explores the broader relational influences on decision-making. Going beyond the woman-midwife relationship and social networks, it looks at how experiences that stem from place and the wider socio-political context impact decision-making in the woman-midwife relationship. The impact of the politics particular to a place is especially evident in the data from Ontario, where midwifery is still very much on the edge of health care and growing and, therefore, vulnerable to the politics within the health care system. Unlike in New Zealand, where midwifery service is the standard practice, in Ontario, the midwifery option is the exception to the rule.

Socio-political Influences on Decision-making

This study explores relational influences on decision-making through consideration of their entanglement in intimate personal relationships (Granovetter, 1973, 1985) and the embeddedness of participants in the wider socio-political environment, including their spatial location (Jones, 2012; 1993; Massey, 1992; Massey et al., 1999; Sherwin, 1998). In this thesis the term *relational* is used in its broadest sense as discussed by Sherwin (1998) and Secker (1999) and also includes the idea of space and place (Massey, 1992). This use of the term *relational* is broader than that used in other feminist literature where relational is concerned with the implications of human relationships, such as in the work of Carol Gilligan (1982) or in health literature (Gadow, 1985; Bergum & Dossetor, 2005), as discussed in Chapter 5¹⁹. Relational can also be extended to include place or location, both concrete and metaphorical (Jones, 2012; Stoller, 2003).

Place and Space

Place is not only geographical but encompasses the sense people have of a place holding special significance (Kearns, 1993). Place, or space, is relational in nature in that it is constructed from social processes, but, in a reciprocal fashion, social processes are spatially constructed (Massey, 1992, 2005). Space is dynamic, with an individual's sense of place changing with context. At the same time, an individual's sense of identity is tied to place (Dyke, 1995). Space refers to location; for this study it is the regions of New Zealand, and the towns and cities in the province of Ontario, Canada, in which the study was conducted. Space also refers to the intersection of the local and the global (Dyke, 1995) and metaphorically is present in the sense of group identity that is constituted partly by space or location (Massey, 2005). In addition, space is political (Massey, 1995), as it is constituted and

¹⁹ In these contexts relational deals with human relationships and recognizes that our autonomy is only in relationship to the others in our lives and with that comes responsibility to others (Gadow, 1999; Gilligan, 1982) as well as the moral imperative to consider relationality in our professional interactions (Gadow, 1999). Gilligan also contends that women's interactions in the world are relationship based, accounting for the difference seen between women and men.

reconstituted via uneven distributions of power (Dyke, 1995). Thinking about space as a living construct (Kearns & Moon, 2002), enables one to look at groups as “closed circles” (Kirby, 1993, p. 174), which fits well with an understanding of professional projects.

In this thesis, I consider maternity care as a space or place in which professionals and consumers jockey for position and choice (Butler & Parr, 1999; Witz, 1992), with professions using professional projects to gain, maintain and protect their place in health care (Khoury, 2012; Witz, 1992). With this in mind, the relational aspects of decision-making used within the thesis also encompass these contests.

Politics of Location

Autonomy and decision-making are impacted by political and economic ideology as well as by institutional and social rules. In midwifery, the impact can differ depending on the location in which care takes place (Jones, 2012). This may be referred to as the politics of location (Borsa, 1990; Rich, 1986). When people are in a hospital, they are in a vulnerable position where institutional rules and policies cause dependency on professionals who, for the most part, are in positions of power (Secker, 1999; Sherwin, 1998). This is especially the case in places where midwifery is considered a peripheral profession, such as in Ontario (Kelner, Wellman, Boon, & Welsh, 2004). The majority of women will enter a hospital at some time during their childbirth experience, with most women in New Zealand and Ontario having their baby there. While in hospital, women and midwives are in a system that has protocols and rules. Midwives work within and with the health care system and are influenced by the broader political issues, which include such things as workforce size, institutional protocols, scope of practice, access arrangements, funding arrangements, the organization of maternity services, policies or guidelines of legislated bodies, as well as institutional and professional cultures and practices, both local and global. It is argued in this thesis that these contextual factors impact decision-making by opening up or closing down choices in childbirth.

Places and Professional Projects

Some professional practices have been recognised as professional projects, which encompass the mechanisms professions use to achieve recognition, the way they lay claim to an exclusive body of knowledge and skills, and the attempts to close their profession or area of work to others (Tully & Mortlock, 2004; Witz, 1990, 1992). The discussion of the history of midwifery in Canada, Ontario and New Zealand, as outlined in Chapter One, illustrates some of the professional projects undertaken in the late 1800s and the 1900s to achieve professional recognition and status. In this chapter, *professional projects* refer to strategies professionals undertake to build and maintain their position of exclusivity (Khoury, 2012; Witz, 1990).

Professions within health care, particularly medicine, have, over their history, used various practices to achieve and maintain professional status and professional closure. Some of these strategies have also been used to prevent the professionalization and work of midwives as well as other health professionals (Tully & Mortlock, 2004; Witz, 1992). Midwives, in response, have sought ways to promote their professional status. Projects of professional closure and maintenance include such things as registration or licensure which seeks legal protection, regular professional competency monitoring, and the strategic alliance with others who assist in gaining professional status, as can be seen in Ontario and New Zealand when midwives aligned with women to gain autonomy.

Professional projects are about the movement of power within and outside the profession in order to maintain a monopoly (Witz, 1992). It has been proposed by Suddaby and Vale (2011) that professionals play a central role in institutional change by introducing new rules and standards, challenging incumbent hierarchies or practices, by using their social value to increase the number of professionals in that location and, by extension, using their professional power to restrict other professions. In this thesis, professional projects are seen as an aspect of the politics

of location (Rich, 1986) that midwives push against as well as use to their advantage in their move to increase and maintain their position in maternity care.

In addition to the influence of personal relationships on decision-making, evident in the talk of the women and midwives, wider socio-political issues arose in the data, issues that illuminate the role of professional projects and the politics of location in influencing decision-making. An understanding of the current midwifery context in the two locations of this study helps to highlight differences and similarities between New Zealand and Ontario in relation to midwifery and how location and the contextual factors discussed can challenge the neoliberal view of autonomy and thus choice and decision-making.

Current Midwifery Context

As this study progressed it became apparent that the context in which the midwives practiced and in which women received care had an influence on choices and decision-making. This then required an exploration of the context for midwifery practice in each jurisdiction as well as questions for midwives and women in subsequent interviews.

Although midwifery in New Zealand and Ontario has similarities in day to day practice and some of the same philosophical values, there are differences. In both New Zealand and Ontario, midwifery saw resurgence in the early 1990s when political ideology and consumer wishes collided and supported each other. The development of the profession in both countries since has much to do with the political ideologies that developed as midwifery re-emerged. Similarities are evident in the type of caseloading care midwives offer, their underlying values, their embracing of the global midwifery community, and their current existence in countries with a conservative federal government that broadly adheres to neoliberal ideologies. The differences in midwifery between the two countries stem from the differing historical development of midwifery as well as their professionalization projects, such as regulatory frameworks, and social, cultural,

and political landscapes. Access to midwifery care and the decision-making that midwifery care enables are impacted differently, depending on the jurisdiction of the study and the location within the jurisdiction. In this chapter, the impact those places and spaces, in which we work and live (Borsa, 1990), have on choice and decision-making are highlighted.

New Zealand

In New Zealand midwifery is the predominant profession in maternity care and it has had a continuous, regulated presence in health care in some form or other since the Midwifery Act of 1904. Since the late 1980s, when the Labour government re-instated midwifery autonomy with a change in legislation, governments, midwives, and women have supported the development of the profession as midwives are seen to be the most appropriate caregivers during the childbearing year (World Health Organisation, 2011). New Zealand has a public health system that is run by District Health Boards and is regulated and funded from central government. Maternity care is free to all women who meet certain eligibility criteria regarding citizenship, set down by the New Zealand Government (Ministry of Health, 2000).

Midwives in New Zealand become registered with the Midwifery Council of New Zealand after a three year degree, with three semesters per year at one of the four tertiary institutions in the country. Overseas educated midwives have additional education requirements to meet the competencies to register with the Midwifery Council of New Zealand (2012). When midwives become registered they enter the workforce as a caseloading, self-employed midwife or as a core, employed midwife working in a shift work system in one of the primary birthing units or in a secondary or tertiary hospital. Newly graduated midwives take part in a yearlong mentorship programme. In the hospital, the midwives provide care to women who may be admitted to the hospital in the antenatal or postnatal period or when clinical responsibility for care is transferred from the Lead Maternity Care provider (LMC) due to complications in labour. Hospital midwives also provide care when the LMC is an obstetrician or general practitioner using hospital midwifery services.

In New Zealand, there were approximately 1027 midwives caseloading, including both self-employed and employed, according to the 2011 workforce data (Midwifery Council of New Zealand, 2011), with 61,031 births recorded for the year ending June 2012 (Statistics New Zealand, 2012). Women choose a registered health professional who may be a midwife, general practitioner, or obstetrician as their LMC. Approximately 80% of pregnant women in New Zealand register with a midwife as their LMC (Ministry of Health, 2012d). LMC maternity care in New Zealand is funded through a modular system under the Primary Maternity Services Notice 2007, pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000 (Section 88) (Ministry of Health, 2007c, 2012c). The practice arrangements of midwives are usually informal; however, some practices will have more formal arrangements dealing with, for example, payment of the second midwife. All practices will have some arrangement about equitable payment for rental of office space. Midwives, who are registered with the Midwifery Council of New Zealand, apply to the funding arm of the Ministry of Health, HealthPac, to make notification of their desire to practice under section 88 and to be paid for their work (HealthPAC, 2007). They then complete a national access agreement (Ministry of Health, 2007c) for their local District Health Board (DHB), facilities which outlines the obligations of both parties. Once access is granted, they are able to provide the full range of services, within their scope of practice, to women. Each midwife is paid on a fee for service basis, submitting a claim after each module of care either directly through HealthPac or via a business administration organisation, such as the Midwifery and Maternity Provider Organisation (MMPO) (Dixon, Fletcher, Hendry, Guilliland, & West, 2010). A total course of care is divided into a number of modules, including first and second trimester, labour and birth, and postnatal (Ministry of Health, 2012c).

Under Section 88 the LMC is responsible for ensuring care is provided to the woman throughout the childbirth experience (Ministry of Health, 2007c). The intent of Section 88 is that women receive continuity of care from a registered care provider [midwife, obstetrician or GP] and her named backup. The predominant model of

care is 'continuity of care' where the same practitioner and her backup provide care throughout the childbirth experience. In some situations, antenatal care may be undertaken in conjunction with an obstetrician or family doctor, who would generally be the LMC. In other situations, the midwife who provides care antenatally and during labour and birth may have another midwife provide postnatal care. In all cases, a woman will have a named midwife involved in all parts of her care. For the majority of women in New Zealand, this means they have their care provided by one midwife and her backup. The midwife is generally the practitioner who is involved in providing information for discussion to facilitate decision-making during the childbearing year. Midwives provide care to the woman from early pregnancy up to four to six weeks postnatal, when care is transferred to the well child provider and family doctor.

Canada/Ontario

Midwifery in Canada is a growing profession and only a small percentage of women can access midwifery services. Health Canada is the federal department that oversees the health of Canadians while respecting their choice and autonomy through funding to provincial and territorial ministries of health. Among its remits, it administers the Canada Health Act which directs provinces and territories on the general principles underpinning the use of federal health care funding. Although the federal government does not legislate for midwifery, in 2006 it supported the World Health Assembly in endorsing WHA resolution 59:27, encouraging member states to recommit to strengthening the capacity of midwifery to provide primary health care (Health Canada, 2008). As a result, support for midwifery in Canada has strengthened. However, under the Canada Health Act, each province and territory develops and administers its own health legislation and provides health services for its citizens, which results in midwifery legislation being enacted across Canada at variable rates and in variable forms. In Canada, most provinces and territories currently have legislation governing midwifery. However, for some these laws are still being enacted.

All provinces and territories in Canada, apart from Newfoundland and Labrador, Prince Edward Island, and the Yukon, are regulated and have registers for midwives. Traditional aboriginal midwives are necessarily not covered by this legislation, and they practice within their aboriginal communities, unless they have become registered within their province or territory (National Aboriginal Council of Midwives, 2012). In jurisdictions where legislation is pending, is not yet enacted, or is absent, there are advocacy groups who are lobbying for the legal recognition of midwifery and provision of midwifery care for women (BORN, 2012; Canadian Association of Midwives/ Association Canadienne des Sages-Femmes, 2012a, 2012c; Friends of Midwifery NL, 2012; Saulnier, 2003), including local midwifery associations.

Despite the growth of midwifery in Canada, the federal government does not have a job description for *midwife* in the national treasury. Hence, in jurisdictions where the federal government is responsible for health, which includes aboriginal reserves, there is little support for direct midwifery services (Canadian Association of Midwives/ Association Canadienne des Sages-Femmes, 2012a). This means that aboriginal midwives working in the north are funded through provincial or territorial governments. But, more importantly, the lack of support at a federal level means many women in remote areas must leave their community weeks before the birth, removing them from their social networks and support, rather than being supported by a midwife in their community (Canadian Association of Midwives/ Association Canadienne des Sages-Femmes, 2012a). Additionally, there is no voice for midwives in the federal government and so influencing relevant federal policy is difficult. To address these concerns and increase the influence of midwifery in the national health policy agenda, the Canadian Association of Midwives/ Association Canadienne des Sages-Femmes (CAM/ACSF) continues to work toward a federal job description in the treasury board when that possibility opens in 2014. The implication of this move would be that midwifery care would become part of the health services provided for aboriginal communities under federal jurisdictions. The association is also promoting the establishment of a midwifery advisor at Health Canada which will increase the midwifery profile and influence at a national level.

(Canadian Association of Midwives/ Association Canadienne des Sages-Femmes, 2012a, 2012c)

Midwives in Ontario and Canada become registered after a four year degree in one of seven universities in the country while midwives educated overseas must complete a bridging programme (Canadian Midwifery Regulators Consortium, 2011; College of Midwives of Ontario, 2007). Individuals who meet licensure requirements are able to register with the College of Midwives of Ontario (CMO), or the regulatory authority within a jurisdiction with regulation. In Ontario, midwives and midwifery practices apply, with a business plan, a needs assessment of the area, plus other documentation to the Ministry of Health and Long Term Care, which approves the application if there is indication of an unmet need (Weston, L. personal communication, September 3, 2013). Newly graduated midwives are required to work in an established practice, alongside an experienced midwife for a one year mentorship period (Ontario Hospital Association et al., 2010). The latest figures from the Association of Ontario Midwives (AOM) indicate that there are over 600 midwives in practice in Ontario (Canadian Association of Midwives/ Association Canadienne des Sages-Femmes, 2012b).

The birth rate for Ontario in 2011-2012 was 141,799 (Statistics Canada, 2012). Less than 10% of women in Ontario have a midwife (Hutton, Reitsma, & Kaufman, 2009). Unlike in New Zealand, it is the minority of women in Ontario who have maternity care provided by midwives. Moreover, in 2008, Ontario midwives were only able to meet 65% of the requests for their service (Ontario Hospital Association, College of Midwives of Ontario, & Association of Ontario Midwives, 2010a), and midwifery practices continue to have waiting lists (Hutton, E. Personal Communication, May 2, 2012). The 10% rate for midwife attended pregnancy and birth means that obstetricians are the predominant maternity provider, with the birth being attended by a nurse and obstetrician in hospital (Fairbrother et al., 2012). Furthermore, Ontario outranks other Canadian provinces and territories in availability of midwives; hence, only a small minority of women in Canada, overall, can avail themselves of the service of a midwife.

Midwifery in Ontario, rather than being funded on a fee for service basis, is funded by practice based on the number of courses of care completed (Ontario Hospital Association et al., 2010a). Midwives are also compensated for care provided to women who are not covered by the provincial health plan (Ontario Hospital Association et al., 2010a). The midwifery practice group applies for funding from the transfer funding agency, based on the number of midwives, their years of midwifery practice experience in Ontario, and the number of courses of care for each midwife (International Midwifery Pre-registration Program (IMPP), 2013). The rationale for funding the practice is to support the CMO's and AOM's model of practice statements (Ontario Hospital Association et al., 2010a), which encourage group practices. To assist hospitals and health authorities to integrate midwifery into their service the Ontario Hospital Association alongside the College of Midwives of Ontario and the Association of Ontario Midwives developed a tool kit in 1994 which was updated in 2010 (Ontario Hospital Association et al., 2010).

Midwives work in caseloading practices. Nurses provide episodes of care should a woman be admitted to hospital during the antenatal period, in the postnatal period, when care is provided by the obstetrician or family doctor, and when a woman's care is transferred before or during labour. Midwives provide care to women from early pregnancy to 4 to 6 weeks postnatal, at which time the women and baby are transferred to the care of their family physician.

The contexts of midwifery in New Zealand and Ontario have many similarities; the professions had resurgence in the early 1990s when the political ideology and consumer wishes combined and supported each other. The development of midwifery in both countries since has much to do with political ideology over the time the professions were growing, and it highlights how the politics of location, political and social events, and beliefs and practices particular to an area impact professional projects and development.

Models of Care

New Zealand and Ontario have very similar models of caseload midwifery. Informed decision-making, leading to informed choice, is upheld as an integral part of the relationship between woman and midwife and is part of the requirements of the regulatory authorities in both jurisdictions (College of Midwives of Ontario, 1994d; Midwifery Council of New Zealand, 2004). In both countries, professional codes of ethics, standards of practice, and competencies to register include respecting women's right to make informed choices. The starkest differences between the two countries relate to the degree to which midwives have autonomy to practice impacting the percentage of women who receive midwifery care, workforce numbers as well as the differing levels of integration and acceptance of midwifery into the health care system. Midwifery in New Zealand is a practice accepted by the national health care system, whereas in Canada regulations and acceptance levels vary across the provinces and territories, owing to the autonomy the provinces and territories have over health care (Government of Canada, 1985) and the lack of regulation in some provinces (Canadian Association of Midwives/ Association Canadienne des Sages-Femmes, 2013).

Midwifery in New Zealand is guided by the Partnership Model (Guilliland & Pairman, 1994, 1995) of practice which holds that there is a partnership between the woman and midwife. Each has responsibilities within the relationship and each brings unique knowledge to the relationship. For women in New Zealand, equality of care is ensured through both Section 88 of the New Zealand Public Health and Disability Act and by the New Zealand College of Midwives, which encourages continuity of care and the building of trusting relationships (Ministry of Health, 2007c; New Zealand College of Midwives, 2012). Most midwifery practices in New Zealand are comprised of 4-8 midwives. Each woman meets the primary midwife and the backup midwife, which ensures that the woman is familiar with the midwife who will be with her in labour.

The model of practice in Canada is based on continuity of care similar to the model of care in New Zealand. Midwives in Canada work in small groups, so women may meet more than one midwife. In British Columbia and Ontario, for example, midwifery care is provided by small group practices and relationships may be one midwife to one woman or three/four midwives to one woman (Association of Ontario Midwives, 2011b; Cameron, 2005; College of Midwives of Ontario, 1994e). The antenatal care is carried out within a midwifery practice and women meet the primary midwife and at least one other, to ensure continuity of care through the labour and birth and postnatal. The midwives who participated in this study worked in practices comprised of 6 to 11 midwives, and a review of the websites of other practices in the region showed midwife numbers ranging from 2 to 14 practitioners. The model of care encourages midwives as the primary care providers. However, there is provision for shared care with a family doctor in circumstances where this is deemed necessary, for instance in remote rural areas where there may be no other midwife (College of Midwives of Ontario, 1994e, 1995). A nurse can also be the second attendant at a birth, if there is prior arrangement (College of Midwives of Ontario, 1994c)

Examination of the context of midwifery services both historical, as discussed in Chapter Two, and current, highlights how, within the same profession, there are local influences on the development of services. The differences in development are related to how each professional body responds to the socio-political context. The midwifery services in New Zealand and Ontario share similarities in their model of continuity of care and midwifery regulatory authorities and professional organisations in both countries hold very similar philosophies and tenets of practice. In both countries, midwifery care is publically funded and so women can access the service without their decision being influenced by cost. The most notable differences, however, relate to workforce numbers in each country, the regulatory history, and the extent of midwifery services across the health systems. These locational differences impact women's choices as governments, institutions, and groups of professionals respond to midwifery in different ways by, for example,

limiting midwives' ability to practice fully or by increasing choices by facilitating midwifery integration into the system.

Consultation and Choice

Policies and guidelines in health services are risk management tools used to assist practitioners when complications arise during the course of care. New Zealand and Ontario each have documents that guide midwifery practitioners as to when discussion with a specialist is warranted and which outline how the subsequent care may be undertaken. However, in the maternity care space within the jurisdictions and between the jurisdictions, the interpretation of and adherence to these guidelines varies, pointing to how place and organisational practices affects choice and decision-making. The differences may be related to the authority attributed to the guidelines as well as organisational structures and practitioner choice.

At the time of this study in New Zealand, midwives, general practitioners, and hospitals followed the (2007a) national Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines) which have since been updated (Ministry of Health, 2012a). These guidelines have been consulted on and agreed to by the professions involved in maternity care, including midwifery. The Referral Guidelines give LMCs direction on when consultation with another health care provider is recommended or required, the ongoing roles and responsibilities once referral happens, and when transfer of clinical responsibility for care must be recommended to the woman (Ministry of Health, 2007, 2012). In all cases, a referral and subsequent care decisions must be a three way discussion between woman, midwife and the health professional referred to. However, personal experience indicates that some obstetric personnel in some DHBs, have not always followed the referral guidelines as they were laid out, resulting in unnecessary transfer of clinical responsibility for care of women without a three way conversation. The 2012 Referral Guidelines are meant to address any areas that have been unclear in the past. The LMC's access to maternity facilities is also guided by The Maternity

Facilities Access Agreement (Ministry of Health, 2007b). This means that District Health Boards cannot arbitrarily restrict midwives access or require them to demonstrate competencies other than those required for registration, before giving access. The maternity services are also guided by service specifications for the various levels of care (Ministry of Health & District Health Boards New Zealand, 2011a, 2011b, 2011c), which outline the expectations of the DHB for service provision.

The purpose of these various guidelines is to ensure women get access to the care and care provider they want and need, and that there is equity across the country. However, as Goldberg (2003) points out, these standard policies can limit the choices women have, as information given is constructed within a health care environment in which medicine is still dominant (Benoit et al., 2010). Data collected for this study identifies how women's choices are sometimes overruled or limited by the health care environment.

Kate, in New Zealand, was in her first pregnancy when her membranes ruptured prior to labour, which resulted in her going into the hospital for an assessment and a consultation with the obstetric team, as recommended by the Referral Guidelines. The backup midwife, Ruth, went with her. Kate ended up having her labour induced and had an unplanned caesarean section. During the postnatal exchange, Kate referred to the choices offered regarding pre-labour rupture of membranes and induction, saying:

But I would have liked to maybe discuss some of the issues. There's a threat of infection. ... But I guess, I hadn't researched premature rupture of membranes and I didn't know much about it. I knew infection is bad. But what I would like to know, I guess, is more around, like you know...?

I finished Kate's sentence with "what your options are?" Kate agreed and also indicated that she would have liked more information about the possible complications associated with prolonged rupture of membranes. In the exchange

that followed Kate and her partner both indicate that there were a limited number of options given. Kate said:

Ruth [the backup midwife] was also in negotiating so she would find out what we wanted and negotiate on our behalf, you know, and then, and then we also had some direct communication with the hospital, you know. So we did ha[ve] a say, but it was within a very limited [set of options].

Kate's comment and the continuing comments support the claim that, not only do the events of the pregnancy influence choice, obstetric practice can also impact decision-making. Kate had mentioned that another woman she heard of had waited, against a doctor's advice, for five days after her membranes ruptured. Although Kate considered that option was not for them, she would have liked further information about prolonged rupture of membranes and the associated risk of infection. In this case the choices Kate was offered, but also the exchange of information, did not meet her needs. This exchange also points to the fact that the doctors Kate and Ruth consulted, controlled the information and options Kate was given to the options that they considered acceptable. Kate's ability to make a fully informed choice was constrained. It would appear that, although the midwife was negotiating and advocating for Kate, the doctors involved in making the decision were not negotiating. In other words, consultation puts both the midwife and the woman in a vulnerable position with regard to decision-making. The Referral Guidelines, although valuable and necessary for practitioners, require that both the parties consulting and those being consulted enter a three way discussion in good faith to ensure that women's decisions are fully informed and their choices explored. In the maternity space in which this consultation took place, it is the doctors who hold the power because they are positioned within the hospital, through referral policies and in interactions, as experts on a situation outside the 'normal' progress of pregnancy and birth. Lack of communication between midwife Ruth, Kate, and the doctor worked to marginalise Kate within the consultation by positioning her as a visitor within

the health system, potentially increasing Kate's vulnerability and thus her ability to participate in decision-making. Kate's narrative illustrates the way in which doctors still work within a social and institutional system that affords them a great deal of power over both patients and other health care professionals and, therefore, they have the ability to control the conversation, make unilateral decisions, and/or shape the options that are provided in the decision-making process.

For Mania, consultation and institutional practices worked in a different way, both in facilitating and blocking her wishes. After consultation, because of lack of progress in labour and the baby showing signs of distress, Mania had an emergency caesarean section. Her choice about the birth and care of the placenta had been that her partner would cut the umbilical cord at birth and that the baby's umbilical cord would be tied with a sterilised piece of flax, which she had prepared. This was a Māori cultural wish in consideration of her grandfather and her partner. The midwives at the birth ensured the cord was left long enough for Mania's partner to be able to cut it afterwards. However, the staff in the neonatal unit did not allow her to use the flax, and gave no reason for that decision. Mania said:

I wanted to have Māori [consideration]. We had a harakeke which is [a] flax tie, to tie her umbilical cord and the doctors in SCBU which is special care baby unit, just said absolutely, "no." They just point blank refused it. I was actually thinking about that yesterday. I should have actually pushed that 'cause they didn't even ask. They said they liked to have this [cord clamp] on for 3 or 4 days and that was it. I was quite, I was actually thinking there was no reasoning, or there didn't seem to be anything that indicated there was even a cultural awareness of that. I was thinking about that yesterday and, I then, I was thinking I could have pushed that.

Mania's final comment also supports the assertion that women, especially in a situation like this, are often vulnerable and can have their wishes overruled by the system. Mania recognised in hindsight that she could have insisted on having their cultural needs met.

Like Kate's, Mania's involvement in decision-making was limited by the personnel involved when labour became complex. In Mania's story, the behaviour of the staff may have been related to what Bourdieu (1977) calls *doxa* or doing things because of the taken-for-granted aspects of the practice. In this situation with Mania, using the plastic clamp on the cord is the accepted or dominant way of doing things, so her request challenged the accepted practice. For *doxa* to be maintained, differences have to be eliminated (Bourdieu, 1977). This was achieved through refusing Mania's request for an alternative to the plastic clamp on the cord. From Mania's description the decision-making around use of the plastic clamp on the cord was not shared, as the personnel involved did not consider Mania's cultural request, with the decision being more of a paternalistic one. Mania's and Kate's comments suggest that, within a large health care system, women's vulnerability in relation to health professionals who have the power in that space calls into question the woman's autonomy and has an impact on her choices (Sherwin, 1998; Secker 1999).

Limitations on choice are also demonstrated in Ontario but in a different way. Similar to national Referral Guidelines in New Zealand, the Indications for Mandatory Discussion, Consultation and Transfer of Care (IMDCTC) (College of Midwives of Ontario, 2000) assists midwives when referral or transfer of care are required. These guidelines can be seen as part of the professional project to assist midwives in gaining a position in the maternity scene. However, unlike the situation in New Zealand, the implementation of these guidelines varies across hospitals as indicated in the midwives' talk. As a result, some hospitals may require transfer of care when procedures, such as an epidural, for which the midwife may be certified (College of Midwives of Ontario, 1997, 2006), or induction of labour, which also falls within the competencies of the midwife and requires consultation only (Association of Ontario Midwives, 2011c; College of Midwives of Ontario, 2006), are undertaken. The epidural certification and recertification requires the assistance and supervision of the Anaesthetic chief (College of Midwives of Ontario, 1997). The latest figures from the Association of Ontario Midwives indicate that, in 2011, transfer of clinical responsibility of care when it was within the midwives' capabilities was

approximately 48% (Association of Ontario Midwives, 2011b). Although there is no reason given for this transfer of care to occur, it may have been related to lack of knowledge of the midwives' abilities, the stage of integration of midwives into the hospital service, and the lack of infrastructure such as epidural certification programmes within the service (Ontario Hospital Association et al., 2010a). Statistics from midwifery practices in Ontario indicate that 48% of the hospitals in which midwives have privileges provide certification programmes (Association of Ontario Midwives, 2011a). These barriers can be another way that doxa or professional projects of maternity personnel impact decision-making. Remarks made by women and midwives in Ontario demonstrate how their decision-making is constrained in a hospital setting.

Hildy was in her first pregnancy and went into hospital for an induction of labour. Her midwives were Barb and another midwife at the practice. At the beginning of the postnatal interview, Hildy was recounting her birth experience and said:

"So I was overdue at the 10 days mark so care was transferred to the hospital."

I confirmed this with Midwife Barb, who said, "Though we can go and stay with them, like provide the support, but we don't make the [clinical] decision[s]."

Nevertheless, Barb did confirm that she and the other midwives in the group, if they are present, usually keep women informed if they anticipate a change in birth plans and advocate for women in that situation.

Midwife Mary, when talking about midwife privileges in the hospitals in the area, also commented on the restrictions placed on midwives when she said:

We don't have full scope. We're still waiting for epidural privileges so we can provide care when a woman has an epidural. That's our only kind of snag. But other than that we actually have good relations.

In the hospital where Mary's midwifery group practices, there is a Chief Midwife, who influences the working relationship the midwives have with the hospital, as she advocates for midwives. In this hospital, there are no caps on hospital births or the number of midwives with admitting privileges.

In the situations that Mary and Hildy talk about, women's choice of caregiver and the type of care she wanted is contingent on hospital policy, which is contrary to documentation set out by the legislated regulatory body. The College of Midwives of Ontario views care of epidural, if the midwife is certified, and induction of labour to be in the midwives' capabilities (Ontario Hospital Association et al., 2010a), yet, from the women and midwives' stories, there is inconsistency from hospital to hospital. The delay in getting epidural privileges in Mary's practice may be related to delay in implementing an epidural assessment programme, but they are still negotiating the right to care for a woman when she has an epidural. Indications from AOM are that 48% of the hospitals that give privileges to midwives provide opportunity for the midwives to gain certification in management of epidural care and oxytocin infusion (Association of Ontario Midwives, 2011a) a practice that may put supervisory personnel at risk and which is not required (Association of Ontario Midwives, 2013b). Midwife Erin, in response to my recent email questioning her about handover of care, indicated that, in their practice, they are required to hand over care to the obstetric team when a woman is induced or augmented. Erin also indicated that, until a couple of years ago, they were required to hand over care when the woman had an epidural. Further clarification from Erin found that:

We've developed such good and trusting relationships at our hospital that we usually continue to fill the nursing role, except the nurse runs the pumps, both the epidural and the oxytocin. Often the OBs [obstetricians] will even let us do the delivery, except they like to be called to the birth - only for oxytocin. We don't involve the OBs for a birth with just an epidural.

Midwife Tilly replied to my email about transfer of care by writing:

I have experienced different things at different hospitals. My current hospital we transfer care temporarily to begin an IOL [induction of labour] until

the woman is in active labour (3-4 cm dilated and strong regular contractions) then the care is transferred back and we continue IOL. Six months previous to this it was a TOC [transfer of care] for all IOL. We do not transfer care for epidural as of 6 months ago as well. Many of the TOC for these things are dictated by the hospital that the midwives are granted privileges from. In some cases it is the midwifery practice's choice to do a TOC for IOL and epidural because they do not believe it is normal labour and birth any more, or because of the time commitment to doing an IOL, possibly days, which can be difficult in our model of care, with few people to relieve us.

Tilly's, Erin's and Mary's comments points to the importance of building good relationships, with the other professionals in the hospital, in gaining the right to provide care that their regulatory authority deems part of their competencies. Both Erin's and Tilly's comments demonstrate how practices have changed over time to enable midwives to carry on care of women during an epidural or induction of labour, something that is confirmed by the latest figures from the Association of Ontario Midwives (2011a). Also evident in Erin's comments is the power the obstetric personnel have within that maternity space to the extent that they sometimes "allow" the midwife to provide the care and birth the baby but the obstetrician is present for the birth, when there has been an induction of labour. The role the nurse plays in this situation is to support the institutional policy. In situations like those that Tilly, Erin and Hildy talk of, any choices of the woman, and thus decisions, are impacted by the influence of the obstetric personnel and policies at the hospitals. Tilly, who can speak of her experience from knowledge of a couple of hospitals, demonstrates how the politics of location or decisions made by personnel other than the women impact their choices. The inconsistency from place to place in whether a woman's midwife can provide care when there is an epidural or induction of labour, again, means there is inequity in choices from place to place.

Tilly's comment also shows how workforce issues, such as managing workload, are influencing a midwifery practice's decisions about the care they can provide. In this situation collaboration with the hospital personnel enables midwives to provide

care in a way that is manageable. For other midwifery practices, it appears that there is a philosophical belief that influences the decision not to provide care when there is an induction. In either situation, decision-making is influenced by institutional policies that are not women centred and which vary from place to place. Communication with the president of the AOM revealed that the AOM is working with the Ministry of Health and Long Term Care, Midwifery Program to address these concerns. AOM in association with the Ontario Hospital Association and the College of Midwives of Ontario has also available a document for its members the Hospital Integration Tool Kit (Association of Ontario Midwives, 2013a; Ontario Hospital Association et al., 2010a) to aid midwives in working with in the hospital environment. The AOM support of collaborative activities and improved communication with health professionals will also see an improvement in integration of midwifery (Association of Ontario Midwives, 2013b). The Association of Ontario Midwives is also working with the Ontario Medical Association to promote collaborative relationships between physicians and midwives regarding maternity care (Ontario Medical Association & Association of Ontario Midwives, 2011).

Five of the eight women in New Zealand had an epidural, with two having an induction of labour or augmentation with oxytocin. These women retained their midwife until such time as clinical responsibility was transferred; four of the women had a caesarean section. Like in Ontario, epidural care is not a competency of practice for New Zealand midwives, as an additional certification is required for epidural care. Although lack of certification did not affect the women in this study, it can limit women's access to the caregiver of choice should that midwife choose not to be certified to provide care when an epidural is in place. As for induction of labour in the New Zealand referral guidelines, this aspect of care requires a consultation but does not require a transfer of clinical responsibility unless agreed upon through a three way discussion. Similar to the collaboration illustrated in Tilly's comment, the induction process is begun by the obstetric personnel in some hospitals with the LMC midwife being able to come in once the woman is

transferred to the delivery suite/case room. I am aware of some midwives in New Zealand who have, at times, chosen transfer of clinical responsibility to hospital staff and not to carry on with care during an induction of labour. In both New Zealand and Ontario, the main reasons for handing over care are the requirement of transfer to the tertiary hospital, and difficulties associated with carrying on with an induction which can be a long process, given how caseloading midwives in New Zealand and Ontario practice.

Stories, from both the woman and midwives in Ontario and New Zealand, about situations that are outside of the expected for low risk pregnancy, illustrate how, within the same profession and even within the same province, professional projects can determine the degree of equity in decision-making. Although consultation guidelines exist in both jurisdictions, how those guidelines are used can depend on the individuals involved in the consultation and the place in which the care is carried out. Also illustrated is how building relationships can open opportunities in situations that would otherwise disadvantage the woman. In the maternity space in both New Zealand and Ontario, it can be seen that there is competition for power in decision-making, and midwives and women must negotiate this space in which obstetric personnel have more power. However, it is not only consultation that can influence choice and decision-making, but, as can be seen by Mania's story about the umbilical cord, institutional cultures and "accepted practice" also have an impact.

Professional Culture and Choice - birth of the placenta

Part of Mania's narrative relating to her desires around the clamping of the cord (see page 155), indicates a culture of flexibility in order to meet women's choices. The umbilical cord was left long, enabling her partner to cut the cord. This would have been facilitated by the hospital midwife and surgeon who had incorporated women's wishes into their practice. However, the refusal by the neonatal unit staff to use the flax tie for the umbilical cord demonstrates a culture in which a lack of acceptance of practices that fall outside the accepted doxa is present. Professional

or organisational culture is a set of shared perceptions, values, and beliefs adhered to by a group of workers within an organisation, that guide individual practices at work (Bloor & Dawson, 1994; Davies, Nutley, & Mannion, 2000). In practice it can be defined as “the way things are done here” (Bloor & Dawson, 1994, p. 112). This culture of “accepted practice” may influence the way midwives’ work, either by shutting them out or by supporting diverse approaches and thus impacting choices. In New Zealand, midwife Jasmine, when asked about policies on third stage management that might influence her practice regarding birth of the placenta, replied:

To be honest, because I have been doing it for so long it’s, it’s more about the woman rather than the policies. I can’t even remember what the policies say about the [third stage], to be honest now I really can’t. I know it says it’s abnormal if it’s over a certain amount of time, ya know. It’s never come to that to be honest.

New Zealand midwife, June, when talking to Mania about physiological birth of the placenta, replied to Mania’s question about the length of time it can take for the placenta to be born physiologically with:

An hour is kind of the limit in the unit I’m in. After an hour they get a bit twitchy. I do actually get a little twitchy after half an hour. I do like to monitor quite closely as far as blood loss and things. Sometimes it can be a bit hidden.

Interestingly, both June and Jasmine admit women to the same hospital. However, Jasmine has been in practice for close to 10 years longer than June. In this case it is possible that experience affects how these midwives respond to tensions within the hospital birthing unit regarding the acceptable practice of birth of the placenta. Experience may also impact how comfortable a midwife is with her own practices and enables the establishment of a relationship with the hospital staff and a knowing of each other. It must be noted that one of the obligations of the New Zealand access agreement is that all available policies and procedures be evidence

based and consistent with national guidelines. The agreement also states that both parties must follow the Referral Guidelines and that care provided by the practitioner or facility must “incorporate the skills and standards of the relevant profession” (Ministry of Health, 2007c, p. 1107). I interpret this to mean that the safety of the woman is paramount but also that her informed choices should be respected. Hence, the tension felt by June about the time limit on birth of the placenta may be related to the institutional culture with regard to accepted practice and relationships with LMC midwives.

Jane, in New Zealand, when talking about her wishes regarding the option for birth of the placenta, explained that her first two placentas had been birthed naturally. However, when Midwife Cindy mentioned instances in which she would need to use Syntocinon® for birth of the placenta and that it could be put down the drip, Jane commented:

T, he’s my [first child], I was 36 weeks and so I had the drip and everything to be induced like that because my waters broke so they could have done that [given her the IV injection] wouldn’t they? They would have known [about her getting the injection]. Cindy replied: They would have. Jane came back: Without me even knowing? Cindy answered: Yeah, they would have done that.

In Jane’s first pregnancy, her midwife [not Cindy] would have consulted and transferred care because of Jane’s premature labour. Although physiological birth of the placenta would not have been wise in this situation and active management of birth of the placenta was necessary, Jane’s lack of knowledge about the fact that she would have had an IV injection of Syntocinon® possibly points to the accepted practice of active management without informing the woman.

In New Zealand and Ontario women appear to receive active management as a matter of routine when under the care of an obstetrician. However, tensions around birth of the placenta do not appear to happen with the Ontario midwives interviewed for this study. What is pointed out by midwives who contributed to this

research in both countries is that women's wishes are prioritized within midwifery and that there is active resistance to the hospital culture around birth of the placenta. The following section considers talk about protocols and practices around birth of the placenta in the narratives of the Ontario women and midwives who contributed to this study.

Midwife Erin, who works in a practice in a small town in Ontario, when asked about third stage policies in the hospital, replied:

"Mmm, good question. I am **sure** there is a policy of active management because I have never seen an obstetrician do physiological management so there must be a policy." To which I asked: "But does that influence your practice when you are in there?" Erin replied: "No" and gave a little laugh. Then, "I mean some things I know I will say to women. No, there is a hospital policy of dadadadadah but you still have a choice and I will still respect your choice."

Catherine confirms Erin's comments about the accepted practice of active management and a culture of lack of information when she talks about her previous pregnancies with an obstetrician:

...I don't ever remember this discussion about the placenta with either the family doctor or the OBs I had with some of my earlier births. So it was something sort of new to me when I came to midwives....

Tilly had just returned from maternity leave and joined this practice after practicing in another Ontario city for a couple of years. When asked whether there is a limit on the time given for physiological birth of the placenta, she said:

I'm a new midwife here. I've only been a midwife here since February 1, so I still need to know all the protocols in the hospital but I don't think there is any policy in active management that you have to do active management. That would just go against midwifery. I mean there's always hospital protocols. Whether we choose to follow hospital protocols is another thing 'cause we do informed choice. Like there are hospital protocols on vaginal birth after caesarean. We don't necessarily

follow them because we give informed choice, and we talk about what those are with our patients.

The culture of lack of informed choice regarding birth of the placenta, as mentioned by Catherine, was backed up by Midwife Ellie who, when asked about what influences her discussion with women, replied:

If I think back, if I go, if when women had OBs in hospital or family docs in hospital and I go to talk to women about, like say they are coming to me in their second pregnancy and they had an OB the first time around, and I go to talk about third stage they have no clue what happened in third stage. They're like, 'I got a shot really?' And I'm going, 'Yes, if you were in hospital you automatically did.'

Not only do Tilly's and Erin's comments show how the principle of informed choice strongly influences midwives' practices, ensuring women are able to make fully informed decisions, they also hint at the midwives' resistance to some practices that could restrict informed choice. Furthermore, Tilly's comment about being new to the area points to how location impacts her identity as a midwife because of her limited knowledge of the local scene. However, the assurance with which she replied about midwifery supporting informed choice shows a firm commitment to her identity as a midwife. The remarks of the four midwives illustrate as well how institutional culture, although not always spoken, is felt as an undercurrent, which makes the caseloading midwives feel like outsiders. It is not only institutional practices that can impact choice and decision-making but also more concrete actions, like professional projects of others that restrict midwives' practices in particular locations.

Politics of Location-Access and Choice

Professional projects can work to impede a professional's ability to provide care or can strengthen a profession. Policies around midwives' privileges in hospitals, which can often be seen as professional projects, are another factor that impact women's choices. Midwives in Ontario, like obstetricians, are granted admitting

privileges to a particular hospital. Like in New Zealand, here there is provincial by law in Ontario regarding admitting privileges. The Ontario Hospital Association/Ontario Medical Association Hospital Prototype Board Appointed Professional Staff By-law, 2011 is carried out according to the Public Hospital Act and amendments (Government of Ontario, 1990). The By-law outlines the application process, and, among other things, that the midwife, once she obtains privileges, must adhere to the by-laws and rules of the hospital. The application is accompanied by proof of registration and “good standing” with the COM and confirmation of practice insurance. The requirements include giving permission for the board to obtain a report from the appropriate regulatory authority if required. The Board of Directors after consultation with the Medical Advisory Committee (MAC) then meets to make a decision about the applicant; this can take up to 60 days or longer under certain conditions. Each applicant re-applies yearly. The rules for medical staff are the same. Practices regarding midwifery admitting privileges differ from hospital to hospital, with some areas delaying the approval of privileges for midwives (Association of Ontario Midwives, 2011a; Gordon, 2011; Tollinsky, 2012), while about 23 percent put a cap on the number of midwives with privileges and 11 percent cap the number of hospital births a midwifery practice can do in a year (Association of Ontario Midwives, 2011a). In these by-laws is also the provision (section 8) for the board after consultation with the MAC and Professional staff to draw up policies and regulations applicable to the professional staff, to decline privileges to a practitioner if there is no need for the service as determined by the board, if there are insufficient or if the appointment is not in line with the Mission or Strategic plan (Ontario Hospital Association & Ontario Medical Association, 2011).

Hospital capping of midwife numbers and midwife attended hospital births impacts access to midwifery services. During the conversation with Midwife Ellie and Gail, when talking about capping of admitting privileges and hospital births, Ellie talked of the impact the restrictions had on choosing women into the practice:

All clients are self-referred. Like, we do get referrals from other health practitioners but they don't get any special priority over others. We get so many phone calls a day looking for a midwife. If, generally, the only thing whether or not they get one is; one, how early they call in their pregnancy and two, where was their choice of birth place. And that is not whether we prefer or not. It is just that hospitals are capping either the number of births we can do there or capping the number of midwives that have privileges in the hospital.

When Ellie was asked how women came to their practice, she expanded on how they decide which women to accept. During the narrative she explained that when the practice was reaching capacity, they choose women who want homebirth because:

It is just that hospitals are capping either the number of births we can do there or capping the number of midwives that have privileges in the hospital. So we are only allowed to do in our practice X births a year. So we can do unlimited homebirths. But we have limited number of hospital births. So if a person calls up and says, "I want a homebirth," they're generally gonna get in unless we're full...

Ellie's practice is a well-known and established practice in the city. Not only does her talk refer to the number of women who ask for their service, but she also talks of barriers to choice and to midwives practicing in the hospital setting.

Limitation on practice caseloads and how it impacts selection of clients was also evident in other Ontario practices that participated in this study. While I was waiting to begin the antenatal interview with Midwife Tilley and her client Nancy, the receptionist informed a number of callers that they were on a waitlist for the month they were due. The practice receptionist also informed one caller that the practice takes women from only a certain geographical area of the city, a means of controlling the waitlist. Also, Mary, although from a practice that doesn't often have a waitlist, did say that they had criteria for choosing women. They were in an area that had good relations with the local hospital, which had a Chief Midwife, and there was no cap on the number of midwives with privileges or the number of

births the practice could have at the hospital. However, Mary's practice gives preference to women who want a homebirth because:

Then we look at choice of birth place. So as midwives we're the only people who offer homebirth. So you are not going to deny somebody who wants a homebirth over somebody who wants a hospital birth, because there is a practitioner who can take care of it, her. So we look at when they called, if they're a repeat, and where they're having their baby and prioritize based on that.

Midwife Erin talked about how her practice dealt with the waitlist. She said:

Unfortunately, we have to make a decision about which ones we take because we have such long waitlists so what we'll do is if someone's already had a baby low risk, then we'll take them for sure. So I mean things like if someone wants a homebirth because we are the only provider of homebirth we'll give that a priority. Certainly if, if somebody wants a VBAC [vaginal birth after caesarean] we'll give that extra, as long as it's straight forward and no complications so stuff like that yeah. And definitely repeat clients we take no matter what. That's how we get overbooked.

When Genie was asked about whether capping the number of midwives with privileges occurs with their Ontario practice, she indicated that it did and speculated on the reasons for capping:

In one of the two hospitals where we have privileges they have capped it, I think because there [are] a lot more midwives that have privileges than obstetricians. So, from some of the obstetricians there has been a concern that they, I think, feel a little threatened by that. So, they have tried to cap it, and the other hospital where we have privileges they are midwifery friendly. Not that they are not midwifery friendly here, but they are there [in the other hospital] like whatever, the more the merrier so why not.

Genie's and Ellie's comments demonstrate how activities of one professional group who have more power are put in place to maintain exclusivity, in this case in maternity care. Midwives hold less power because they are a smaller professional

group overall and they hold a less prestigious position in the medical community and likely the community at large.

Midwife Mary reported that capping of the number of midwives with privileges or the number of hospital births per practice was not the case in the hospital she practiced in but said:

I've heard rumours in [another town] but we have, our practice actually has one of the best relations with the hospital in Ontario. We have a chief of midwifery, not a head midwife, a chief of midwifery who sits on MAC [Medical Advisory Council], [who] has voting privileges. And then we attend, we have staff meetings. We've actually go[ne] that way. [Building relationships with the hospital staff through staff meetings, and having a midwife on the MAC]

Mary's comments indicate how the midwives in that particular community have gained voice by working within the system to achieve their goals. In this case the strategy to gain professional ground was to align themselves to a powerful group, the MAC, and to build relationships with the hospital. This means that women under this midwifery group's care may have choices that women elsewhere may not, such as lack of choice regarding hospital birth or the hospital of their choice if their midwife doesn't have admitting privileges. Genie's response, on the other hand, indicated how the dominant obstetric profession may have closed down opportunities for the midwives to practice by limiting the numbers with privileges. The control of admission privileges can be seen as a demonstration of how professions contest other professions that are in a similar area of practice (Adams, 2004), with open protest, political manoeuvring and/or, in this case, by making access difficult.

Further investigation in the local media and with the AOM supported both Genie's and Ellie's comments. The media reported that, in some areas, midwives often have delays in getting privileges (Tollinsky, 2012), and there is some suggestion that obstetricians may be influencing these delays (Gordon, 2011; Hospital Trying to Attract Midwives," 2012). This results in some women having to travel longer

distances to access a hospital where their midwife can practice (Gordon, 2011) or not being able to have a midwife (Rivers, 2012).

Workforce Issues - Decision-making and Place of Birth

The impact of workforce shortages on decision making around care, have been illustrated with Tilley's comment:

In some cases it is the midwifery practice's choice to do a TOC [transfer of care] for IOL [induction of labour] and epidural because... or because of the time commitment to doing an IOL, possibly days, which can be difficult in our model of care, with few people to relieve us.

Moreover, the capping of midwifery privileges in some hospitals in Ontario also has repercussions for employment opportunities for midwives, thus impeding the growth of midwifery and access to midwifery services in the region.

Although the demand for midwives is evident, Genie indicated that the cap on the number of midwives that are permitted in one particular hospital would restrict her practice from hiring additional midwives:

It's more about if our practice or the other practice in [the city] is looking to hire a new midwife to the practice. We need to know first if we can get privileges for her 'cause we can't hire her, promise her a job, and sign a contract and then not have her approved and not be able to do hospital births.

In the AOM survey 36% of the midwifery practices reported that this capping affected the growth of the practice. Hence, in a jurisdiction where a midwifery workforce shortage already results in women being unable to find a midwife, capping the number of midwives with access can lead to further workforce shortages. Capping and midwifery workforce shortages not only influence midwives' abilities to practice but limit opportunities for self-employed midwives and therefore choices in childbirth. As illustrated in the talk of the Ontario midwives and supported by the AOM 2011 survey, this varies from one location to another;

as a result, there is inequality in access to midwifery care and to public health facilities within the same province, a situation which potentially violates the Canada Health Act (Government of Canada, 1985) and has consequences for women when it comes to informed choice. Correspondence with the President of the AOM reveals that the Association is working with the government to address the problems associated with the integration of the midwives into the maternity system (L. Weston, personal communication, February 9, 2013).

Midwifery workforce shortages are found in both countries but are most noticeable in Ontario. Midwifery shortages in Ontario, coupled with the barriers placed on midwives' work within some of the hospitals, have a number of implications for decision-making by midwives and the care that women receive. Midwifery practices have to make decisions about which women to provide care to. The remarks of the midwives pointed to a number of criteria used to avoid overbooking, such as desire for homebirth, repeat client, intention to have a vaginal birth after caesarean section, and geographical location in the city. As a result, women's choices during their childbirth experience are impacted, firstly when they cannot get a midwife as they would wish and then by having limited choices during their childbirth experience. While the Ontario government has recently indicated they will provide employment for more midwives and schools of midwifery have increased their student numbers (CBC News, 2012b), continued work is needed to overcome individual hospital board practices around admitting privileges and capping of hospital birth numbers.

In New Zealand, although midwives are the predominant practitioners in maternity, there is a shortage of midwives, especially in rural areas (Midwifery and Maternity Providers Organisation Ltd, 2011; Torrie, Bailey, Benn, King, & Pipi, 2011). Because midwives have the freedom to choose where they practice rural areas often have midwife shortages (Torrie et al., 2011) as midwives often choose to go to urban areas and this impacts rural women's choice of midwife. A review of the New Zealand government careers website confirms that there are workforce shortages (Government of New Zealand/careersnz, 2013) and Immigration New Zealand has

midwifery on its long term skills shortage list (Government of New Zealand, 2013). Under capacity has resulted in midwifery care being offered by teams within the hospital, such as is the case in one of the hospital in the region of the New Zealand part of this study. In addition, it has resulted in midwives having to put boundaries around their caseload in order to avoid burnout. Boundary criteria include some of the things that Ontario midwives use, such as limiting caseloads, taking on return clients or multiparous women who have quicker labours and births, or handing over care in the early stage of an induction of labour (Engle, 2003; Young, 2011). Unlike in Ontario, these workforce issues are not influenced by limits put on midwives' practice by hospitals but simply by supply and demand. Like Ontario schools of midwifery, New Zealand schools have increased their student numbers and some District Health Boards have increased recruitment of midwives from outside the country in an attempt to address this issue. However, in both countries student numbers are ultimately limited by the number of practicing midwives who are prepared and available to act as preceptors. To address the issues for rural women and midwives in New Zealand, the government has funded the Rural Midwifery Recruitment Service collaboration between the Midwifery and Maternity Provider Organisation (MMPO) and the New Zealand College of Midwives (NZCOM) to run a rural recruitment and retention programme (Midwifery Recruitment and Retention, 2013).

Women in New Zealand who cannot access a midwife due to the workforce shortage have to adjust their initial wishes, and this also can mean that decision-making during the childbirth process is altered. For women in Ontario who desire a midwife and cannot access one, their expectations of choice and continuity change. Practices within the hospital system or of other practitioners have been highlighted previously with regard to choice and information. For women in Ontario who do not get their choice of caregiver, their care will be by their family doctor or an obstetrician, and there is some evidence that family doctors are leaving obstetrics in Ontario (Hutton, personal communication, May 2, 2012). This is supported by a report from CHSRF (Canadian Health Services Research Foundation/Fondation canadienne de la recherche sur les services de sante, 2006).

The comments of the midwives demonstrate how midwifery workforce issues in both countries, compounded by arbitrary professional projects and practices of hospitals in Ontario, impact decision-making. For midwives, it means they have criteria to assist them in prioritizing which women to provide care to when they are unable to meet all women's needs, as in Canada, while in New Zealand midwives make those decisions in order to avoid burnout (Young, 2011).

Place of Birth - Infrastructure, Regulation, and Decision-making

Decision-making is carried out in relation to factors both inside and outside the hospital or individual. These factors include the local configuration of maternity services, which can be determined by economics and political ideologies that are outside the control of the hospital. Included in these outside factors are regulatory requirements which are legislated for public safety but also the professional projects of health workers. How maternity services are structured and regulated is therefore a powerful influence on decision-making as they can increase or limit options for care, frame service provision decisions in subtle ways, and influence how that service is carried out.

In New Zealand, the Canterbury District Health Board funds four primary birthing units, whereas in the Wellington Region the Capital and Coast District Health Board funds two units with no primary birthing units being located within Wellington city. Consequently, most births occur within the secondary or tertiary maternity units in the region. In other regions, maternity services in small local birthing units are under threat, putting women's choices and health at risk (Guilliland, 2012). Guilliland (2012) attributes potential rationalisation of maternity services to government policy and lack of consultation with midwives. Other factors that come into play are the reassertion of medical dominance in health care provision under the current government resulting in service reorganisation and loss of focus on women's issues (Scott, 2012).

In Ontario, it was only in early 2012 that the provincial government indicated that it would provide funding for primary birthing units (Office of the Premier, 2012), with an expectation that the first pilot units could be open in mid-2013 (Association of Ontario Midwives, January 24, 2013, December 18, 2012 ; CBC News, 2012a). This means that, until such time as a primary birthing unit is established, women under midwifery care either birth at home or in the secondary or tertiary hospital in their area. This may not seem, on the surface, a major obstacle to choice; however, research has shown that intervention rates are higher in the hospital setting as compared to a primary setting, such as a home (Davis et al., 2011; Hutton et al., 2009; Johnson & Daviss, 2005; Miller, 2008b) or in primary midwifery led birthing units (Davis et al., 2011; Hartem, Sandall, Devane, Soltani, & Gates, 2004; Walsh & Downe, 2004). Moreover, narratives, in the previous chapter and in a previous section, from the Canadian participants who had had care from doctors in their past pregnancies indicate that, with regard to management of birth of the placenta, active management was routine when care was provided by a doctor and nurse.

The limited options for place of birth indirectly influence decision-making around not only birth of the placenta but other care, such as whether anaesthetic and pain management are used. Older studies (Rogers et al., 1998) indicate that, for example, an epidural would be contraindicated for physiological birth of the placenta, while Stojanovic (2011) would suggest that any intervention would be a contraindication because it interrupts the physiological process of labour and birth. Miller, in her 2008 mixed method study with midwives in New Zealand, found that a midwife's practice may differ depending on whether she is in a hospital or home setting, even when caring for a similar, low risk woman population. Women were more likely to have pharmacological pain relief, experience more interventions during their labour, and have active management of third stage, when they were in the hospital. The midwives in Miller's focus groups indicated that they felt more relaxed and were able to establish a better interaction with women in the home setting. The explanations for this may be that the midwife and woman are visitors within the hospital setting and do not fit within or identify with that organisational culture.

It can be seen here that government and local hospital board decisions about how to structure the maternity health system can directly influence decision-making for midwives and women and birth outcomes. Regulatory frameworks can have the same influence. Within the midwifery professions in Ontario and New Zealand, requirements by the regulatory bodies (CMO, MCNZ) impact woman's choices as well as informal choices midwives make about their practice preference. Ontario midwives, as a part of their initial and ongoing registration, are expected to have a certain number of homebirths per year (College of Midwives of Ontario, 2007; Multi-jurisdictional Midwifery Bridging Project, 2009). Combined with the demand for midwives outstripping supply, the College of Midwives of Ontario requirement means that midwifery practices in Ontario have an overall homebirth rate of 20 to 25% (Hutton et al., 2009; Ontario Hospital Association et al., 2010a). The requirement for a minimum number of homebirths to maintain professional registration ensures that women who wish to have a homebirth can have one and can feel confident that their care provider is experienced, and it also ensures midwives have a strong normal birth philosophy. However, as discussed, selection criteria can impact some women's choices of caregiver by excluding some women from midwifery care when midwifery practices have to prioritize care provision.

In New Zealand, the number of homebirths is not specified by the regulatory authority, and since around 80% of women have a midwife as their LMC (Ministry of Health, 2012d), the homebirth rate in the country, at approximately 7% (Home Birth Aotearoa, 2012), reflects the choices of the female population. In this environment midwives can choose the type of practice they will offer, homebirth, hospital birth, or both. There are some midwifery groups that practice only hospital births while others only homebirth and yet other groups that will do both home and hospital births. This could restrict decision-making for some women as some options may not be offered by a particular practice with rural and indigenous women being most likely to experience a lack of choice in childbirth.

This section has demonstrated how governmental practices, through infrastructure projects and regulatory frameworks can influence how midwives provide care and the influences these can have on choices and decision-making. Government decisions on how to structure maternity care and regulatory decisions on competency expectations of the profession highlight how wider factors influence care decisions and birth experience. The decisions by government are in relation to political ideology and economic factors, while those made by the regulatory authorities are in response to contextual factors of the location like expectations of the female population.

Conclusion

This chapter has reviewed the complexity of the wider socio-political influences on decision-making of women and midwives, by exploring the context of midwifery and practice in both countries. The women and midwives' talk, as well as popular and professional documentation, identified how place and the politics of location impact choice and decision-making in addition to those created through relationships. For example, guidelines and policies, some of which are implemented differently in different institutions in the same jurisdiction, and professional cultures, which may block choices that go against what is accepted in that work environment or interventions carried out as routine without informing women, impact decision-making for the woman and midwife. Moreover, decision-making and choices are impacted because of institutional cultures, the status of caseloading midwives, and the positioning of women as visitors within the hospital environment. Midwifery workforce issues, compounded by limitations on midwives' practice in Ontario, restrict midwives' ability to provide care to all women who request their services and thus limit women's choice of caregiver. It has been illustrated in this chapter that decision-making is carried out in relation to factors outside the woman-midwife relationship. However, as has been illustrated by some midwife participants in the study, building relationships with other professionals can help to make incremental changes. The following chapter draws

together this thesis, presents a relational decision-making model, and discusses the limitations of the study and implications for practice.

Chapter 7: Conclusion

Introduction

This final chapter ties together the different aspects of this thesis, methodological development, research methods, and the analysis of decision-making in the woman-midwife relationship. The thesis has outlined an emerging relational research methodology, and presented a relational model of decision-making. In this chapter I reflect on the main argument of this thesis in relation to methodology, decision-making and the research journey itself.

Weaving together the concepts of embeddedness, relationality, participation, and partnership, with key research principles, the thesis demonstrates an emerging relational methodology for midwives. Using the concepts of identity, positioning, place, and embeddedness, plus ideas of power/knowledge in the analysis, the thesis illustrates that decision-making in the woman/family-midwife dyad is relational in nature, influenced by relationships and the social, political, and economic location in which they are embedded. The chapter concludes with an exploration of the relevance of this study for midwifery practice and research, with limitations and suggestions for further study also being considered.

Developing a Relational Methodology

The methodology that developed for this research came from my identity as a midwife, midwifery educator, and a peer reviewer, and from my understandings of the woman/family-midwife relationship. Most importantly, the methodology came from the challenges of the research journey itself and from consulting with and listening to midwives and women and their support people, both before and during the collection of participants' contributions. In keeping with a relational methodology, participants' voices are used to demonstrate the findings and the main argument of this study that decision-making in the woman/family-midwife

dyad is relational in nature, influenced by relationships and the social, political, and economic location in which they are embedded. Using participant's voices also enables readers to identify with the stories and place themselves within the research. The thematic approach to analysis of the participants' talk as a whole, and in part has allowed a flexible and focused way of listening to the women and midwives. The theoretical framework for analysis used concepts of identity, positioning, embeddedness, relationality, the politics of location, and Foucault's ideas of power relationships.

In the analysis, Somers' (1992, 1994) ideas of personal and public identity being created relationally through narrative, and Frank's (2005) notions of identity also being created in dialogue, allows the exploration of identity in participants' talk. The ideas of Phibbs (2008) and Plummer (1995), that personal identities are constructed from the available public narratives, enables the exploration of how choice is undertaken and the contextual influences on those choices and subsequently decision-making. An analysis that incorporates historical, socio-political, and locational aspects of the research enables the complexity of the relational aspects of research and decision-making to be traced. Linking ideas about context with Harré's theory's on positioning and Foucault's discussions of discourse, power, and resistance allows the researcher to explore the complexity of relations that impact on human action. This methodology acknowledges the embeddedness of researchers, women, their families, and midwives in social networks and wider socio-political contexts which play an important part in our understanding of the research process as well as the women/family-midwife relationship.

A Relational Methodology

This study has put forth the argument that a relational methodology is fitting for midwifery research and realistically reflects the research journey undertaken and the position of the researcher in the midwifery community. The evolving methodology presented here also has relevance for other caring professions where relationships develop over time. The methodological framework embraces

principles and theoretical concepts that acknowledge the complexity of research with people in situations where inter-personal connections are important. The methodology incorporates four key principles including partnership, protection, participation, and communication and twelve explanatory concepts within those four key principles. The explanatory or supporting concepts include; equity, biography, continuity, and relational autonomy; safety, ethics, and trust; negotiation, empowerment and flexibility, and consultation and consent. The methodology incorporates the fifth key principle of participant centeredness in which the researcher is a co-participant and it recognises that the research relationship is a partnership in which all participants have knowledge important to the research and responsibilities within that research project. In order to achieve partnership, equity and continuity are necessary and involves ensuring participation and protection of participants. Achieving a research partnership of this kind requires the facilitation of good communication at all stages, including the dissemination of the findings. Protection involves following not only traditional ethical research principles but also relational ethical principles which recognise the importance of the human relationship and all that it entails. Communication is about not only the skills but includes confirming consent for continued participation when research conditions change, confirming of findings with participants at all stages and being responsive to participants' talk. These and the other supporting concepts such as equity, flexibility, biography and safety have been demonstrated in the research design and the execution of the research methods.

This research required acknowledgement of the embeddedness of people in a complex social and contextual network that influenced the research design. The research incorporated relational techniques of consultation, the use of social networks, and relationship building to construct the eventual design, recruit participants, and carry out the study. Throughout the study, relational techniques of reflective conversations and discussions with the women/partners and midwives were undertaken to collect data. Analysis used methods that explored the relational aspects of the participants' talk. Throughout, emerging themes were confirmed with participants and followed up as interviews progressed. Post data

collection undertakings continued to involve participants to the extent they wished, offering opportunities to provide feedback on the findings and the research process.

Relational themes such as identity, philosophies, and positioning, as well as wider contextual issues with regards to midwives' and women's decision-making, are explored through the participants' conversations, and supported by exploration of relevant literature and other documentation. The central argument of the thesis that decision-making is embedded in relationships and context has been developed by incorporating key theoretical as well as midwifery concepts in the analysis.

Using social theories as well as theory from midwifery, this thesis has argued that research is a relationship which is embedded in the social, political, and locational/spatial context in which it takes place. The contention that humans are enmeshed in a complexity of relational networks (Callon, 1999; Granovetter, 1985) that influence our actions has been demonstrated, both in the methodology and in the findings of this research. The neoliberal idea of the autonomous decision-maker has been shown to be flawed, at least in this setting. In New Zealand, I was identified and identified myself as a midwife and educator. It was from that location that my interest in the research was undertaken and that I positioned myself in Ontario, Canada. Research that encourages participation and in which members work together and collaborate in a partnership, realizes the human need for relationships but also acknowledges the influence of wider contextual issues. Within a social constructionist and participatory epistemology (Heron, 1996; Heron & Reason, 1997), all are participating, including the researcher.

This thesis has demonstrated the embeddedness and relationality of research through how decisions about the study design were influenced by the contexts in which the research took place, necessitating flexibility, reconsideration, and adaptation. The contextual and relationship issues were important in recruiting midwives, and thus women, into the study. Methods employed in recruitment, using social networks and introducing myself to midwives in Ontario, mirror the

relational nature of midwifery. Acknowledging that research is a relationship draws attention to principles within this methodology. The process of the research journey documented in this thesis, in many ways reflects the process of decision-making in the woman/family-midwife relationship in that decision-making is not an individualistic undertaking where the researcher stands apart and remains objective, but is a shared journey where the researcher and participants are embedded in a wide social network, where decision-making is relational and participants and researcher co-construct the narratives.

Developing a Model of Relational Decision-Making

The aim of this research was to explore influences upon decision-making in the woman-midwife dyad in New Zealand and Ontario and identify an effective model for decision-making within midwifery practice. This outcome of this study proposes a model that reflects the complexity of decision-making for women and midwives. Decision-making in the woman/family-midwife partnership has been found to be relational in nature, influenced by social networks and the social, cultural, historical, political, and economic context/location in which they are embedded.

Relationships and Decision-making

Chapter Five highlights the influence of identity projects and personal relationship influences on decision-making for the woman/family-midwife partnership. The identity the women and midwives had of themselves and each other was identified in the decision-making discussions and the conversations. Women's childbearing identity was impacted by past experience, such as a positive empowering pregnancy and childbirth experience, an experience that did not meet their expectations, or from the childbirth experiences of others. Women chose midwives in New Zealand or midwifery in Ontario because they wanted a midwife whose practice would fit with their beliefs around childbirth and their identity of themselves as birthing women. The women found, through social networks, the type of midwife, who matched their desires for care in childbirth.

The women's choice of midwife, or midwifery itself, was strongly influenced by relationships as women sought midwifery care that met their expectations. These relational aspects were in the form of: personal networks of friends, family, and acquaintances helping women find a midwife; the desire for a meaningful relationship with the caregiver; cultural beliefs that influenced some women's choice of midwife; and wider considerations about the care of the placenta. The women identified the midwife or midwives who provide a particular type of care through social networks, which intersect with the midwives' client networks. The midwives are identified in the networks as a particular type of midwife.

The desire for a meaningful relationship was particularly strong for women in Ontario as a number indicated the importance of knowing who was to be there when you have a baby. In New Zealand, cultural fit was important for women, for one woman this was because her mother was involved in her care and she needed a midwife who spoke her language. Cultural considerations were also important for women in New Zealand because of the cultural significance of the placenta, particularly to women with Māori connections.

The importance of relationships was highlighted for women whose decision-making was impacted by unplanned events during their labour and birth. In these circumstances the woman's and her partner's decision-making was affected by their vulnerability, which necessitated a trust in their midwife and the health professionals involved in their care. The trust in the midwife was based on a developed relationship, in addition to accepting her particular knowledge and experience. The women also trusted that the midwife would provide care that met the woman's wishes for her birth and would also ensure safety.

Choosing a midwife in Ontario and a particular midwife in New Zealand affected how discussions were undertaken. Women in Ontario chose midwifery because they identified midwives as giving choice; as a result, the discussion with the midwife, about birth of the placenta, was detailed. Midwives discussed how each method for the birth of the placenta was undertaken. Only one midwife used

language that showed any sign of preference, although for two midwives active management was the preferred method of birth of the placenta because of the woman's past birth history. The New Zealand women chose a midwife who they knew was a "natural midwife", so discussions concentrated around the natural or physiological birth of the placenta. Active management was discussed in New Zealand in contrast to physiological birth of the placenta and to point out situations when active management would be recommended. Past birth experience was one factor considered during the decision-making for the birth of the placenta in both Ontario and New Zealand. The women's decision to choose a midwife and subsequent decision-making were also influenced by wider contextual issues from global to local, highlighting the similarities and differences in relation to how women find their midwife and why women choose midwives between the two locations and within the two places.

Decision-making in Context

Chapter Six, in keeping with Sherwin's (1998) broad concept of relational autonomy and making more explicit the locational aspects of context, showed how decisions are made in relation to circumstances greater than the woman/family-midwife relationship. Literature from professional institutions such as the Association of Ontario Midwives and hospital boards, from research databases and from the local press confirmed issues raised by the women and midwives. The most notable contextual issue highlighting the locational differences was the availability of midwives, and thus the percentage of women who have a midwife providing their care in each country. While around 80% percent of women in New Zealand have a midwife as their lead care provider (Ministry of Health, 2012d), in Ontario it is the minority of women (10%) who have midwifery care, with approximately 35% of women who wished for midwifery care not being able to access it (Ontario Hospital Association et al., 2010a; Rivers, 2012). The talk of the women and midwives in Ontario indicated that midwives were the only maternity practitioner who offered women choices around birth of the placenta as well as place of birth. The midwifery regulatory authority in Ontario has guidelines regarding consultation and other statements which outline the midwives' scope and range of practice capabilities

which are supported by the Hospital Association. However, some institutions block midwives from working within their full capabilities, and thus they reduce women's choices and impact decision-making. In some hospitals, the woman's choice of caregiver is affected by the delaying or limiting of admitting privileges to hospitals or by limiting the number of births a midwifery practice can attend in the hospital. There is the suggestion from the talk of the midwives that the professional projects of the obstetric practitioners may be underlying some of these barriers. However, what is also highlighted is how building inter-professional relationships has opened up opportunities for some midwives in relation to practicing within their capabilities. In addition it has been demonstrated how professional projects such as competencies and requirements of practice can impact decisions midwives make. Government economic decisions about funding of maternity services also impact decision-making as options for place of birth are impacted either by primary units being closed or, alternatively, being opened.

A Model of Relational Decision-Making

Decision-making in the woman-midwife relationship involves a multitude of factors within and outside the woman/family-midwife relationship, as illustrated in Figure 7.1. These factors begin with the woman and her family's beliefs about childbirth and the woman's identity in relation to childbearing. These beliefs and identities are constructed, shaped, and reshaped through the available discourses and over time and location. The woman's choice of midwife is not only influenced by these discourses and her own identity but by relational networks consisting of friends, families, and acquaintances, networks which sometimes intersect with those of the midwife. The impression the woman has of the midwife was gained from these networks and through the identity the midwife and midwifery has within the community. The choice of midwife during pregnancy is consistent with the woman's idea of self; she chooses a midwife that meets her expectations. The midwife's choices in decision-making are influenced by her identity as a professional and

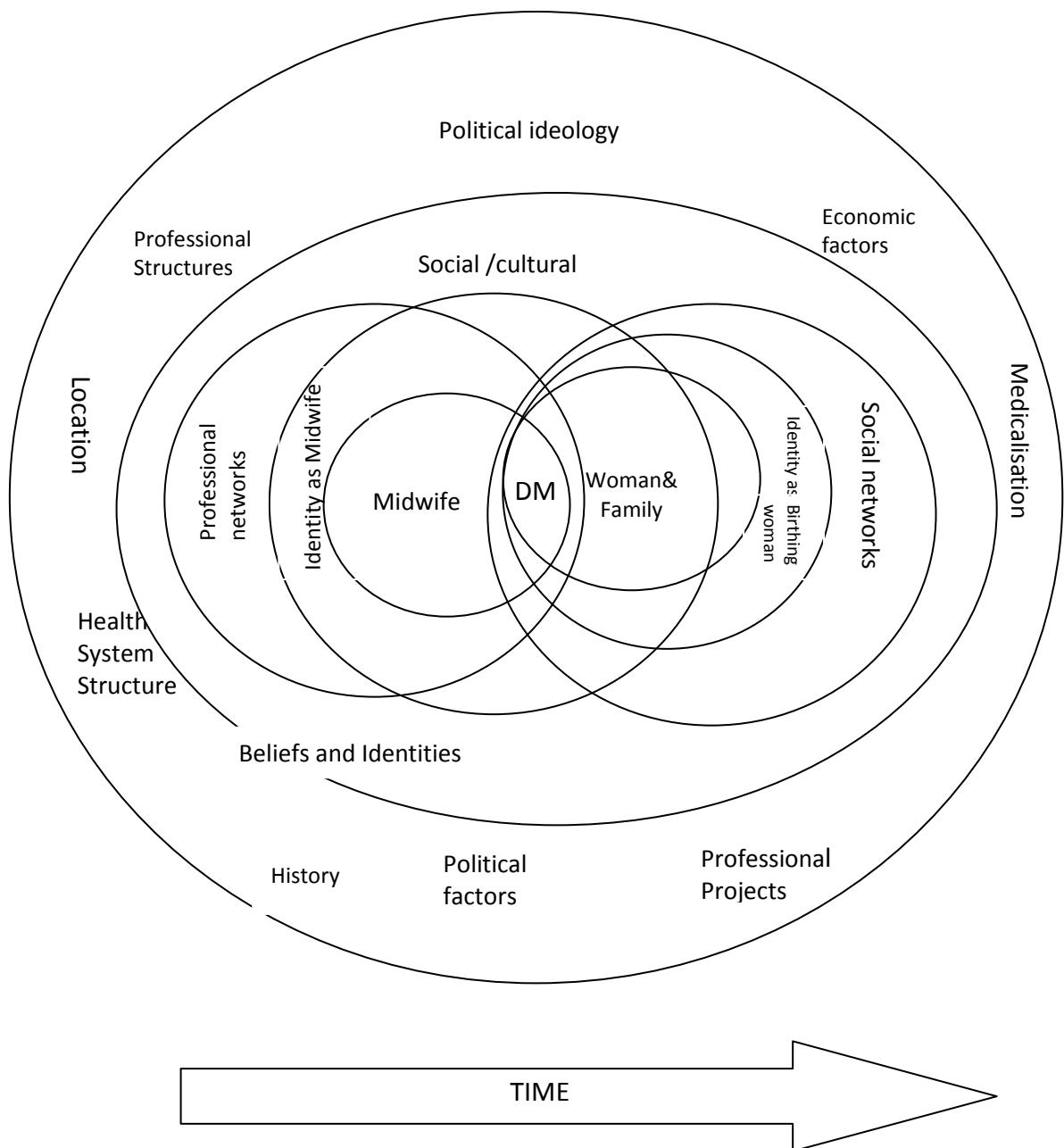


Figure 7.1: Relational Decision-Making (DM)

professionalization projects such as registration requirements, which are in turn influenced by government regulations, provincial and national expectations and regulations, international midwifery, and WHO expectations. However, most importantly, those choices in decision-making are driven by what women expect of the midwife. For some, that expectation may be that of a “natural midwife”, for

others the expectation may focus on choice and continuity. This initial choice of midwife and midwifery practice philosophy then directs how discussions are undertaken. Moreover, influences on decision-making between woman and midwife are not confined to these relationships.

Structural influences are hidden when midwives can choose the type of practice they offer, such as homebirth only or hospital birth only or urban or rural, such is the case in New Zealand, where the majority of women have a midwife. In Ontario, where the minority of women can access a midwife, structural barriers are highlighted with choice and continuity being identified by women and midwives as being very important. However, those same structural influences which give women choice may also restrict choice by limiting the midwifery workforce, putting barriers in place for access and/or constraining the midwife's ability to practice to her full capabilities. Practices that support institutional culture that offer choices that fit with what is deemed (medically) acceptable, and, on a broader level, governmental policy and economics that limit primary birthing venues may also restrict choices in childbirth. For example in Ontario that has a Liberal Government, with a centre-left ideology, primary birthing units are being opened. Meanwhile, in New Zealand, which currently has a conservative government, midwives and communities are expressing concern about centralisation of some maternity services (Guilliland, 2012) and there is no support to open new primary birthing units despite research indicating that birthing outcomes are better when low risk women birth in a primary unit or at home (Davis, et al 2011).

A relational decision-making model opens up the possibility for wider contextual factors that influence choices in childbirth to be considered. Within midwifery, a relational decision-making model moves away from decontextualised decision-making to consideration of the ways in which participants are embedded in a web of relations from the personal to the global (Granovetter, 1985; Callon, 1999; Sherwin, 1998, 2004). Relational decision-making also acknowledges the constraints on choice such as available options and policies and guidelines that may impact on

choice and thus decision-making. This model recognizes the complex influences at play.

The ongoing relationship between women/family and midwife adds a dimension of time which enables decisions to be to be considered, discussed with others, and altered, and contingencies to be put in place. A decision-making model that is relational opens up the consideration of how to enable clients to make decisions rather than concentrating on whether they ought to make decisions (Secker, 1999). A relational decision-making model adds time and identity to Gadow's (1990) idea of existential advocacy. Decision making is more than information giving and negotiation, it also involves self determination.

Research Limitations

The best-laid schemes o' mice an' men
Gang aft agley"
An' lea'e us nought but grief an' pain
For promis'd joy. (Burns, 1785)

The strength of this research and research methodology comes from a plan gone awry but which developed into a flexible, context relevant research methodology when I adapted to the situation and followed the participants' lead. The aim of qualitative research is to explore the everyday conditions of life in depth, to provide readers and practitioners with a deeper knowledge of life around them, rather than with breadth of knowledge (Cluett & Bluff, 2006; Flick, 2002). However, the findings do not necessarily apply to those outside the research participants. The voices in this research are contextual and specific to each participant, yet others may recognize the talk, narratives and situations as similar to their own.

As befits a relational methodology, the midwives self-selected to participate in this study after an invitation and came out of the social networks in which I was embedded. The method of participant selection, while demonstrating the embeddedness and relationality within the research, can mean that those who did not practice both methods of third stage or who did not offer the options would not

accept my invitation to participate. One midwife who declined the invitation to participate said she did not offer physiological management, while another indicated that all women chose active management despite her offering both options. I may also be assumed that midwives/women who felt their relationship did not work would also not participate. For this reason, the findings may not reflect what happens in all woman-midwife relationships.

The fact that the midwives chose the women participants in the study may have also introduced bias into the study. Asking women participants to invite their midwives to participate may address this issue. In addition although involving the woman and midwife together enables more thoughtful discussion, it may constrain both the woman and midwife during the process as they may feel they must please each other and maintain an image. An opportunity outside the woman-midwife interview may enable participants to express any concerns by means such as a journal or email correspondence.

This decision-making model has highlighted the socio-political context of decision making through focusing on situations that were relevant for the women and midwives involved in this research. However, although this study was carried out in two countries, there was involvement of only a small number of participants of non-European origin. An exploration of this topic with aboriginal people may well find additional contextual issues that impact decision-making.

No other health professionals' voices were heard in this study, which may cause some to question whether there is a balanced perspective. This study was focused on decision-making in the woman-midwife dyad. Time limitations and scope of the study prevented this issue being addressed.

Audio-recording a conversation is not a natural occurrence, It can take time for participants to be comfortable to talk while being recorded. Therefore the decision-making conversations may not be an accurate reflection of what would

normally occur between woman and midwife (even if the researcher is not present). In one instance, when beginning to talk with the woman, the midwife commented:

So we're gonna talk about third stage. Um, there are two ways to manage the third stage, one is physiological management and one is active management, and we're pretending you haven't heard this from your other pregnancies, cause I know you know it. I'm gonna go through this like you don't know this.

Although the decision-making discussions, between midwife and woman were very similar from midwife to midwife in both countries, we must appreciate the possible implications of midwife Mary's comments as well as that is that the research interviews are somewhat contrived and do not necessarily capture naturally occurring talk.

Use of the Methodology

Comments from women and midwives, who contributed to this research from which the relational methodology developed, suggest that it is safe and respectful of participants and reflective of midwifery; its continued use and development in midwifery research is therefore recommended. The principles and concepts in this relational methodology have application in the wider research community as it acknowledges the broader influences on research undertaken. Specifically, it would be appropriate to use this methodology in fields such as family health/general practice, social work, counselling services, or any field where relationships develop over time. Because this methodology has principles that are inclusive, flexible, and context dependent, and has been tested in two countries, it has the potential to be used across a variety of locations and with a variety of cultural groups.

Implications and Future Work

This study enables an understanding of the complexity of influences on decision-making in the woman/family-midwife relationship to be developed adding to the

knowledge base of midwifery. It confirms and extends feminist arguments about the relational aspects of autonomy. This knowledge further describes the relationship between women and midwives and reinforces Kenney's (2009) suggestion of the need to make the women's family and other contextual factors evident, not only in midwifery models of care like the Midwifery Partnership Model (Guilliland & Pairman, 1995), but also within professional documentation and practices. The deeper understanding of the influences on women's choice and thus the impact on decision-making enables health providers to facilitate informed decision-making.

The relational methodology developed during this study, involving woman/family and researcher, has a potential for use in other areas apart from research. The principles of the methodological model apply across all relationships that involve health care and continuity. This methodological model as presented in Chapter Four also has potential to be used as a model for practice in health care. The principles of person centredness, participation, partnership, protection, communication and the other concepts included in the model are all important components of a caring relationship. The model also recognises the embeddedness of those involved in the relationship in the socio-political contexts in which they are located.

Actively supporting choice means respecting women and their autonomy (Douché, 2007), and recognizing that it is relational (Sherwin, 1998). As demonstrated in this study, some women choose midwifery care because of unsatisfactory past experiences with another health provider and because of the public narrative about midwifery care as being more personalised. Studies have shown midwifery care has benefits for both mother and baby, such as reduced interventions, increased vaginal birth rates and reduced hospital stay (Harten, Sandall, Devane, Soltani, & Gates, 2008; Janssen et al., 2002; Page et al., 2001) and, by reducing interventions such as caesarean section, it is cost effective (Association of Ontario Midwives, 2007; Cameron, 2005; Canadian Health Services Research Foundation/Fondation canadienne de la recherche sur les services de sante, 2006; Douché & Carryer, 2011). In a health service which is experiencing a crisis in maternity care, both in

New Zealand and Canada but particularly in the Canadian north (Canadian Health Services Research Foundation/Fondation canadienne de la recherche sur les services de sante, 2006), the continued support, at all governmental levels, for midwifery is necessary, not only to provide a cost effective service but to ensure a woman/family/community-centred service.

Within Ontario, the continued collaboration of midwives, midwifery organisations, other health professionals, and health authorities is recommended, to ensure that women's needs are met with regard to access to midwives and to the midwife of choice during all aspects of care. It also necessitates hospital boards working with midwives and midwifery organisations to: ensure midwives are provided with the structures to ensure they can practice within their full capabilities, are provided privileges in a timely fashion, appoint Chiefs of midwifery so midwives are represented on hospital advisory boards so that integration can be facilitated and thus women's choices respected with regard to care provider and place of birth. The midwifery-tool-kit (Ontario Hospital Association et al., 2010a; Ontario Hospital Association, College of Midwives of Ontario, & Association of Ontario Midwives, 2010b) is a good tool to assist hospitals and midwives to facilitate the integration of midwifery into their service.

Within New Zealand and Ontario, work to address midwifery workforce shortages needs to continue with forward planning, education, recruitment and retention, and other measures of increasing midwife numbers so that women can continue to have choice of health professional. This requires that federal as well as provincial and territorial governments work with National and Jurisdictional midwifery Associations, and health boards.

Further Research

Because this study did not include the voices of other professionals working in maternity, a study involving women and their health care provider, other than midwives, could highlight other influences on choice and decision-making. It would also give voice to those not included in this study, both health professionals and women.

The methodology's principles of participant centredness, partnership, participation, protection and communication with the underlying explanatory concepts and its contextually driven flexibility make it a methodology and a method of analysis that has potential with Indigenous and other cultural groups. A study, using this methodology, with indigenous and other cultural groups could identify other influences on decision-making and give voice to those groups not included in this research.

Contribution to methodological literature

Methodology presents a way of "us(ing) your ways of thinking to gain more knowledge about your reality" (Wilson, 2001, p. 175). Within the qualitative literature in recent years there has been a proliferation of methodologies that embrace a relational philosophy (Denzin & Lincoln, 2011) as researchers attempt to engage with humanity and make research relevant to their context. The evolving relational methodology developed during this study adds to that engagement. The basis of the methodology is participant centredness and its key principles and underlying explanatory concepts provide a guide for methods design that is context driven and thus responsive to both participants and researcher.

This methodology may be considered a variation of a participatory methodology and adds to feminist methodologies as it has resonance within a women centred profession.

Concluding Remarks

This thesis has woven together a number of epistemological paradigms, theoretical concepts, and philosophical beliefs and has presented a new understanding of decision-making within midwifery. Decision-making in the woman/family-midwife partnership has been found to be relational in nature, influenced by social networks and the social, cultural, historical, political, and economic context/location in which they are embedded. In doing so, it has offered an evolving relational methodology that acknowledges the embeddedness of researcher and participants in the broad contextual environment which influences decision-making within the research relationship. Not only does the developing methodology add to midwifery theory and knowledge, but it outlines a methodological framework that has potential for use in areas of health care in which relationships develop over time.

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Appendices

Appendix 1

Draft response (138) (Ethical considerations to carry out research in Canada)

Page 1 of 2

Noseworthy, Ann

From: DeGroot, Therese [Therese.DeGroot@pre.ethics.gc.ca]
Sent: Thursday, 5 March 2009 6:59 a.m.
To: Noseworthy, Ann
Cc: Z-SecretariatRE
Subject: Ethical considerations to carry out research in Canada (138-2009-TDG)

Dear Ms Noseworthy,

I am following up on your email below which was forwarded to the Secretariat on Research Ethics by CIHR.

I am responding on behalf of the Interagency Secretariat on Research Ethics to your question below.

You are registered as a student at Massey University in New Zealand, not a recipient of any award from any of the three Canadian granting agencies, CIHR, NSERC or SSHRC, and not affiliated with a Canadian university eligible to administer federal granting agencies' funds. This presumes that you are undertaking your research under the auspices of your institution in New Zealand and we understand that you have received approval from the research ethics committee at your institution in conformity with the requirements for ethics review in New Zealand.

You ask what the research ethics requirements are to undertake research in Canada. Based on the information above, the following points should be considered and are referenced to the appropriate articles in the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS):

1. The policy of Massey University is the lead policy given that your institution is responsible for the research you will undertake, wherever this will take place (TCPS, article 1.14).
2. There is no centralized body in Canada that reviews research to be conducted by a researcher from abroad in Canada. Access to research sites and research participants is to be determined on a case-by-case basis and will depend on the entity a researcher is seeking access from (TCPS, article 1.14).
3. Access to a research site and its members is subject to approval from the body responsible for the site or the data, which may or may not require submitting a proposal to an REB if such exists in that site (TCPS Article 1.14). In some cases, such entity does not exist.
4. We understand that your research will involve interviews with midwives, some of which may be of Aboriginal ancestry. We suggest that you consult Chapter 6 of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans available at www.pre.ethics.gc.ca which addresses research involving Aboriginal Peoples. An additional resource for research involving Aboriginal Peoples is the CIHR policy which is available at the following address: <http://www.cihr-irsc.gc.ca/c/29134.html>
5. Given that a questionnaire will be used, it presumes that the consent process will address all necessary ethics questions that might arise (TCPS, Articles 3.1 and 3.2, subject to the use of personal interviews or standardized interview questionnaires).
6. There may be other applicable laws and policies that need to be considered beyond the TCPS.

You may consult the following interpretation response discussing US/CANADA clinical trials research ethics requirements available on our website:
<http://pre.ethics.gc.ca/english/policyinitiatives/interpretations/interpretation004.cfm>.

Please do not hesitate to contact me if you have additional questions.

Thérèse De Groot

Analyste principale des politiques/Senior Policy Analyst
Secretariat on Research Ethics/Secrétariat en éthique de la recherche

5/03/2009

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From: Noseworthy, Ann [mailto:D.A.Noseworthy@massey.ac.nz]
Sent: Tuesday, February 03, 2009 5:29 PM
To: INFO
Subject: Information

Hello

Although I am not interested in a Grant or Award I am trying to find out information regarding ethical considerations to carry out research in Canada.

I am doing my PhD in Midwifery at Massey University in New Zealand and have received ethical approval from Massey University human Ethics committee. Part of my research I hope to carry out with about 7-8 Midwives and women in the Greater Vancouver region.

I have been trying to get some information about ethical requirements to do this and any considerations required should first nations women or midwives be involved. So far my enquiries have not been successful.

I would appreciate if you could direct this email to someone who could be of assistance in answering these queries.

Please find attached a copy of my Massey University Human Ethics committee and the letter confirming approval.

Ann Noseworthy

Massey University

School of Health and Social Services

Bachelor of Midwifery Programme coordinator

Private Box 756

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New Zealand

04 801 5799 ext 6873

5/03/2009

Appendix 2



Massey University

27 January 2009

Ms Ann Noseworthy
School of Health and Social Services
WELLINGTON

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Dear Ann

Re: HEC: Southern A Application – 08/58
Decision making during pregnancy and childbirth: A New Zealand and Canadian comparative study

Thank you for your letter dated 8 January 2009.

On behalf of the Massey University Human Ethics Committee: Southern A, I am pleased to advise you that the ethics of your application are now approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor John O'Neill, Chair
Massey University Human Ethics Committee: Southern A

cc A/Prof Cheryl Benn & Dr Susanne Phibbs
School of Health and Social Services
PN351

Prof Carol McVeigh, HoS
School of Health and Social Services
WELLINGTON

Massey University Human Ethics Committee
Accredited by the Health Research Council



Appendix 3

Date, 2009

Dear Midwives

My name is Ann Noseworthy and I am a PhD (Midwifery) candidate and midwifery lecturer at Massey University School of Health and Social Services. I am undertaking research that involves an exploration of the decision making during the childbearing year using the birth of the placenta/whenua as the vehicle.

The aim of the research is to gain an understanding of the decision making that takes place during the childbearing year and specifically for the birth of the placenta/whenua and what influences that decision. The purpose of this project is to understand effective decision making between women and midwives.

I am extending an invitation for one or two of you in the practice to participate in the study. If you wish to do so I also ask that each midwife invites one woman/client to participate as well.

Enclosed please find a number of information sheets for the midwife and woman. If there are any questions please contact me via the details below.

Thank you for your support.

Ann Noseworthy

Massey University

School of Health and Social

Services

04 801 5799 x 6873 D.A.Noseworthy@massey.ac.nz

Appendix 4



Decision making during pregnancy and childbirth: a New Zealand and Canadian comparative study.

Information Sheet Woman

My name is Ann Noseworthy and I am a PhD (Midwifery) candidate and midwifery lecturer at Massey University School of Health and Social Services. I am undertaking research that involves an exploration of the decision making during the childbearing year and I am using how the placenta will be born as the decision that is made.

The aim of the research is to gain an understanding of the decision making that takes place during the childbearing year. The purpose of this project is to understand effective decision making between women and midwives.

I am extending an invitation for your LMC midwife and you to participate in the study. Should you and your midwife wish to take part in this study you will be invited to participate in up to three audio tape recorded sessions along with your chosen midwife. Each session will take place in a location that is convenient for you and your midwife and will be less than one hour long.

The first session will involve audio recording the discussion between you and your midwife regarding the decision making for the birth of the placenta/whenua. This will be followed by an opportunity for a three way conversation involving me, the researcher, this session would only be around 20-30 minutes longer than your appointment. The second session will involve a three way discussion after the birth of your baby to discuss the actual birth of the placenta/whenua. If there is a third session it will occur at the time of discharge from your midwife's care and will involve discussions about the whole process including the research process.

As part of this research participants will be asked to keep a diary, which I will provide, in which they can record any thoughts or feelings related to the decision making for the birth of the placenta. The diary will be read only by me the

researcher. I would also like copies of any printed material you have used in making your decision.

Audio taped sessions will be transcribed by me or a transcriber and you will be offered the opportunity to review your contribution to the conversations as recorded in the transcripts. For audit purposes following your review of the transcripts, the audio tapes will be securely stored, with your permission for a minimum of 5 years from the end of the study. Participant diaries will be returned to the participants following the research. All tapes, diaries, transcripts and other sensitive material will be stored in a locked drawer in a locked office.

At the end of the study each participant will be sent a summary of the research findings.

- Your confidentiality will be respected at all times, in order to maintain your confidentiality your name will not be included in any publication or presentation nor will your region/city of abode or the DHB district be identified.

Please note your confidentiality can only be guaranteed to the extent allowed by law.

- If you agree to participate you may withdraw from the study at any time.
- You can participate in discussions as you feel comfortable and
- You can ask for the audio tape to be turned off at any time.

It is not envisioned that you will suffer distress or find this project distressing in any way, however if issues regarding the childbirth experience should arise I can direct you to the appropriate agency.

In the event of an adverse outcome you will be given the option to withdraw. Should the outcome become the subject of an enquiry the data and recordings may be requested for use in any proceedings.

If there are any questions please contact me or my supervisors

Researcher

Ann Noseworthy

Massey University

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Dr. Cheryl Benn

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This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern Region A application 08/58. If you have any concerns about the conduct of this research, please contact: Professor John O'Neill, Chair, Massey University Human Ethics Committee: Southern Region A, telephone - 06 350 5799 x 8771 e-mail humanethicsoutha@massey.ac.nz



Massey University
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
Te Kura Pūkenga Tangata

Decision making during pregnancy and childbirth: a New Zealand and Canadian comparative study.

Information Sheet Midwife

My name is Ann Noseworthy and I am a PhD (Midwifery) candidate and midwifery lecturer at Massey University School of Health and Social Services. I am undertaking research that involves an exploration of the decision making during the childbearing year using the birth of the placenta/whenua as the vehicle.

I am extending an invitation for you and a client* to participate in the study. I include information sheets for you to pass on to a client. Should the client decline participation please pass on an information sheet to another client who may wish to participate.

Should you and your client wish to take part in this study you will be invited to participate in three audio tape recorded sessions. Each session will take place in a location and at a time that is convenient for you and your client and will be approximately one hour long.

The first session will involve recording the discussion between you and your client only regarding the birth of the placenta/whenua. This will be followed by a three way conversation involving me the researcher. The second session will involve a three way discussion after the birth of the baby to discuss the actual birth of the placenta/whenua. The third session, around the time of discharge, will involve discussions about the whole process including the research process.

As part of this research participants will be asked to keep a diary, which I will provide, in which they can record any thoughts or feelings related to the decision making for the birth of the placenta. The diary will be read only by me the

researcher. I would also like copies of any printed material you have used in your discussion with the woman.

The aim of the research is to gain an understanding of the decision making process that takes place during the childbearing year and what influences those decisions. The purpose of the project is to understand effective decision making between women and midwives.

Audio taped sessions will be transcribed by me or a transcriber and you will be asked to review your contribution to discussions as recorded in the transcripts. For audit purposes, following your review of the transcripts, the audio tapes will be securely stored, with your permission for a minimum of 5 years from the end of the study. Participant diaries will be returned to the participants following the research. All tapes, diaries, transcripts and other sensitive material will be stored in a locked drawer in a locked office.

At the end of the study each participant will be sent a summary of the research findings.

- Your confidentiality will be maintained at all times, in order to maintain your confidentiality your name will not be included in any publication or presentation nor will your region/city of abode or the DHB district be identified.

Please note your confidentiality can only be guaranteed to the extent allowed by law.

- If you agree to participate you may withdraw from the study at any time.
- you can participate in discussions as you feel comfortable and
- you can ask for the audio tape to be turned off at any time.
-

It is not envisioned that you will suffer distress or find this project distressing in any way, however if issues regarding the childbirth experience should arise I can direct you to the appropriate agency.

Professional responsibility means that if practice safety issues arise regarding any of the midwives, I need to inform the midwife of any concerns and that I may have to report my concerns (Health Practitioners Competence Assurance Act 2003; Health Professions Act, 1996 (BC)). In the event of an adverse outcome you will be given the option to withdraw. Should the outcome become the subject of an enquiry the data and recordings may be requested for use in any proceedings.

* Client includes the woman plus usual support person(s)

If there are any questions please contact me or my supervisors

Researcher

Ann Noseworthy

Massey University

School of Health and Social

Services

04 801 5799 x 6873

D.A.Noseworthy@massey.ac.nz

Supervisor

Dr. Cheryl Benn

Massey University

School of Health and Social

Services

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Dr. Suzanne Phibbs

Massey University

School of Health and Social Services

06 356 9099 x 2319

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern Region A application 08/58. If you have any concerns about the conduct of this research, please contact: Professor John O'Neill, Chair, Massey University Human Ethics Committee: Southern Region A, telephone -06 350 5799 x 8771 e-mail humanethicsoutha@massey.ac.nz

Appendix 6

Decision making during pregnancy and childbirth a New Zealand and Canadian comparative study.

Take part in exploring decision making during pregnancy and developing a midwifery model of decision making?

I am doing my PHD (Midwifery) at Massey University and am exploring the decision making process between the woman and her midwife during pregnancy. The study will involve women and their LMC midwife in a series of three audio taped sessions discussing the decision making about the preferred and actual birth method of the placenta/whenua.

I would like to invite you to be a part of the study, please contact me

Ann Noseworthy
Massey University
School of Health and Social Services
Midwifery Programme
04 801 5799 x 6873
027 358 8092
D.A.Noseworthy@massey.ac.nz



Massey University
WELLINGTON

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Wellington 6140
New Zealand
T 64 4 801 5799
F 64 4 801 2692
www.massey.ac.nz

June 15, 2009

Massey University Human Ethics Committee

Southern A

Dear Committee Members

Re: HEC: Southern A Application - 08/58

Decision making during pregnancy and childbirth: A New Zealand and Canadian comparative study.

Since ethical approval from the committee, my attempts at participant recruitment have not been successful and I have had to reconsider aspects of my prospective participant pool. In light of this I propose and seek approval from the ethics committee for the following changes.

- Participants are able to be drawn from the region in which I live and work.

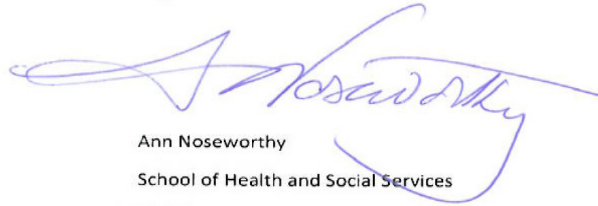
To avoid the possible conflict with my role as a Midwifery Standards reviewer in that region I will ensure that:

- I do not involve any midwife in the study whom I have reviewed in the past year or who I am scheduled to review during the rest of this year.
- That I will decline to be a Midwifery Standards reviewer for those midwives involved in this research project for a period of 5 years.
 - *To facilitate the above during the five years I will review only DHB midwives and those I had reviewed in 2008 and 2009 as neither of these groups are included in my participant pool.*

The amended information sheet is attached for your information, with changes indicated in italics.

I look forward to your reply in relation to these proposed changes.

Regards



Ann Noseworthy

School of Health and Social Services

Wellington

Encl: Amended information sheet Midwife

Amended cover letter

Appendix 8



Massey University

19 June 2009

Ms Ann Noseworthy
School of Health and Social Services
WELLINGTON

OFFICE OF THE ASSISTANT
TO THE VICE-CHANCELLOR
(RESEARCH ETHICS)
Private Bag 11 222
Palmerston North 4442
New Zealand
T 64 6 350 5573
64 6 350 5575
F 64 6 350 5622
humanethics@massey.ac.nz
animaethics@massey.ac.nz
gtc@massey.ac.nz
www.massey.ac.nz

Dear Ann

Re: HEC: Southern A Application – 08/58
Decision making during pregnancy and childbirth: A New Zealand and Canadian comparative study

Thank you for your letter dated 15 June 2009 outlining the changes you wish to make to the above application.

The changes made, to increase the participant pool, have been approved and noted.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee. If over time, more than one request to change the application is received, the Chair may request a new application.

Yours sincerely

Professor Julie Boddy, Chair
Massey University Human Ethics Committee: Southern A

cc A/Prof Cheryl Benn & Dr Susanne Phibbs
School of Health and Social Services
PN351

Prof Warwick Slinn, Acting HoS
School of Health and Social Services
PN351

Massey University Human Ethics Committee
Accredited by the Health Research Council





Decision making during pregnancy and childbirth: a New Zealand and Canadian comparative study.

Information Sheet Midwife

My name is Ann Noseworthy and I am a PhD (Midwifery) candidate and midwifery lecturer at Massey University School of Health and Social Services. I am undertaking research that involves an exploration of the decision making during the childbearing year using the birth of the placenta/whenua as the decision to be made.

I am extending an invitation for you and a client* to participate in the study. I include information sheets for you to pass on to a client. Should the client decline participation please pass on an information sheet to another client who may wish to participate.

Should you and your client wish to take part in this study you will be invited to participate in two audio tape recorded sessions. Each session will take place in a location and at a time that is convenient for you and your client and should be less than one hour long.

The first session will involve recording the discussion between you and your client only regarding the birth of the placenta/whenua. This will be followed by a three way conversation involving me the researcher. The second session will involve a three way discussion after the birth of the baby to discuss the actual birth of the placenta/whenua and the decision made.

The aim of the research is to gain an understanding of the decision making process that takes place during the childbearing year and what influences those decisions. The purpose of the project is to understand effective decision making between women and midwives.

Audio taped sessions will be transcribed by me or a transcriber and you will be asked to review your contribution to discussions as recorded in the transcripts. For

audit purposes, following your review of the transcripts, the audio tapes will be securely stored, with your permission for a minimum of 5 years from the end of the study. Participant diaries will be returned to the participants following the research. All tapes, diaries, transcripts and other sensitive material will be stored in a locked drawer in a locked office.

At the end of the study each participant will be sent a summary of the research findings.

- Your confidentiality will be maintained at all times, in order to maintain your confidentiality your name will not be included in any publication or presentation nor will your region/city of abode or the DHB district be identified.

Please note your confidentiality can only be guaranteed to the extent allowed by law.

- If you agree to participate you may withdraw from the study at any time.
- You can participate in discussions as you feel comfortable and
- You can ask for the audio tape to be turned off at any time.

Please also note to avoid the possible conflict with my role as a Midwifery Standards reviewer in this region I will ensure that:

- I do not involve any midwife in the study whom I have reviewed in the past year or who I am scheduled to review for the rest of this year.
- That I will decline to be a reviewer for those midwives involved in this research project for a period of 5 years.
 - To facilitate the above during the five years I will review only DHB midwives and those I had reviewed in 2008 and 2009 as neither of these groups are included in my participant pool.

It is not envisioned that you will suffer distress or find this project distressing in any way, however if issues regarding the childbirth experience should arise I can direct you to the appropriate agency.

Professional responsibility means that if practice safety issues arise regarding any of the midwives, I need to inform the midwife of any concerns and that I may have to report my concerns (Health Practitioners Competence Assurance Act 2003; Health Professions Act, 1996 (BC)). In the event of an adverse outcome you will be given

the option to withdraw. Should the outcome become the subject of an enquiry the data and recordings may be requested for use in any proceedings.

* Client includes the woman plus usual support person(s).

If there are any questions please contact me or my supervisors

Researcher

Ann Noseworthy

Massey University

School of Health and Social

Services

04 801 5799 x 6873

D.A.Noseworthy@massey.ac.nz

Supervisor

Dr. Cheryl Benn

Massey University

School of Health and Social

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06 356-9099 x 2543

C.A.Benn@massey.ac.nz

Dr. Suzanne Phibbs

Massey University

School of Health and Social Services

06 356 9099 x 2319

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern Region A application 08/58. If you have any concerns about the conduct of this research, please contact: Professor John O'Neill, Chair, Massey University Human Ethics Committee: Southern Region A, telephone -06 350 5799 x 8771 e-mail humanethicsoutha@massey.ac.nz



Decision making during pregnancy and childbirth: a New Zealand and Canadian comparative study.

Information Sheet Woman

My name is Ann Noseworthy and I am a PhD (Midwifery) candidate and midwifery lecturer at Massey University School of Health and Social Services. I am undertaking research that involves an exploration of the decision making during the childbearing year and I am using the decision about how the placenta will be born as the focus for decision making.

The aim of the research is to gain an understanding of the decision making that takes place during the childbearing year. The purpose of this project is to understand effective decision making between women and midwives.

I am extending an invitation for your LMC midwife and you to participate in the study. Should you and your midwife wish to take part in this study you will be invited to participate in up to two audio tape recorded sessions along with your chosen midwife. Each session will take place in a location that is convenient for you and your midwife and will be less than one hour long.

The first session will involve audio recording the discussion between you and your midwife regarding the decision for the birth of the placenta/whenua. This will be followed by an opportunity for a three way conversation involving me, the researcher. This session would only be around 20-30 minutes longer than your normal appointment. The second session will involve a three way discussion after

the birth of your baby to discuss what actually happened regarding the birth of the placenta/whenua.

The audio taped sessions will be transcribed by me or a transcriber and you will be offered the opportunity to review your contribution to the conversations as recorded in the transcripts. For audit purposes following your review of the transcripts, the audio tapes will be securely stored, with your permission for a minimum of 5 years from the end of the study. All tapes, transcripts and other sensitive material will be stored in a locked drawer in a locked office.

At the end of the study each participant will be sent a summary of the research findings.

- Your confidentiality will be respected at all times. In order to maintain your confidentiality your name will not be included in any publication or presentation nor will your region/city of abode or the DHB district be identified.

Please note your confidentiality can only be guaranteed to the extent allowed by law.

- If you agree to participate you may withdraw from the study at any time.
- You can participate in discussions as you feel comfortable and
- You can ask for the audiotape to be turned off at any time.

It is not envisioned that you will suffer distress or find this project distressing in any way, however if issues regarding the childbirth experience should arise I can direct you to the appropriate agency.

In the event of an adverse outcome you will be given the option to withdraw from the study. Should the outcome become the subject of an enquiry the data and recordings may be requested for use in any proceedings.

If there are any questions please contact me or my supervisors

Researcher

Ann Noseworthy
Massey University
School of Health and Social
Services

04 801 5799 x 6873

D.A.Noseworthy@massey.ac.nz

Supervisor

Dr. Cheryl Benn
Massey University
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06 356-9099 x 2543

C.A.Benn@massey.ac.nz

Dr. Suzanne Phibbs
Massey University

School of Health and Social Services

06 356 9099 x 2319

S.R.Phibbs@massey.ac.nz

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Appendix 11

May 20, 2010

Massey University Human Ethics Committee
Southern A

Dear Committee Members

Re: HEC: Southern A Application - 08/58

Decision making during pregnancy and childbirth: A New Zealand and Canadian comparative study.

Since ethical approval from the committee, circumstances surrounding the aspect of the study in Canada have changed. In light of this and to ensure adequate data for completion of my PhD I am requesting approval for an increase in participant numbers in New Zealand to a **minimum of 8**. In addition as I am returning to the East Coast of Canada to live, the area of recruitment in Canada will also now need to change. I am requesting approval to change the area I will be recruiting from Vancouver to **any province in Canada where midwifery is legislated**. This will enable me to recruit midwives from a province near where I will be living and/or where I have networks.

I look forward to your reply in relation to these proposed changes.

Regards

Ann Noseworthy
School of Health and Social Services
Wellington

Appendix 12



MASSEY UNIVERSITY

14 June 2010

Ms Ann Noseworthy
School of Health and Social Services
WELLINGTON

Dear Ann

Re: HEC: Southern A Application – 08/58
Decision making during pregnancy and childbirth: A New Zealand and Canadian comparative study

Thank you for your letter dated 21 May 2010 outlining the changes you wish to make to the above application.

The changes have been approved and noted, as follows:

- Increase in participant numbers in New Zealand to a minimum of 8;
- Recruitment in any province in Canada where midwifery is legislated.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee. If over time, more than one request to change the application is received, the Chair may request a new application.

Yours sincerely

Professor Julie Boddy, Chair
Massey University Human Ethics Committee: Southern A

cc A/Prof Cheryl Benn & Dr Susanne Phibbs
School of Health and Social Services
PN351

Prof Steve LaGrow, HoS
School of Health and Social Services
PN351

Te Kunenga
ki Pūrehuroa

Massey University Human Ethics Committee
Accredited by the Health Research Council
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E humanethics@massey.ac.nz animalethics@massey.ac.nz gtc@massey.ac.nz
www.massey.ac.nz

Appendix 13



March 24, 2011

Dear Midwives

My name is Ann Noseworthy and I am a PhD (Midwifery) candidate at Massey University School of Health and Social Services in New Zealand. I am undertaking research that involves an exploration of the decision making during the childbearing year using the birth of the placenta/whenua as the vehicle.

The aim of the research is to gain an understanding of the decision making that takes place during the childbearing year and specifically for the birth of the placenta/whenua and what influences that decision. The purpose of this project is to understand effective decision making between women and midwives.

I am extending an invitation for one or two of you in the practice to participate in the study. If you wish to do so I also ask that each midwife invites one woman/client to participate as well.

Enclosed please find a number of information sheets for the midwife and woman. If there are any questions please contact me via the details below.

Please note I have recently returned home to Newfoundland to live.

Thank you for your support.

Ann Noseworthy

Massey University

School of Health and Social

Services

709 739 7963

ann.noseworthy@gmail.com



Massey University

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Te Kura Pūkenga Tangata

Decision making during pregnancy and childbirth: a New Zealand and Canadian comparative study.

Information Sheet Midwife

My name is Ann Noseworthy and I am a PhD (Midwifery) candidate at Massey University School of Health and Social Services, New Zealand. I am undertaking research that involves an exploration of the decision making during the childbearing year using the birth of the placenta/whenua as the decision to be made.

I am extending an invitation for you and a client* to participate in the study. I include information sheets for you to pass on to a client. Should the client decline participation please pass on an information sheet to another client who may wish to participate.

Should you and your client wish to take part in this study you will be invited to participate in two audio tape recorded sessions. Each session will take place in a location and at a time that is convenient for you and your client and should be less than one hour long.

The first session will involve recording the discussion between you and your client only regarding the birth of the placenta/whenua. This will be followed by a three way conversation involving me the researcher. The second session will involve a three way discussion after the birth of the baby to discuss the actual birth of the placenta/whenua and the decision made.

The aim of the research is to gain an understanding of the decision making process that takes place during the childbearing year and what influences those decisions. The purpose of the project is to understand effective decision making between women and midwives.

Audio taped sessions will be transcribed by me or a transcriber and you will be asked to review your contribution to discussions as recorded in the transcripts. For audit purposes, following your review of the transcripts, the audio tapes will be

securely stored, with your permission for a minimum of 5 years from the end of the study. Participant diaries will be returned to the participants following the research. All tapes, diaries, transcripts and other sensitive material will be stored in a locked drawer in a locked office.

At the end of the study each participant will be sent a summary of the research findings.

- Your confidentiality will be maintained at all times, in order to maintain your confidentiality your name will not be included in any publication or presentation nor will your region/city of abode or the DHB district be identified.

Please note your confidentiality can only be guaranteed to the extent allowed by law.

- If you agree to participate you may withdraw from the study at any time.
- You can participate in discussions as you feel comfortable and
- You can ask for the audio tape to be turned off at any time.

It is not envisioned that you will suffer distress or find this project distressing in any way, however if issues regarding the childbirth experience should arise I can direct you to the appropriate agency.

Professional responsibility means that if practice safety issues arise regarding any of the midwives, I need to inform the midwife of any concerns and that I may have to report my concerns (Health Practitioners Competence Assurance Act 2003; Regulated Health Professions Act, 1991). In the event of an adverse outcome you will be given the option to withdraw. Should the outcome become the subject of an enquiry the data and recordings may be requested for use in any proceedings.

* Client includes the woman plus usual support person(s).

If there are any questions please contact me or my supervisors

Researcher

Ann Noseworthy

Massey University

School of Health and Social
Services

Supervisor

Dr. Cheryl Benn

Massey University

School of Health and Social
Services

709 739 7963

ann.noseworthy@gmail.com

64 6 356-9099 x 2543

C.A.Benn@massey.ac.nz

Dr. Suzanne Phibbs

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64 6 356 9099 x 2319

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Dr. Shirley Solberg

Memorial University

School of Nursing

709 777 7493

ssolberg@mun.ca

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Massey University

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Te Kura Pūkenga Tangata

Decision making during pregnancy and childbirth: a New Zealand and Canadian comparative study.

Information Sheet Woman

My name is Ann Noseworthy and I am a PhD (Midwifery) candidate at Massey University School of Health and Social Services, New Zealand. I am undertaking research that involves an exploration of the decision making during the childbearing year and I am using the decision about how the placenta will be born as the focus for decision making.

The aim of the research is to gain an understanding of the decision making that takes place during the childbearing year. The purpose of this project is to understand effective decision making between women and midwives.

I am extending an invitation for your LMC midwife and you to participate in the study. Should you and your midwife wish to take part in this study you will be invited to participate in up to two audio tape recorded sessions along with your chosen midwife. Each session will take place in a location that is convenient for you and your midwife and will be less than one hour long.

The first session will involve audio recording the discussion between you and your midwife regarding the decision for the birth of the placenta/whenua. This will be followed by an opportunity for a three way conversation involving me, the researcher. This session would only be around 20-30 minutes longer than your normal appointment. The second session will involve a three way discussion after the birth of your baby to discuss what actually happened regarding the birth of the placenta/whenua.

The audio taped sessions will be transcribed by me or a transcriber and you will be offered the opportunity to review your contribution to the conversations as recorded in the transcripts. For audit purposes following your review of the transcripts, the audio tapes will be securely stored, with your permission for a

minimum of 5 years from the end of the study. All tapes, transcripts and other sensitive material will be stored in a locked drawer in a locked office.

At the end of the study each participant will be sent a summary of the research findings.

- Your confidentiality will be respected at all times. In order to maintain your confidentiality your name will not be included in any publication or presentation nor will your region/city of abode or the health district be identified.

Please note your confidentiality can only be guaranteed to the extent allowed by law.

- If you agree to participate you may withdraw from the study at any time.
- You can participate in discussions as you feel comfortable and
- You can ask for the audiotape to be turned off at any time.

It is not envisioned that you will suffer distress or find this project distressing in any way, however if issues regarding the childbirth experience should arise I can direct you to the appropriate agency.

In the event of an adverse outcome you will be given the option to withdraw from the study. Should the outcome become the subject of an enquiry the data and recordings may be requested for use in any proceedings.

If there are any questions please contact me or my supervisors

Researcher

Ann Noseworthy

Massey University

School of Health and Social

Services

Canada 709 739-7963

ann.noseworthy@gmail.com

Supervisors

Dr. Cheryl Benn

Massey University

School of Health and Social

Services, NZ

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Dr. Suzanne Phibbs

Massey University

Dr. Shirley Solberg

Memorial University

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School of Nursing

St John's, Newfoundland

709 777 7493

ssolberg@mun.ca

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern Region A application 08/58. If you have any concerns about the conduct of this research, please contact: Professor John O'Neill, Chair, Massey University Human Ethics Committee: Southern Region A, telephone –NZ 06 350 5799 x 8771 e-mail humanethicsoutha@massey.ac.nz

Appendix 14

Ann Noseworthy <ann.noseworthy@gmail.com>

1/19/1

1

to admin

Hello,

I don't know if you are the right contact but I am sure you can assist. I have now returned home to St John's after a number of years living and working in New Zealand. I am in the midst of doing research for my PhD (from Massey University NZ) and after completing the NZ part of my research I am now wanting to carry out similar research with Canadian Midwives. Because I have family in Toronto I have chosen that city to recruit.

I am looking for 4-5 midwives and one client each to participate in two "interviews". For logistic reasons I am wishing for the women to be due around the same time and once I clarify things around work here I will have a better idea of when that would be.

I would like to circulate an information sheet on my research including a call for midwives in the Toronto area to participate.

Thank you

Association of Ontario Midwives <reception@aom.on.ca>

1/19/1

1

to me

Hello Ann,

Thank you for contacting the Association of Ontario Midwives.

You would actually need to contact the midwifery practices directly. For a full list of midwifery practices in Toronto, please visit the "Find a Midwife" section of our website (www.aom.on.ca).

Melanie Kurzfield-Bryan

Reception

Association of Ontario Midwives

365 Bloor St. E., Ste. 301

Toronto, ON

M4W 3L4

Telephone: [416-425-9974](tel:416-425-9974)

Fax: [416-425-6905](tel:416-425-6905)

admin@aom.on.ca

www.aom.on.ca

Appendix 15



My name is Ann Noseworthy. I was born in St John's Newfoundland and did all my schooling in Newfoundland. I did my Nursing degree at Memorial University of Newfoundland and after working for a couple of years in various places in Canada I went to Edinburgh Scotland in 1989 and did my Midwifery. I worked in England from 1991 to 1993 and for the last 18 years I worked in New Zealand both in midwifery practice, as a core (hospital) and well as a case-loading midwife and in Midwifery Education. I completed my Masters degree in Midwifery and commenced my PhD while living in New Zealand. I have recently returned home to Newfoundland to be near family.

Throughout my career in Midwifery I have been involved in all aspects from practice to involvement in the professional organisation. My interest in this research has come from my experience both in practice and with students. I am interested in involving Canadian women and midwives because midwifery practice is similar in Canada and New Zealand but there are also differences. It is this I am interested in.

I am a member of CAM through the Association of Midwives of Newfoundland and Labrador.

I would like to extend an invitation for you to participate in my research and be a part of developing midwifery knowledge.

Thank you

Ann



Massey University
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
Te Kura Pūkenga Tangata

Decision making during pregnancy and childbirth a New Zealand and Canadian comparative study.

Consent form Woman

This consent form will be held for a period of five (5) years.

I have read the information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction and I understand that I may ask further questions at any time.

I agree/ do not agree to participate in the audio taped decision making discussion with my midwife.

I agree/ do not agree to participate in the audio taped conversations between myself, my midwife and the researcher

I agree not to disclose anything discussed in the sessions.

I agree to participate in this study under the conditions set out in the information Sheet.

Signature: _____ Date: _____

Full name – printed: _____



Massey University

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Te Kura Pūkenga Tangata

Decision making during pregnancy and childbirth a New Zealand and Canadian comparative study.

Consent Form Support Person

This consent form will be held for a period of five (5) years.

I have read the information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction and I understand that I may ask further questions at any time.

I agree/ do not agree to participate in the audio taped decision making discussion with my midwife.

I agree/ do not agree to participate in the audio taped conversations between myself, my midwife and the researcher

I agree not to disclose anything discussed in the sessions.

I agree to participate in this study under the conditions set out in the information Sheet.

Signature: _____ Date: _____

Full name – printed: _____



Massey University

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
Te Kura Pūkenga Tangata

Decision making during pregnancy and childbirth a New Zealand and Canadian comparative study.

Consent Form – Midwife

This consent form will be held for a period of five (5) years.

I have read the information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction and I understand that I may ask further questions at any time.

I agree/ do not agree to participate in the audio taped decision making discussion with the woman.

I agree/ do not agree to participate in the audio taped conversations between the woman, myself and the researcher

I agree not to disclose anything discussed in the sessions.

I agree to participate in this study under the conditions set out in the information Sheet.

Signature: _____ Date: _____

Full name – printed: _____

Appendix 17

symbol	name	Meaning
[]	Square bracket	Overlapping talk
=	Equal sign	No discernible interval between turns (also used to show that the same person continues speaking across an intervening line displaying overlapping talk.
>	Greater than sign	“Jump started” talk with loud onset
(0.5)	Time in parentheses	Intervals within or between talk (tenths of a second)
(.)	Period in parentheses	Pause of gap too short to measure.
.	period	Closing intonation
,	comma	Slightly upward “continuing “ intonation
?	Question mark	Rising intonation, question
¿	inverted question mark	Rising intonation weaker than indicated by question mark
!	exclamation	Animated tone
-	dash	Abrupt cut off of sound
:	colon	Extension of preceeding sound, the more colons the greater the extension
↑↓	Up or down arrow	Rise or fall in intonation immediately following the arrow
<u>underlining</u>	underlining	Emphasized relative to surrounding talk
HERE	Upper case	Louder relative to surrounding talk
°soft°	Degree sign	Softer than
>speed<		Speeded up or compressed relative to surrounding talk

<slow>		Slower or elongated relative to surrounding talk
hhh		Audible out breath (the number of h's indicates length)
.hhh		Audible in breath
(h)		Audible aspiration in speech
Hah/heh/hih/hoh/huh		All variants of laughter
()	Empty parentheses	Transcriber unable to hear word
(word)	Word in single parentheses	Transcriber uncertain of hearing

Source: (Kitzinger, 2007; Kitzinger 2008)

Appendix 18

May 7, 2012

Hello All

I want to thank you again for participating in my PhD study looking at decision-making between women and midwives. I hope you have found your involvement interesting and a good learning experience.

I have now completed my study and am in the final few months of writing up; I am looking forward to completing.

To keep you up with what I learned and to make sure you agree with what I have found, following is a summary of the research project and main themes or findings.

I would really appreciate feedback on the findings and any feedback on the research process itself as it ensure your contribution was respected, that the research process was respectful and will help me for future research.

In total 8 midwives and women participated in New Zealand and in Canada 6 women and 11 midwives (in Canada I was able to speak to midwives who were at the birth).

All women came to the midwife having an understanding of what midwives or the particular midwife did. For the most part women in New Zealand picked a midwife whose philosophy coincided with what the women wanted for their birth. So they picked a particular type of midwife. The midwives in the study also had a philosophy and way of practice which guided how they discussed the decision regarding birth of the placenta. For this group of midwives and women they predominantly wanted a midwife who practiced as a "natural midwife". They did discuss both methods for birthing the placenta, however the midwives generally knew which way the woman was leaning and for this group of women and midwives it was toward physiological birth of the placenta. Most of the midwives asked at the beginning of the discussion but they also knew the woman's beliefs around birth. So really they choose each other and fit together well.

In Canada women choose midwives because midwives provide choice and continuity, the women get to know the midwife who will be with them in labour

which was important. Developing a relationship was important. So women identify midwives as providing choice and continuity. The midwives saw themselves as the only provider who offered women choice. So one of the ways they identify themselves is as providers who offer choice. The Regulatory body and the Association of midwives in the province hold choice and continuity as two of the principles of the profession. The discussion about birth of the placenta was generally very detailed about both methods. Women still wanted natural birth or as close to natural a birth as possible with three women choosing active management based on their previous history and the advice of the midwife.

A number of the women in Canada had unsatisfactory previous birth experiences with another practitioner and that was another of the reasons for choosing a midwife for subsequent care. However part of this was also related to choice. Past experience also had a positive influence; an unplanned birth at home, the previous birth experience that went well, the experience with the midwife previously. These factors influenced the choice for birth of the placenta.

Family and friends played a very important role in finding the midwife and finding out about her practice. In both countries women were referred to the midwife, or to midwives in Canada, by a friend, acquaintance or family member, three of the women had had the midwife before. And these social networks shared information about midwives with the women. So word of mouth was very important.

When women's labours and births became more complex especially for the women who ended up with caesarean sections in both countries, the main theme was that that vulnerability limited choice however the women trusted the health professionals to make the right choice. This was especially if the midwife recommended some action or for instance if there was a change in plan for birth of the placenta. In one instance when the woman ended up with an emergency caesarean section the midwife's presence provided comfort.

I am calling the model of decision making Relational Decision-making.

Although relationships and building a relationship with the midwife is important in choosing the midwife and indirectly making the decision about how the placenta will be born, I also found other things influence the decision making or should I say choice.

In Canada there are an insufficient number of midwives to meet the demand, so many women do not have the choice of care giver and so do not have choice in the management of birth of the placenta, or other choice such as place of birth. In some places individual hospital policy may limit the scope of the midwives practice and thus women's choices, for instance if a woman is induced or has an epidural. Some hospitals may limit the number of midwives who can practice in the hospital or the number of births the midwife practice can carry out in the hospital. Some midwife practices would then, when they have a wait list, choose those women who were planning a home birth because as one midwife said no other provider will give that choice.

For many women in NZ birth of the placenta also includes care of the placenta after birth as it has cultural significance. This does not seem to be the case in Canada however when asked one midwife did say she asked women after the birth if they would like to keep it.

Again thank you for your participation.

Ann Noseworthy

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