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**LEAD MATERNITY CARER MIDWIVES'
CONSTRUCTION OF NORMAL BIRTH:
A QUALITATIVE STUDY**

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A thesis presented in fulfilment of the requirements for the degree of
Master of Arts

MASSEY UNIVERSITY
PALMERSTON NORTH, NEW ZEALAND

December 2002

What is normal birth? I wonder if we really know anymore. The modern birth has been so managed, arranged, choreographed, augmented, drugged; sliced and diced that many of us have forgotten its very nature.

(El Halta, 1996, p.2)

*labour and birth unfold within a
complex, and infinite web,
spun by the mother,
and by everyone who has ever taught her
about mothering, birth, sexuality, pain
control and surrender
all the people at her birth
help spin the web with threads from
their histories, beliefs, experiences, fears ...
and recent birth experiences that they have witnessed,
which empowered
or terrified them.*

(England & Horowitz, 2000, p.151)

ACKNOWLEDGEMENTS

My thanks go to many people for support and encouragement received in the process of completing this thesis.

Firstly, thank you to the nine midwives who agreed to be a part of this study. Without your participation the study would not have been possible. I have learnt a lot from each of you and after every interview I came home re-inspired and excited by the research process and midwifery practice. We have so much to learn from each other and it is so important for our profession that we discover ways to remain open, to listen and to keep learning. In an atmosphere of critical affirmation we can embrace the need to affirm one another and also have space for critique.

A heartfelt thank you to my family and especially thank you to two people. My son, Jason; thanks for being you and being patient (as much as any 11 year-old can be!) and for telling me to 'go and do your thesis' sometimes when I became distracted. My mother, Barbara Jordan; thank you for the practical support and for hearing me out through the highs and the lows, you are an inspirational 'life-long learner' role model.

Professor Jenny Carryer, my supervisor, challenged and guided me academically and supported me as I grappled with the process of undertaking this work. Thank you Jenny for your belief in my abilities, your flexibility and your sense of humour along the way.

Thank you to Karen Guilliland for commenting on the research proposal. Thank you to Wheturangi Walsh-Tapiata for commenting on the ethics proposal and agreeing to the role of cultural advisor for this project.

Finally thank you to the midwifery colleagues who have supported me throughout this process. My ideas, at times, I am sure have seemed challenging, vague and sometimes unrelated to our day-to-day practice reality. I hope that in reading this thesis you may come to understand some of my 'rush of words' a little better.

ABSTRACT

Midwives provide maternity care for the majority of women in New Zealand and in 2000 midwives were the Lead Maternity Carer for seventy one percent of childbearing women. The aim of this research was to explore the assertion that continuity of midwifery care 'enhances and protects the normal process of childbirth' (New Zealand College of Midwives, 1993, p.7). I aimed to explore the meaning of 'normal birth' in Lead Maternity Care midwifery practice in the current New Zealand context and to understand the complex influences surrounding midwives' construction of normal birth.

In order to explore the construction of 'normal birth' Lead Maternity Carer midwives were invited to participate in a small qualitative study. In-depth one to one interviews were used to collect data from nine Lead Maternity Carer midwives. Interviews were recorded, transcribed and analysed using thematic analysis. Using a qualitative approach allowed me to make thoughtful links with the literature and build upon what is already known about the construction of normal birth.

Data analysis revealed that midwifery practice and women's birthing experiences occur in a contested context that remains firmly entrenched in a medically dominant model of care. There is an increasing normalisation of intervention and technology leading to ongoing medicalisation of the physiological processes of labour and birth. The midwives interviewed employed a number of strategies for promoting the normalcy of labour and birth including supporting women's choice to birth at home, and working with women in the hospital setting to birth without intervention. However, the medical model influenced the midwives' practice in a number of subtle ways and I argue that the medical model is the default mode: it is always there and is taken as the 'right' way to 'do' birth unless it is actively contended.

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CHAPTER ONE: Introduction

1.1 Introduction

In 2000 New Zealand midwives were the Lead Maternity Carer for seventy one percent of women (Ministry of Health, 2001). How midwives construct and define a midwifery concept of 'normal birth' is becoming increasingly important as significant increases in intervention rates continue during the labour and births of well healthy women and babies. During this study I found that it was not possible to explore a midwifery construction of normal birth without an exploration of the wider context of labour and birth.

This first chapter defines two key concepts used in this thesis and introduces the aims and the background and justifications for undertaking this project. My own position is presented and finally an overview of each chapter is presented.

In response to the increasing medical intervention and the increasing caesarean section rates, the midwifery role in promoting normal birth has become widely discussed in professional journals (New Zealand College of Midwives, MIDIRS Midwifery Digest, British Journal of Midwifery) and at midwifery conferences. One of the key messages of the 2002 New Zealand College of Midwives Dunedin conference was the role midwives have to play to "strive to reduce medical intervention in the birth process" (Bree, 2002, p.14). Likewise, the topic of normal birth was a key feature of the 2002 International Confederation of Midwives convention in Vienna. In October 2001 fifty purposively selected attendees gathered in Preston, United Kingdom, for the 'National symposium on the current evidence base for normal birth'. A second symposium was held in October 2002.

For the current study on Lead Maternity Carer midwives construction of 'normal birth', I selected a qualitative approach with feminist underpinnings as the most appropriate research approach. This approach allowed for the inclusion of the midwives' stories, experiences, knowledge, practice contexts and constructs to be illuminated, and allowed me to make thoughtful links with the literature and build upon what is already known about the construction of normal birth. A feminist perspective on research relates to research questions that are important to women, are of interest to women, and arise from political struggles. As discussed further in Chapter Three, I felt it appropriate that feminist hues underpinned this study on 'normal birth' and would add depth to my work. More importantly feminist ethics gave me a way of working with the participants that was respectful and congruent with my own feminist worldview.

1.2 Key Words

To facilitate meaningful discussion, I will begin by articulating meanings for two concepts used throughout this thesis.

1.2.1 Lead Maternity Carer (LMC)

A Lead Maternity Carer is a midwife, a general practitioner with a diploma in obstetrics or an obstetrician who has been selected by the woman to provide her Lead Maternity Care. Lead Maternity Care includes full antenatal, labour and birth, and postnatal maternity services (Ministry of Health, 2002). The Lead Maternity Carer maternity system was introduced in New Zealand in 1996 and has had two reviews with alterations. Lead Maternity Carer midwives can be self-employed or employed by a District Health Board.

1.2.2 Medicalisation and technologicalisation

In the 1970s Irving Zola first coined the term 'medicalisation' (Hillier, 1991). It is a sociological term that purports that there is an increasing tendency for medicine and the medical profession to expand its claims. Medicine has come to define and control more and more of human life and social processes. This in turn has led to an expansion of the professional power that medicine holds over society (Thomas, 2000).

The related term technologicalisation is taken as an extension of medicalisation and alludes to the way that technology is expanding its hold of society.

1.3 Aim of the study

The aim of this research study was to explore the assertion that midwifery care 'enhances and protects the normal process of childbirth' (New Zealand College of Midwives, 1993, p.7). I aimed to explore the meaning of 'normal birth' in Lead Maternity Care midwifery practice in the current New Zealand context and to understand the complex influences surrounding midwives construction of normal birth.

1.4 Background and Justification for the study

'Normal birth' is an 'everyday' term in midwifery practice, yet no agreed definition exists in theory or in practice. Practitioners and women each hold their own interpretation of what a 'normal birth' consists of. A variety of societal forces come together to define who holds the authority to interpret the birth process, attend women during labour and birth, and dictate processes and procedures used during labour and birth. These societal forces include economics and politics; attitudes and beliefs about

science, technology, religion and medicine; ideas about women and their bodies; and the attitudes and beliefs that a society holds toward birth (Banks, 1999).

A commonly held view is that a minimum of eighty to eighty five percent of women should be able to give birth without complications or intervention (Banks, 2000; Donley, 1986; New Zealand College of Midwives, 2000). The International Confederation of Midwives believes that “menstruation, pregnancy, birth, and menopause are normal life events that rarely require medical intervention” (International Confederation of Midwives, Vision of Midwifery, 2001). Yet, in New Zealand and throughout the world increasingly large numbers of women are experiencing medical intervention during their labour and births (Chalmers & Porter, 2001). What is an appropriate or reasonable rate of intervention during labour and birth remains contested (Roberts, Tracy & Peat, 2000).

Although there has been considerable debate over many years around the concepts of ‘normality’ in labour and birth, no standardised or universal agreement has been reached. The introduction of ‘new’ pharmacological, technological or surgical interventions is often viewed with initial suspicion, however, “what is perceived as dangerous can be normalised over time and, ... gradually achieve approval” (Murphy-Lawless, 1998, p.201). There continue to be many questions and divergences of opinion: Is birth a ‘normal’ and ‘attended’ life event, or an ‘abnormal’ and ‘managed’ crisis?

In New Zealand there have been many changes with regard to care during pregnancy, labour and birth and determining who is the primary practitioner attending births. All parts of the complex matrix that forms the childbirth context have been effected. Economic, legislative, technological, social and political events have all played a part. The Maternity Services notice pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000 (Ministry of Health, 2002) governs provision of maternity services in New Zealand. The Maternity Notice has no mention of ‘normal birth’ being a goal of the maternity service, nor any definition of what constitutes a normal labour or birth. A recent Health Funding Authority publication refers to the “quest to achieve

normal vaginal deliveries” (Health Funding Authority, 2000, p.61) but does not define a normal delivery/birth. In another recent government report, considering introducing a new funding model, the Maternity Incentive Project (Health Funding Authority, 2001), there was a call for agreement on how to measure indicators of ‘best practice’, including ‘normal delivery’. The need to define normal in this context was acknowledged.

In New Zealand all women have a midwife present during labour and birth and, in 2000, seventy one percent of women had a midwife as their lead carer (Ministry of Health, 2001). The New Zealand College of Midwives (2002, p.4) scope of practice of the midwife says:

The midwife works in partnership with women, on her own professional responsibility and accountability to give women the necessary support, care and advice during pregnancy, labour and the postpartum period, to facilitate births and to provide care for the newborn.

The midwife promotes and supports the normal childbirth process, identifies complications in mother and baby, accesses appropriate medical assistance and implements emergency measures as necessary.

Midwives have an important role in health and wellness promotion and education for the woman, her family and the community.

Midwifery practice involves informing and preparing the woman and her family for pregnancy, birth, breastfeeding and parenthood and extends to certain areas of women’s health, family planning and infant wellbeing.

The midwife may practise in any setting including in the home, the community, hospitals, clinics, health units, or in any other maternity service.

It is crucial to midwifery practice to claim and articulate definitions of normal labour and birth and thus the definitions of midwifery practice. Dutch midwife, Beatrijs Smulders (2002) believes that “the most important aspect of keeping birth normal is having an independent and strong midwife present at a birth” (p.19). With this in mind, midwifery’s consensus on what is ‘normal’ is vital. Smulders (2002, p.19) goes on to say:

The more confidence the midwife has in herself, in the physiological process and in her ability to screen between normality and pathology the more chance the birth will be normal. Empowering a woman in labour, convincing her to take full responsibility for the safety of her body and her child takes power and confidence of the midwife.

The role of midwives in 'normal birth' has been identified as becoming increasingly important as more and more women are experiencing medical, technological and pharmacological intervention during labour and birth. Harding (1986) has noted that "whoever gets to define what counts as a scientific problem also gets a powerful role in shaping the picture of the world that results from scientific research" (1986, p.40). Childbirth is an arena where our scientific and cultural knowledge about 'normal birth' is overlaid with multiple and competing interests. Numerous writers have called for research into 'normal birth' and midwifery's role (Anderson, 2002; Downe, 2000 & 2001; Johanson & Newburn, 2001; Johanson, Newburn & Macfarlane, 2002).

One of the tenets of a profession is a unique body of knowledge. Pairman (1998) says that midwifery "research is essential in New Zealand, as elsewhere, to continue the development of midwifery knowledge and secure its place as a profession" (p.197). This research will contribute to an exploration of the maternity environment and contribute to articulating New Zealand midwifery. In exploring the notion of 'normal birth' I believe this study increases our knowledge of the influences and constraints on Lead Maternity Carer midwifery practice. It contributes to the growing body of knowledge on the unique model of midwifery that has developed in New Zealand.

1.5 Declaring my position

My interest in birth began with my own pregnancy and birth experience. In 1990 I planned to give birth to my baby at home surrounded by my family. As I approached

the end of my pregnancy choices rapidly decreased and decisions seemed outside of my control. Eventually I consented to an induction of labour, which ended with an emergency caesarean section. As a new mother I had no understanding or framework with which to deal with the traumatic personal aftermath that I experienced following my very medicalised experience. I became involved with the Home Birth Association and with the support of this personal and political group, alongside some university studies, I began a consciousness raising and healing process.

My involvement with the Home Birth Association began my midwifery journey, which continues to develop and evolve. I completed a three-year direct entry midwifery programme, graduating in 1995. For the last seven years I have worked as a self-employed Lead Maternity Carer midwife and identify as a home birth midwife, although I practise in all midwifery settings. I acknowledge that I have only worked as a self-employed midwife, so have little knowledge or experience of the issues pertaining to employed, core midwifery practice.

I have a strong belief that each woman is her own expert and has the inherent knowledge, strength and ability to nurture and give birth to her baby. Our challenge is to enable women to 'see and know' birth positively. As Leap (2000) says: "the skill lies in knowing when to inform, suggest, act, seek help and, most importantly, be still or withdraw and remove ourselves" (p.5).

I also acknowledge my position as a middle class, Pakeha (non-Maori white New Zealander) woman. No doubt this positioning is reflected in this thesis.

1.6 Review of chapters

Chapter One introduces the thesis topic and aims, the background and justification for the current study. My own position is declared and an outline of each chapter is provided.

Chapter Two examines the literature concerning the construction of 'normal' and 'normal birth'. What the literature reveals is a lack of consensus and many debates about normality in the context of birth. There exists no definition of 'normal' labour and birth. In New Zealand pharmacological, technological and surgical interventions used during labour and birth are common, including during the labour and births of well, healthy women. The literature further discusses two dominant discourses or models of care. The midwifery model and the medical model are thus introduced, including the 'midwifery partnership model'. I briefly discuss the history of childbirth, obstetrics and midwifery practice. Finally, I consider women's views in relation to labour and birth, highlighting the dilemma of women being subjected to competing discourses of childbirth.

Chapter Three provides an overview of the philosophical underpinnings and the research method. A qualitative approach with feminist underpinnings was selected as the most appropriate for understanding midwives' interpretations and construction of 'normal birth'. Using a qualitative approach allowed me to make thoughtful links with the literature and build upon what is already known about the construction of 'normal birth'. Semi-structured interviews were chosen to collect data from nine Lead Maternity Carer midwives. Thematic analysis offered a flexible and fluid way to analyse the interviews. Concluding this chapter, I highlight and discuss some research dilemmas that I experienced during the process of conducting this research.

Chapters Four and Five present the data from the interviews using relevant literature to consider excerpts from the midwives. During the interviews I found that participants were not able to discuss 'normal birth' without also discussing the wider context of childbirth. Chapter Four demonstrates the contested nature of the current birthing environment and show that the dominant ideology is based on a deeply entrenched medical model. A number of interrelated aspects are identified and discussed. Chapter Five goes on to consider the midwives adaptation to the contested environment and discusses again a number of interrelated aspects and issues.

Chapter Six is the final chapter and discusses my interpretations and insights gathered in the research. I revisit some material introduced in the data chapters and explore in further depth the cultural construction of labour and birth, including an examination of the role of the 'referral guidelines'. I discuss and critique the 'partnership model' and its role in enhancing and protecting the normal process of childbirth. Limitations of the current study are identified and finally I offer some concluding statements.

1.7 Conclusion

This chapter has provided a summary of the thesis, which explores how a group of nine self-employed Lead Maternity Carer midwives construct 'normal birth' within the current New Zealand maternity context. I have introduced the topic of 'normal birth' with a brief background and justification for the study and discussed my personal position in relation to midwifery practice. In this way I declare how my own subjectivities have guided and influenced this project. The following chapter reviews the literature surrounding construction of 'normal birth'.

CHAPTER TWO

A review of the literature

2.1 Introduction

In the previous chapter I introduced the aims of the study and provided an overview of this thesis. In this chapter I review relevant literature in the area of 'normal birth' and examine some definitions of 'normal birth'.

A variety of views are held around the concepts of 'normal' and 'normal birth' and a number of questions can be raised. What do women believe is 'normal' when they are giving birth to their babies? What beliefs do midwives hold around labour and birth and 'normal birth'? How have these views been developed and changed over time? In this examination of the literature I explore the context of the current study.

Initially I examine some alternative definitions of normal, and the literature relating to 'normal birth', including contemporary and historical positions. The literature details two dominant discourses existing in childbirth; accordingly both the midwifery and the medical models of birth are examined. The current New Zealand maternity system is briefly outlined and finally women's views on birth are explored.

2.2 'Normal?'

The term 'normal' to describe labour and birth has been in common use for centuries (Towler & Bramhall, 1986). A normal labour and birth is most commonly taken to mean a physiological labour and a vaginal birth with little or no external intervention (Lee, 1999). 'Normal birth' is used synonymously with 'spontaneous vaginal delivery'.

This may mean that the woman experienced an intervention free labour and birth with freedom of movement, her choice of positions, support and access to food and drink. However, in common practice 'normal birth' is also used to describe a vaginal birth, which may have included a wide variety of pharmacological, technological or surgical interventions. Interventions may include all or any combination of the following: restriction of movement, restriction of food and drink, induction of labour with prostaglandins and/or syntocinon infusion, continuous electronic foetal monitoring, repeated routine vaginal examinations, artificial rupture of the membranes, augmentation of labour, narcotic pain relief, epidural anaesthesia with intravenous fluids and bladder catheterisation, episiotomy, active management of third stage of labour and perineal suturing. So long as the actual moment of expulsion of the baby was unaided, from an obstetric perspective, the actual birth of the baby is considered 'normal' (Murphy-Lawless, 1998).

Normality however cannot be seen as a fixed concept, but one that is historically, socially and culturally defined, and therefore changeable (Downe, 1998; Kent, 2000). Guilliland (1999a) says "despite considerable debate and research over the years the concept of 'normality' in childbirth is not standardised or universal" (p.5).

In the literature varying concepts of normal and normality have been explored. Murphy-Lawless (1998) found that in medicine, the word normal as we have come to know it first came into use in the 1820s. Normal became that which was not abnormal or pathological. In this way normal can be seen as the starting point for abnormality, and potentially normality can be lost to watching and waiting for abnormality to appear. Murphy-Lawless (1998) argued that in its search for normality, obstetric medicine has succeeded in creating an ever-expanding domain of abnormality, but has failed to define that which is normal.

In science normal can also be used to represent the middle point, or an 'average' or 'norm'. In this way 'normal' allows individuals to relate personal circumstances to the 'normal' or average course or experience (Murphy-Lawless, 1998). For example, the

average age of women having their first baby or the average weight of New Zealand babies. In reality, it has no bearing on individual experiences or situations, but is a mathematical marker. In medical usage, Hacking (1990) identified that it has become common for us to think of 'normal' as a factual concept, or as 'what is' or 'what ought to be', rather than as an average mathematical marker. In defining 'normal labour' in terms of a medical 'norm' or average, definitions can become narrow and focused on watching and waiting for a deviation from the 'norm' to appear.

Friedman (1955; 1956) published his research which evaluated statistical 'limits' against which progress in labour 'should' be judged. Friedman's guidelines or 'curve' has since been widely adopted and held as a benchmark. The partogram is a tool developed from Friedman's research and is used to 'measure' labour. It is a set of mathematical averages that creates a 'truth' about labour, about what is normal and what is abnormal. On the partogram, labour and birth are recorded as a series of events within a given time frame. The graph records the strength and frequency of contractions, dilatation of the cervix, analgesia given, maternal blood pressure, foetal heart rate, descent and rotation of the foetal head, the management of labour and eventually the 'method' of delivery. Each individual woman's labour is judged against the average rate of dilatation and if her body varies her labour is considered 'abnormal' and corrected with pharmacological, medical or surgical intervention. In this way, normal is used as a value of 'what ought to be' (Murphy-Lawless, 1998).

One problem with the 'Friedman curve' or partogram is that it fails to allow for individual variations or circumstances to be taken into account, nor for the many other dimensions of birth for the individual woman, her 'normal' responses to labour. Banks (1998) argued that perhaps the only place that one can see 'normal' physiology and 'normal' emotional, sexual, spiritual and social responses to labour is when the woman is in her own environment.

Kitzinger (2000) also explored an alternative way of 'seeing' birth. She detailed the way in which a social anthropologist or social psychologist observes birth. In this view birth is seen as the relationships between those present: who comes and goes, the effect of their presence or absence, what they do, and what goes on in the space between the different actors, emotion, observations, information shared or withheld. This 'social' view of birth considers liaisons, movement, touch, body language, and the ritual of birth.

A further way in which 'normal' is used or interpreted is in the use of normal to mean the 'norm', or most common experience of women. Beech (1999) argued that obstetric medicine has a tendency to amend normal to encompass the many and varied medical interventions and to justify these interventions on the grounds that 'normal' is that which is commonly experienced during birth. Murphy-Lawless (1998) expressed a stronger position, she believed uncomfortable, alienating, and dehumanising procedures have been made to appear ordinary and normal within obstetrics. In this way it has become 'normal' for women to give birth in a hospital environment and 'normal' for women to have at least one or more scans during their pregnancy.

As caesarean section rates continue to increase in New Zealand and world wide, will this soon represent the 'normal' way for some women to experience the birth of their baby? Some evidence already exists that the normalisation of caesarean section has begun. Coney (2001), who is a long-time campaigner on women's health issues, considers that by the year 2010, half of all women will 'choose' a caesarean section. Kitzinger (2001) highlighted the way that caesarean section delivery is promoted in the United States as a way of keeping the vagina 'honeymoon fresh'. The popular media has made much of celebrities such as Victoria Beckham (also known as 'Posh Spice') and her decision to elect for a 'non-medical' caesarean section, with headlines proclaiming that she is 'too posh to push'. The recent TV One 'Sunday' (24th November, 2002) programme introduced 'designer vagina' into our vocabularies and explored the predominant and growing philosophy of 'value-free' women's choice, as opposed to the philosophy of birth as primarily a physiological process (Johanson, Newburn & Macfarlane, 2002).

2.3 Intervention during labour and birth

In her research into 'normal birth' in New Zealand, Banks (2000) found it difficult to identify in the official figures the women who gave birth without intervention. She concluded "there is simply no data that shows the number of women who give birth without a single or a combination of interventions" (p.33). She expressed concern regarding the existence of a "fallacy of 'normal' birth" (Banks, 2000, p.30) in New Zealand hospitals. There exists a huge range of intervention rates between hospitals and between Lead Maternity Care providers (Guilliland, 2001a), which also indicates varying views on what is 'normal' childbirth.

The latest published (but not complete) figures from the Ministry of Health (2001) demonstrate that high levels of pharmacological, technological and surgical interventions are being used during labour and birth. A 'normal birth' rate of 68.7% overall is reported, however, no definition of 'normal birth' is provided. Epidural anaesthesia is used by 22.8% of women overall, with rates as high as 42.9% of women in one hospital. Other interventions are also high, with nearly a third (27.2%) of all women having labour induced and 11% experiencing instrumental 'deliveries' with forceps delivery or vacuum extraction (Ministry of Health, 2001). It is not possible to identify women who experienced electronic foetal monitoring, artificial rupture of membranes, restriction of movement, restriction of eating and drinking, routine intravenous fluids or antibiotics, or any other 'minor' interventions during labour and birth.

According to the Ministry of Health (2001), New Zealand is following international trends in terms of increasing caesarean section rates and in 1999 had an overall rate of 20.4%. There were wide variations between hospitals with the range being from 45.8% to 5.1% in secondary and tertiary hospitals. Caesarean section was used by 22.3% of women having their first baby and 14.2% of women having subsequent babies. The latest unpublished caesarean section rates continue this increasing trend with overall 22% of women having caesarean sections in 2000 (Sunday, TV One, 24/11/01).

Roberts, Tracy and Peat (2000) conducted a study on rates of obstetric intervention in Australia and found high intervention rates. Among low risk women having their first baby in private hospitals only 18 per 100 women achieved a vaginal birth without intervention, while 28 per 100 private patients in public hospitals and 39 per 100 public patients had this outcome. Low risk women having a subsequent baby had similar results. Lane (1998) in her study of women's experience of birth in Victoria, found that figures suggested intervention was a statistically normal part of giving birth. For example, she quoted one study that showed only 11% of women would emerge from childbirth without interventions such as technological, chemical or surgical assistance.

Downe, McCormick and Beech (2001) carried out a prospective cross-sectional prevalence survey of five units in one region in England. They found that almost two-thirds of births classed as 'normal' by hospital maternity staff involved an obstetric intervention. Included in the study were the birth experiences of 1464 women. In this group, 956 births were recorded as 'normal', however 596 of these 'normal births' actually included some form of obstetric intervention. Downe, McCormick and Beech (2001) concluded, "if normal means physiological, the study indicates that very few women in the sample experienced normality during their labours and births" (p.605).

Downe, McCormick and Beech (2001) based their study on the Association for Improvements in the Maternity Services (AIMS) definitions of births. In response to concerns they had about significant intervention in births recorded as 'normal or spontaneous' they have set out a definition of 'obstetric delivery' versus 'normal birth' (Beech, 1997). An obstetric delivery according to this definition constitutes any one of the following: induction of labour; acceleration of labour; artificial rupture of membranes; epidural anaesthesia or episiotomy. AIMS define a 'normal birth' as a birth that is a purely physiological event without medical intervention (Beech, 1997).

2.3.1 Midwifery and 'normal birth'

Midwifery, as a profession, has claimed that the midwife is the “guardian of ‘normal birth’” (Donley, 1986, p.15). Kent (2000) argued that this claim fails to consider the ways in which ‘normal’ comes to be defined in the first place.

Gould (2000) undertook a concept analysis of ‘normal labour’ which revealed that her midwifery colleagues were enmeshed within the medical model of childbirth. She believed it is the underlying medical culture which has led to a paradox where many midwives “may believe natural childbirth to be normal but do not really believe that normal childbirth has to be natural” (p.420). In discussion with her colleagues Gould found they defined ‘normal labour’ as a ‘purely physiological event with no intervention’; they then went on to explain the many interventions used, but they did not necessarily believe that the intervention put the woman into the realms of ‘abnormal labour’. Gould summarises with her belief that midwives have been “coerced into accepting the medical profession’s measurable parameters of normal labour as defining factors” (p.420). One result of this is that other crucial elements of the labour process have been ignored, because they are difficult to define and too elusive to measure (Gould, 2000).

Downe (2000) proposed that efforts should “be made to redefine the term ‘normality’ and thus reclaim a particular paradigm of birth” (p.337). She believed that little evidence exists on normality in birth and explores three possibilities. Firstly, she proposes that normality is difficult to audit, and cites research that compares one form of intervention to another, but fails to consider the consequences of no intervention. Secondly, she questions the norms that midwives were taught compared with the reality in practice; “we do not seem to notice the dissonance” (p.338). Thirdly, she questions that normal can only be made visible when conceived as ‘not abnormal’, in a similar fashion to health being defined as an absence of disease.

In 1985 the World Health Organisation (WHO) debated the issue of 'normal birth' at a conference on Appropriate Technology for Birth. Representatives of various groups presented papers, expressing a divergence of opinion. An obstetrician argued that birth was normal only if there was no pathology, which could only be determined in retrospect after the baby's birth. According to the epidemiologist, birth is normal when it is an entirely physiological process, although he added that the tendency to intervene has limited our knowledge about normal physiology. A midwife argued that birth is a normal life event, no matter what the outcome, including complications, as long as the woman sees it as normal, something she can relate to her life. Colleagues from anthropology, psychology and sociology supported the midwife's view. They all pointed out that the social nature of birth meant that the social context for each woman played a major role in the outcome, and that birth being treated as normal depended on who held the power to define normality. After intense discussion, no consensus was reached, but the participants agreed the issue of normalcy of birth was worth considerable thought and debates (Murphy-Lawless, 1998; Wagner, 1994).

The World Health Organisation (1996) publication *Care in Normal Birth* debates the evidence on practices related to 'normal birth'. They found enormous variations throughout the world as to the place of birth and level of care, the services available and the status of the caregiver for 'normal birth'. In defining 'normal birth' they considered two factors: the "risk status of the pregnancy, and the course of labour and delivery" (p.3). The report acknowledged that a woman who is at low risk when labour starts may eventually have a complicated birth, or on the other hand, many high-risk women ultimately have an uncomplicated labour and birth.

In challenging the frequently cited medical model statement that 'childbirth can only be declared normal in retrospect', the report highlights several disadvantages to this concept. The disadvantages cited include:

- the potential to turn a normal physiological event into a medical procedure
- the interference with the freedom of women to experience the birth of their children in their own way, in the place of their own choice

- that this concept leads to unnecessary interventions
- the need for large technically well equipped hospitals and centralisation of services

Further, there is a temptation to treat all births routinely with the same high level of intervention required by those who experience complications. In conclusion, the report summarised that 'normal birth' only needs close observation by a trained and skilled attendant in order to detect early signs of complications. It needs no intervention but "encouragement, support and a little tender loving care" (World Health Organisation, 1996, p.13). The aim of the International Confederation of Midwives is to improve the standard of care provided to women, babies and families throughout the world through the development, education, and appropriate utilisation of the midwife (International Confederation of Midwives, International Code of Ethics for Midwives). In keeping with this aim, the 'trained and skilled attendant' present when women give birth would be a midwife. It was the conclusion, in 1996, by the World Health Organisation that midwives are the most appropriate and cost-effective caregivers in normal pregnancy and birth (World Health Organisation, 1996).

2.4 Models of care

Katz Rothman (1982) has been credited with first having distinguished two different underlying models in childbirth: the midwifery model and the medical model. The scientific paradigm or medical model characterises the work of the medical profession, while the midwifery profession is seen as promoting a view of birth as a natural and normal process, which characterises the midwifery model or social view of childbirth. These approaches are founded on different epistemologies or theories of knowledge, different assumptions, ideas and ways of thinking about pregnancy and childbirth.

2.4.1 Medical Model

Murphy-Lawless (1998) argued that all women “must engage with obstetric science in order to give birth” (p.229). Further:

By definition, this is every woman who lives in a setting where obstetric science dominates the experience of childbirth. Arguably, given the power of science in our modern societies and the vital connections between obstetric science and the domains of health care and health planning in a modern state every woman in a developed country is affected by obstetric thinking. She either accepts it because she believes its arguments to be correct and meaningful or because she doesn't know what else to do, or she rejects it and works in opposition to it in order to emerge with meanings around birth which she wants to have (p.229).

The medical model of childbirth is linked to the rise of science and scientific ways of knowing. Scientific ways of knowing espouse reductionism, objectivism and the separation of mind and body, and argue that its procedures (experiments, objectivity, control and validation) provide the only serious model for understanding. Wagner (1994) explained that according to the medical model, life is a problem, full of risk. In relation to pregnancy and childbirth “the medical model assumes an inherent pathology of the body” (Lane, 1998, p.9) and consequently no birth can be ruled normal until it is over because there is always potential pathology.

Murphy-Lawless (1998) argued that obstetrics began with obstetricians and their theories and not with women's experience. This is supported by Rooks (1999) who believed that obstetrics developed from within medicine for the purpose of dealing with the pathologies of pregnancy and childbirth. Murphy-Lawless (1998) further argued that “obstetrics is an utterly social body of knowledge, that is, a human activity built on strong feelings, intuitions, prejudice, entrenched positions, considerations of institutional power, and high passions” (p.229). Rooks (1999, p.371) also supported this position:

Physicians have expanded the proportion of pregnancies considered abnormal or pathologic by using monitoring devices that over-diagnose complications, basing

diagnoses on overly narrow definitions of normal, and treating variation from those definitions as evidence of pathology. The desire to identify complications early has led to use of a sequence of preemptive interventions (to prevent complications or treat them before there is evidence that they exist) and a focus on “risk factors” (conditions that are not pathologic but are associated with an increased incidence of complications). In many instances, the distinction between risk factors and actual pathology has been lost, and women with ‘high risk factors’ are treated as though they have actual complications.

Wagner (1986) argued that obstetric medicine has gained nearly absolute power and control over birth and birth care. He believed one of the ways medicine did this was by redefining birth as a medical problem that is either pathological or potentially pathological, thereby creating the need for a doctor to be present at every birth.

In New Zealand the majority of women have an obstetric consultation during their pregnancy at some point. Guilliland (2002) believes that this is a result of the national specialist referral guidelines and obstetric protocols. These guidelines and protocols ‘require’ Lead Maternity Carers (midwives and general practitioners) to advise women that a specialist consultation is required or recommended. Guilliland (2002, p.12) argued that “indicators for consultation are broad and cover most possible scenarios and this has the effect of heavily medicalising childbirth despite midwives being Lead Maternity Carers (LMCs)”. Despite the gains made by the New Zealand midwifery profession, the medical model of birth continues to be more supported by the political and legal institutions of our society (Daellenbach, 1999). O’Connor (2001) argued that in much of Europe structural and legal barriers prevent midwives from practising their profession to the full and “many midwives are forced to work as obstetric nurses, and births become deliveries conducted according to obstetric protocols” (p.130). In America only seven percent of women have a midwife at all (Birth, 1999).

2.4.2 Midwifery Model

A midwifery model of care emphasises the importance of seeing pregnancy and birth as natural and normal processes, as normal life events rather than medical events. The midwifery model views pregnancy as a critical, vulnerable, but normal part of women's lives. Birth is a biological event integrated with mental and spiritual factors and involves society as well as individual women (Wagner, 1994). The impact of societal factors such as poverty, malnutrition, stress, lack of social support and women's position in society are recognised as important factors. Midwifery developed out of the social, informational, physical and material support women have traditionally provided to one another in times of need (Rooks, 1999). Further, the midwifery model holds the woman at the centre of care and it is the woman who makes decisions regarding her care in pregnancy and birth. In contrast the medical model holds the baby as the focus of care and the decision-making is under medical control.

In the New Zealand context Guilliland and Pairman (1995) have extended the midwifery model in their model for practice, 'The Midwifery Partnership'. Pairman (1999) believes that "the notion of partnership has become part of our identity as midwives in New Zealand" (p.6). This model defines the midwifery partnership as "a relationship of 'sharing' between the woman and the midwife, involving trust, shared control and responsibility and shared meaning through mutual understanding" (Guilliland & Pairman, 1995, p.7). The beliefs that underpin the midwifery partnership model include birth as a normal life event, midwives providing the total maternity service, midwifery as an autonomous profession, and midwifery as women-centred. Further, the principles that are integrated into the partnership are individual negotiation, equality, shared responsibility and empowerment, and continuity of care. Guilliland and Pairman developed the midwifery partnership model of midwifery practice from reflection on the experiences of New Zealand midwives (Guilliland & Pairman, 1995).

The partnership model has been debated amongst midwives and in the literature. Skinner (1999) has found that at a practice level the partnership model is not particularly useful and she provides a critique of the model. Specifically, Skinner (1999, p.16) argued that:

Partnership at the practice level, I think, can be dangerous for the practitioner and misleading for the mother. It reflects a superficial analysis of society, neglecting to identify the dominant underlying right-wing philosophy of individualism, contractualism and patriarchy. It does not recognise inequalities in power, or access to resources and is culturally elitist. Midwifery has the potential to be intensely radical as feminist praxis. Partnership at a practice level does not. It is neither radical nor does it have much to do with what many practitioners are trying to achieve.

In addition, the partnership model does not address the way in which both women and midwives are embedded in the strongly medicalised discourses and cultural practices around childbirth. Skinner (1999) also noted that many women do not understand the nature of what is being challenged and that they are going against the medical model by choosing midwifery care.

However, the concept of partnership is increasingly accepted in New Zealand and internationally as a model for midwifery practice (International Confederation of Midwives position statements, 2000). Pairman (1998, 1999) has further explored the woman/midwife relationship and has refined the partnership model of midwifery. Pairman's (1999) key elements of the midwifery partnership model and the outcomes of the midwifery partnership will be explored here in brief. The key elements of the midwifery partnership are continuity of carer, women-centred care, autonomous/independent midwifery practice and power sharing and reciprocity.

- Continuity of carer gives time and opportunity for a relationship to develop between the woman and her midwife during the pregnancy. Pairman describes this relationship as 'professional friendships' with characteristics including "getting to

know each other on a personal level, relating to each other woman-to-woman, sharing common interests, feeling equal to each other and trusting each other” (Pairman, 1999, p.7). The relationship has a time-limited nature and a professional purpose. Continuity of carer is fundamental to developing trust, negotiation, discussion and informed decision-making.

- Women-centred care underpins the midwifery partnership. The emphasis of the care is the woman and she is seen within the context of her life, her family and her circumstances. “Women-centredness just means working with the woman in whatever way she wants” (Pairman, 1999, p.8).
- Autonomy of midwifery practice “brings freedom to practice” (Pairman, 1999, p.8). The midwife is accountable to the woman, rather than an employer, hospital guidelines or protocols, or medical supervision. Independent practice allows the midwife to work with the woman within the full scope of practice, throughout the pregnancy, childbirth and the postnatal period. Autonomy means that midwives can work within a midwifery framework, rather than a medical model (Pairman, 1998). “Independence is more than just a philosophy, it affects every aspect of the midwives’ lives and is part of who they are as people and as midwives” (Pairman, 1999, p.11).
- Power sharing and reciprocity are intrinsic to the midwifery partnership. Both the woman and the midwife have power and are equal, “one is no more important than the other” (Pairman, 1999, p.8). Each partner brings herself and contributes to the relationship, the woman bringing her expectations, her knowledge of herself and her life, while the midwife brings her midwifery skills, intuition, experience and knowledge. Reciprocity is two-way sharing and involves openness, mutual exchange, shared meanings and shared control. Power is shared, negotiated and mutually agreed within the midwifery relationship. Each partnership works in its own way.

The anticipated outcomes of the midwifery partnership include empowerment, emancipation, challenging the medical model of childbirth and developing midwifery knowledge.

- Empowerment occurs for both the woman and the midwife as a consequence of the partnership relationship. The midwife's role is one of facilitation or enabling power. The tools of empowerment include reflection, self-awareness, self-growth and appropriate use of resources. Empowerment does not involve 'giving' power to another rather it involves recognition of one's own power through critical consciousness raising (Lather, 1991 cited in Pairman, 1999). Within the partnership model, the midwife 'enables' the woman to take control of her own childbirth experience and recognise her own wisdom and knowledge. "Helping women to take responsibility for themselves through support and encouragement is at the heart of midwifery practice" (Pairman, 1998, p.168).
- Emancipation occurs when the woman and the midwife recognise oppression within the maternity system and further within society. Women in turn help others learn about this oppression (Pairman, 1999). As those who are oppressed gain freedom, emancipation involves transformation of the world. The midwifery profession in New Zealand is developing and maturing, we are changing our context (Pairman, 1999).

Pairman (1998, p.173) argued that the partnership model of midwifery practice "challenges the dominance of the medical model of childbirth" and "challenges medicine's right to define and control childbirth". It offers an alternative model in which understanding and knowledge of childbirth arises from midwifery practice and women's experiences. Consumer and activist Rea Daellenbach (1999) agreed and also argued that the concept of partnership is one of the resources midwives and consumer activists can use in challenging the dominant medical model of birth and in establishing more credibility for midwifery.

2.4.3 Midwifery Continuum

Cosslett (1994, p.6) challenged the idea of two competing ideologies and sees this as a “powerful, simplifying cultural myth”. Both models share the common goal of a healthy mother and baby, and in practice and day-to-day reality neither the medical nor midwifery model are used entirely distinct from each other. Individual midwives and doctors vary in the extent to which the midwifery or medical model is an ideal to which they aspire, or a model they actively work with. There are many midwives and many doctors and much variation within each group. For individual midwives, doctors and women the midwifery model and the medical model overlap and are used concurrently with inherent contradiction and inconsistencies. Ambivalence and variety are apparent in the reality of lives.

Bryar (1995) suggested that the medical model and the midwifery model might be seen as a continuum. Midwives may be seen as moving along this continuum and drawing on the both different models. Women also shift their thinking about birth according to different contexts and circumstances. Griffith (1996) also viewed midwifery practices on a continuum and found a diverse range of beliefs are held by Australian midwives about birth, women and midwifery practice. The continuum she developed related to midwifery practices and ranged from an overly medicalised context where care was controlled by technology and a medical discourse, through to home birth midwifery practice where the ideologies of medicalisation and technology are rejected as a means of informing and/or determining the basis or essentials of practice.

Further, as argued by Griffith (1996), the dominance of the medical model of childbirth is still clearly evident and often the medical discourse is taken as the natural order to which midwifery has to respond and be accountable. The medicalisation of childbirth has been an overwhelming success, despite the lack of evidence to support its claims of safety (Tew, 1990). The vast majority of women continue to give birth in hospitals, where the protocols and procedures surrounding birth are still basically dictated by obstetric medicine. Donnison’s (1988) argument that the medical men deliberately set

out to frighten women into believing that male attendance was necessary by exaggerating the dangers of childbirth, still holds true in contemporary maternity care. Continuing efforts by activists and midwives, feminists and non-feminists alike, to resist and contest medicalised childbirth over the last four decades have not significantly dislodged obstetric medicine from its position as the principal authority on the birth process (Murphy-Lawless, 1998).

Wagner (1986) suggested that there is some evidence “that the profession of midwifery has acted as an important deterrent to the rising obstetrical intervention rates and other instances of the medicalisation of birth” (1986, p.204). He further argued that an independent midwifery profession plays an important role in counterbalancing the power doctors hold over birth. There is an increasing recognition that midwifery care can result in shorter labour, less medication, and fewer interventions such as surgical or operative deliveries (ten Hoope-Bender, 1997).

In New Zealand there has been an emerging independent midwifery profession since 1990, with the amendment to the 1977 Nurses Act. However, midwives do not work in social isolation, as discussed previously. So, while we have not managed to halt the ongoing advance of medical dominated childbirth, Guilliland (2002) argued that “New Zealand midwives have been able to contain the anxiety better and in doing so positively influence the choices and outcomes for women and babies” (p.12).

2.5 History

Many writers have detailed the history of childbirth, obstetrics and midwifery (Arney, 1982; Donnison, 1988; Ehrenreich & English, 1979; Katz Rothman, 1982; Oakley, 1984; and in New Zealand Dobbie, 1990; Donley, 1986 & 1992; Mein Smith, 1986; Papps & Olssen, 1997). One such author, Arney (1982) examined the phenomenon of the rise and dominance of obstetrics in Europe and America. He described three

periods. Firstly, the pre-professional period, with midwives dealing clearly with the normal, and barber surgeons with the abnormal. The next phase that Arney called the professional period marginalises the midwives, with birth being defined in terms of its potential pathology. This phase was important as the line between 'normal and abnormal' became blurred; traditional midwifery practice was reformulated. Previously, the midwife had control over the distinction between normal and abnormal, and it was on the control of this distinction that her power rested. The final and current phase Arney proposes is the monitoring period, with the obstetrician in the role of 'expert'.

In the middle years of the twentieth century the movement for alternative birth began to challenge the dominance of the 'expert' in birth. Women began questioning some of the routine obstetric procedures and to resist the medicalisation of normal, healthy reproductive processes such as pregnancy and childbirth. The movement for alternative birth began to build momentum and to challenge the hierarchical relationships between women and health professionals (Ehrenreich & English, 1979; Katz Rothman, 1982). The alternative birth movement was stimulated by a variety of societal forces including the renewed contact and community of women in the feminist movement, the development of a self-help movement and legitimate publicised concerns about the treatment of women during birth. Diametrically opposed philosophies of birth now operate within society (Banks, 1999). What becomes cultural 'common sense' surrounding childbirth is constructed, negotiated, controlled and in some instances imposed by these competing world-views (Guilliland 1999).

Tully, Daellenbach and Guilliland (1998) provided a summary of the New Zealand context, which mirrors the international situation. In New Zealand practices related to childbirth and the provision of maternity care have seen significant changes over the last century. At the beginning of the twentieth century most women gave birth at home with the assistance of other women, who were lay-midwives, often very experienced, but unqualified. Childbirth was accepted as a risky event, but a normal life experience. As society became more medicalised the lay midwife was no longer allowed to practise and by the mid-1930s the majority of babies were born in hospitals with doctors in

attendance; trained midwives or maternity nurses acted as assistants. Childbirth had become increasingly medicalised and midwives were reclassified as maternity nurses. Under the Nurses Act 1971 midwives lost their legal right to work independently and all births, whether at home or in hospital, were required to be supervised by a doctor (Donley, 1986; Tully, Daellenbach & Guilliland, 1998).

While the majority of women gave birth in hospital, a small number of domiciliary midwives continued to practise and offered an alternative service to women and their families. Consumers within the home birth associations that were formed in the late 1970s and early 1980s supported these midwives. Home birth associations and other groups such as 'Parents Centre' lobbied for changes in maternity services and raised the public and political profile of midwifery and maternity services (Dobbie, 1990; Donley, 1992). Midwives were also politicised and the setting up of the New Zealand College of Midwives (NZCOM) in 1989 gave midwives a distinct professional body (Tully, Daellenbach & Guilliland, 1998).

With the passing of the 1990 Amendment to the Nurses Act, 1977, New Zealand midwives regained the legal right to work independently and provide midwifery care to women throughout the maternity cycle, during pregnancy, labour and birth, and following birth until six weeks. This legislation has changed maternity services in New Zealand and while not directly addressing the medicalisation of childbirth, it has directly challenged the medical monopoly of professional authority over childbirth.

2.6 Current situation and legislation

The governing document for the provision of maternity services in New Zealand is the Ministry of Health Maternity Services notice pursuant to Section 88 of the New Zealand Public Health and Disability Act, 2000 (Ministry of Health, 2002). Under this notice, a woman registers with the Lead Maternity Carer of her choice in early pregnancy. The

Lead Maternity Carer is a named individual who can be a registered midwife, a general practitioner or an obstetrician. The Lead Maternity Carer then coordinates care for the woman throughout her pregnancy, attends during her labour and birth and provides care until four to six weeks post partum. The maternity notice details comprehensive service specifications that the Lead Maternity Carer is obliged to meet and sets out terms, conditions and payments to the Lead Maternity Carer (Health Funding Authority, 1998).

The maternity notice allows for a wide variety of midwifery practise models. Midwives are able to offer women care as a Lead Maternity Carer midwife or provide the midwifery component of a woman's care sub-contracted to a Lead Maternity Carer obstetrician or general practitioner, either as an employed or self-employed midwife. New Zealand is acknowledged internationally as a leader in its model of maternity services and Guilliland (2001) claimed that New Zealand midwives are privileged in comparison to most countries in the world. New Zealand midwives enjoy more status, higher pay, have more control over their working lives and practice longer (Guilliland, 2002). However, the politics of gender, institutionalisation, medicalisation and fear are all encompassing and have the same effect whether or not midwives are the lead maternity caregiver (Guilliland, 2002, p.12). Therefore New Zealand midwives are still able to relate to the ongoing international "struggle for personal, social and professional autonomy" in midwifery practice (Guilliland, 2001, p.7).

2.7 Women's views

Birth is an intensely personal and individual experience, totally unique to each woman who experiences it, and birth is also a profoundly significant cultural event. Women obviously hold important views on what constitutes 'normal birth'; however, in considering how I should approach the views which women hold on birth I found myself in something of a dilemma. Women do give birth to their babies, but women are immersed in the medicalised environment and have been involved in efforts to promote

both more and less medicalised birthing (DeVries, Salvesen, Wieggers & Williams, 2001). Women themselves are subjected to the cultural constructs of pregnancy and birth. They are embedded in a system where a medicalised view of pregnancy and birth prevails. Strong messages exist in society telling women it is better to be 'safe than sorry', and that with modern technology and advances in medicine there is some form of guaranteed outcome. Increasingly too our society expects that if something goes wrong, then 'somebody is accountable'. Conversely, some women have a firm belief in the normalcy of birth as a natural, physiological process that they can achieve (Anderson, 2002a; Coyle, Hauck, Percival & Kristjanson 2001). Some women dream of births that match the wonderful stories and have high expectations of the birth experience. "Our expectations about childbirth have skyrocketed along with our access to information" (Maushart, 1999, p.65). Yet other women are realistic and know that labour is hard work, it hurts, but it is 'doable'.

We are living in a time when it has never been easier to get a wide variety of information and it has never been safer to have a baby; however many women are increasingly fearful. While some studies show that women want to take an active part in their labour and feel 'in control', (Gibbins & Thomson, 2001; Paranjothy & Thomas, 2001) many women continue to give away control of their process to an authority outside of themselves, to the expert, the doctor or midwife. Guilliland (2002, p.12) believes "global anxiety around childbirth is at epidemic proportions".

So in approaching this research I find myself in a similar position to Cosslett (1994, p.3):
... in a characteristic post-modern dilemma: both wanting to affirm women's voices, the inscription of their hitherto marginalised subjectivities, and needing to show how these voices, those subjectivities have been culturally constructed by prevailing discourses and cultural practices.

Cosslett (1994) goes on to solve her dilemma in her discussion. She concluded that it is a process of negotiation with prevailing ideologies, whose aim, she would argue, is power: the power to control the experience of childbirth, the power to protest or

celebrate, lack of control. Smith (1988) writes: 'a person is not simply an *actor* who follows ideological scripts, but is also an *agent* who reads them in order to insert him/herself into them – or not' (p.xxxv).

Further, Cosslett (1994) discussed how women's stories of childbirth make use of, is overwhelmed by or resists the two dominant 'official' stories of childbirth, the natural childbirth discourse and the medical discourse. Both these models of birthing have the power to shape the way childbirth is conducted and organised in our society. Maushart (1999) concurs: "one thing is certain: under either of the prevailing definitions, the vast majority of women will 'fail' at childbirth. ... Most of us will experience some form of intervention whether we start out resisting it or insisting on it" (p.79).

Maushart (1999) argued that most women emerge from the experience of childbirth "battle scarred, bewildered, and betrayed. In short, most of us emerge from the experience of childbirth in a state of shock, aghast with the discovery that everyone "prepared" us, but no one told us the truth" (p.65).

Why didn't any woman tell me? Why didn't they tell me it would be like a fuckin' bomb exploding? Why didn't anyone tell me the truth? Fiona Place (quoted in Maushart, 1999, p.65).

Whether a woman 'succeeds' in childbirth is nevertheless largely a matter of definition. The question is whose definition? The majority of women seek a 'good birth'. Yet when it comes to the nitty-gritty of exactly what the 'good birth' should look like and, even more to the point, what it should feel like, all consensus breaks down. When you consider the range of opinion on the matter, both among 'experts' and lay people, this is hardly surprising (Maushart, 1999, p.77). Who decides what is a good and desirable birth?

Davis-Floyd (1992 & 1994) studied the birth experiences of American women. She found that while some women place a high value on the natural processes of birth,

within the familiar environment of home, a larger and more significant number of women actually welcomed what she termed the 'technocratic model' with such interventions as epidural anaesthesia and planned caesarean sections. Davis-Floyd (1992) concluded that she has:

come to understand that even if those interventions come in forms that appear to me to disempower women as individuals and as birth-givers, they do nevertheless make women themselves feel not only powerful over the caprices of nature but also most fully participants in their culture (p.283).

Cosslett (1994) argued that natural childbirth advocates, such as Sheila Kitzinger have idealised birth, and prescriptive certainty can lead to feelings of failure and abnormality in those women who cannot fit this ideal account of childbirth. Cosslett countered this with the idea that "one can always combat Kitzinger's prescriptions by adhering to the competing medical version of childbirth: the fact that there are *two* dominant, opposing discourses here means there will always be at least two kind of mothers, failing or succeeding according to the two versions" (Cosslett, 1994, p.87).

Without realistic, accurate, and abundant information about how real women experience real labour, there is little point talking about 'options' and 'choices'. As long as most of us remain consumers of rather than collaborators in a shared discourse of childbirth, the illusion that we are 'in control' will assuredly remain just that – an illusion (Maushart, 1999, p.100).

Anderson (2002) presented the stories of three British women who found it impossible to have their needs meet within the 'options and choices' available in the hospital environment. The women she quotes were well informed and aware of the increased potential of possible difficulties, yet had their choices denied them. Anderson concluded: "feminism stands helpless at the entrance to the maternity hospital: the oppression of women continues unchecked inside. Choice is an empty promise, a smokescreen behind which the patriarchal medical model churns relentlessly on"

(p.406). She further argued that “in terms of supremacy, little has changed: it is clear that the obstetricians remain the ultimate policy and decision-makers” (p.407).

2.8 Conclusion

In this chapter I discussed the literature surrounding ‘normal birth’ and examined some questions and issues relating to definitions of ‘normal birth’. What the literature revealed is a lack of consensus and many debates about normality in the context of birth. Is normal the actual birth of the baby vaginally without instruments, despite any interventions prior to the actual birth of the baby? Or is it an entirely physiological process? Or is ‘normal’ the most common experience of women? There exists no definition of a ‘normal’ labour and birth.

In New Zealand pharmacological, technological and surgical interventions used during labour and birth are common, including during the labour and births of well, healthy women. From the published data, it is simply not possible to identify those women who have experienced no intervention during their labour and birthing processes. Caesarean section delivery is becoming increasingly common and maybe even regarded as ‘normal’ for some women.

The literature further discussed two dominant discourses or models of care. The midwifery model promotes birth as a natural and normal process, and trusts that women inherently have everything they need to nurture and birth their babies. While the medical model assumes an inherent pathology and consequently labour and birth must be observed and controlled, no birth can be seen as normal except in retrospect. The medical model remains the dominant cultural construction of birth in our society, supported by political and legal institutions.

In New Zealand the midwifery model of care has been further refined and extended to include the notion of partnership. The 'midwifery partnership model' provides the key concept for the New Zealand midwifery profession. The beliefs that underpin this model include birth as a normal life event, midwives providing the total maternity service, midwifery as an autonomous profession, and midwifery as women-centred. There is debate and critique of this model amongst midwives and in the literature.

I briefly discussed the history of childbirth, obstetrics and midwifery practice, detailing how birth has been moved from the domain of home and woman-to-woman caregiving, into the domain of the professionals and hospital based care. There has however been opposition to the medical 'takeover' and the ways that childbirth is constructed, negotiated and controlled is constantly contested. In the New Zealand context, recent changes to the maternity notice (Ministry of Health, 2002) support women-centred care, with women able to select a Lead Maternity Carer for continuity of care, and the ability for midwives to choose a wide variety of midwifery practice models.

Finally, I considered women's views in relation to labour and birth, highlighting the dilemma that women themselves are subjected to the competing discourses of childbirth. Women, as well as midwives, have been involved in efforts to promote both more and less intervention during labour and birth. However, women themselves are not simply following the 'ideological scripts' that are placed in front of them. Women too are active participants in creating a variety of labour and birth stories. No one can know all of the influences that converge to create a woman's labour and birth experience.

Having reviewed aspects of the literature related to this study, the following chapter will consider the current study's philosophical underpinnings, and the methods used in the research process.

CHAPTER THREE:

Research methodology and method

3.1 Introduction

In the previous chapter I reviewed the literature surrounding definitions of 'normal' and 'normal birth'. In this chapter I discuss the research process including philosophical underpinnings and the research method. In seeking a way to research the area of 'normal birth' I was mindful of the multiple world-views held and so sought a research approach that allowed for different ways of viewing the world. I also remained conscious of my personal worldviews. To this end, I elected to research the area of 'normal birth' using a qualitative approach with feminist underpinnings.

In the first section I identify and discuss the epistemological stance I adopted for this research and then move on to the theoretical perspective. The following section explores the methodology. The third section considers the research methods used and in this section I introduce the nine midwife participants and consider the data analysis process and present a 'data trail'. Dilemmas I experienced during the research process are also considered.

3.2 Epistemology

An epistemology gives us a way of understanding and explaining how we know what we know (Crotty, 1998) and informs the theoretical perspective for the research. Constructionism is the epistemology claimed in most qualitative approaches today and will provide the philosophical grounding for this qualitative research.

Constructionism is the view that “all knowledge, and therefore, all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context” (Crotty, 1998, p.42). Therefore, meanings are constructed by human beings as they engage with the world they are interpreting. Different people may construct meaning in different ways depending on their world-view.

The epistemological stance of constructionism allows the possibility to work with the multiple positions midwives occupy concerning the nature of truth and knowledge. Constructionism is relativist: what is said to be ‘the way things are’ is really just ‘the sense we make of them’ (Crotty, 1998, p.64). This ontological position: relativist, recognises that “different people may well inhabit quite different worlds” (Crotty, 1998, p.64).

The epistemological stance of constructionism and the ontological position of relativism give room in the current study to see understandings tentatively and see them as historically and culturally defined, as opposed to truths of some kind. At different times and in different places understandings may well receive a different interpretation. And different people inhabit quite different worlds, and in turn “their different worlds constitute for them diverse ways of knowing, distinguishable sets of meanings and separate realities” (Crotty, 1998, p.64). The view adopted within this research is that midwives actively participate in the construction of knowledge and that the social contexts of midwives play an integral role in determining how they put knowledge into action/practice.

Women also actively participate in the construction of knowledge and have their own social contexts. It is important to acknowledge here that women have important views on what constitutes ‘normal birth’ and can make a valuable contribution to this area of study. However within the confines of a Masters project, I have elected to limit the current study to the views of midwives.

3.3 Theoretical perspective

A theoretical perspective provides the philosophical stance informing the methodology and provides a context for the processes involved (Crotty, 1998). A feminist perspective underpins and informs the methodology in the current study.

As a novice researcher, using feminism to underpin such a study is problematic, as there is much disagreement and discussion in the literature and no consensus existing as to definitions of feminism or feminist research; any definition can be and is contested. Ramazanoglu and Holland (2002) presented the view that feminism “covers a diversity of beliefs, practices and politics, and these overlap and interact with other beliefs, practices and politics” (p.5).

Lather (1991, p.71) argued that feminists see gender as “a basic organising principle which profoundly shapes and mediates the concrete conditions of our lives” and that feminist researchers put the social construction of gender at the centre of their inquiry. In a supporting view Hall and Stevens (1991, p.17) propose three basic principles of feminism:

- a valuing of women and a validation of women’s experiences, ideas and needs
- a recognition of the existence of ideological, structural, and interpersonal conditions that oppress women
- a desire to bring about social change of oppressive constraints through critique and political action.

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

Whilst there are many more definitions and disagreement in the literature, for the purposes of this study, I support the view that research underpinned by a feminist

perspective refers to research questions that are important to women, are of interest to women and arise from political struggles (King, 1994). Similarly, Ramazanoglu and Holland (2002) suggest that feminist research is “politically *for* women; feminist knowledge has some grounding in women’s *experiences*, and in how it *feels* to live in unjust gendered relationships” (p.16).

As discussed in the literature review, midwifery has a long history of political struggle and the current study is concerned with the political nature of midwifery practice and maternity services in New Zealand. Medicalisation and the medicalisation of women’s birthing experiences have been key topics of feminist scholarship; this research contributes to such debate and discussion.

The New Zealand midwifery profession has been identified as “a strongly feminist form of professional practice” (Tully & Mortlock, 1997, p.6). This is reflected in the increasing use of feminist research methodologies by New Zealand midwifery researchers (Fleming, 1995; Hotchin, 1997; McLauchlan, 1997; Pairman, 1998). This research contributes to the growing body of midwifery knowledge in New Zealand. In addition, I have a personal congruency with feminist ethics in determining how I wished to work with my midwifery colleagues in completing this study.

This first section has considered the epistemological position of constructionism and the feminist theoretical underpinnings for the current study. Constructionism acknowledges that meanings are constructed by human beings as they engage with the world they are interpreting and feminist underpinnings support the research in that its basis is in women’s political and personal experiences. The next section goes on to consider the research methodology and research methods.

The terms *methodology* and *method* are sometimes used incorrectly and interchangeably in the literature. Although frequently intertwined, methodology refers to “a theory and analysis of how research does or should proceed” while method relates to the actual “techniques for gathering evidence” (Harding 1987, p.2; King, 1994).

3.4 Qualitative methodology

Methodology in social research is concerned with procedures for making knowledge valid and authoritative. It determines the choice of method, the implications surrounding the choice and how those methods are used (Crotty, 1998; King, 1994). Methodology encompasses “the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcome” (Crotty, 1998, p.3). Qualitative research is generally concerned with the meanings people attach to their experiences of the social world and how people make sense of that world. It therefore tries to interpret social phenomena in terms of the meanings people bring to them (Pope & Mays, 2000).

Oakley (2000) argued “both feminism and health promotion operate in worlds of hegemony - patriarchy and medicine - which push them to extremes in an effort to make their voices heard” (p.42). Similar arguments apply to midwifery research, which, in embracing ‘qualitative’ methods, aim to make a distinctive contribution to understandings of the maternity services context and present the research in ways that society will be challenged to recognise. Further, all three groups, feminists, health promoters and midwives, occupy socially marginalised positions, they are ‘the other’ (Oakley, 2000).

3.4.1 Qualitative descriptive

Sandelowski (2000) sees qualitative description as a common though relatively unacknowledged form of inquiry as opposed to being a new form of inquiry. She acknowledges descriptive research as a “plainer and less sexy” form of inquiry, but argues that “it is one of the most frequently employed methodological approaches in the practice disciplines” (p.335).

Sandelowski (2000) built on the work of Thorne, Kirkham and MacDonald-Emes (1997) who explored the use of interpretive description as a noncategorical qualitative alternative for developing knowledge. They argue that interpretive description “ought to be located within the existing knowledge so that findings can be constructed on the basis of thoughtful linkages to the work of others in the field” (p.173). To this end, the current study builds upon what is already known about the contested construct and context of ‘normal birth’.

In undertaking a qualitative descriptive study, the expected outcome is a “straight descriptive summary of the informational contents of the data organised in a way that best fits the data” (Sandelowski, 2000, p.338). However, in seeking to describe an experience, researchers select what they will describe and in the process may begin to transform the experience. Thus descriptive summaries may yield “the working concepts, hypotheses, and thematic moments for future ... study, or themselves contain early versions of them” (Sandelowski, 2000, p.339).

The aim of this qualitative study is to “illuminate and provide a vicarious experience by making the familiar more familiar (eliciting the often-cited shock of recognition), making the familiar strange, and/or by revealing what is hidden” (Sandelowski, 1995, p.372).

3.4.2 Trustworthiness of the research

The basic question of any research is the credibility of the research findings. Oakley (2000) suggested three issues for how qualitative research is judged to be sound: how qualitative research is done, how it is described, and how its audience is able to decide whether or not its findings are trustworthy. Further Oakley says that “reaching agreement on what criteria to include in assessing the validity of qualitative research is clearly not an easy task” (p.57). She goes on to list four examples of quantitative criteria

for judging the trustworthiness of qualitative research (Table 3.2, pp.58-60) and four examples of qualitative criteria for judging the trustworthiness of qualitative research (Table 3.3, pp.62-63). Oakley concluded that “the distinguishing mark of all ‘good’ research is the awareness and acknowledgement of error, and that what flows from this is the necessity of establishing procedures which will minimize the effect such errors may have on what counts as knowledge (2000, p.72).

In this project I have elected to use the criteria Lather (1991) suggested. She argued that for qualitative research to produce work that is useful in the struggle for a more equitable world it must pursue rigour as well as relevance. She goes on to say that a “lack of concern for data credibility within praxis-oriented research programs will only decrease the legitimacy of the knowledge generated therein” (p.66). She argued for a systematic approach, which includes construct validity, face validity, and catalytic validity.

Construct validity refers to the continual critiquing of the research process and asks the researcher to report on choices made during the research process and to reflect on the researchers contribution to the process. Construct validity can be evaluated by way of reflexivity, Hertz (1997) says “to be reflexive is to have an ongoing conversation about experience while simultaneously living in the moment” (p.viii). Grbich (1999) concurs and suggested reflexivity at the very least requires an awareness of how the beliefs and values of the researcher influence the research process.

In order for the research to have credibility it is important to be open and clear about my own process in undertaking the research. The ‘me’ in the qualitative research process is evident in the selection of the topic, the relationship with the midwives during the interviews and in the analysis of the interview material, and finally in the writing up of the research. Issues arising during the data analysis and writing up are discussed in the next section.

Face validity involves returning or recycling description, emerging analysis, and conclusions back to participants for their reactions, comments and consideration. In this research, interview transcripts were returned to the participants for further comment and confirmation of accuracy. Half of the participants returned marked and confirmed transcripts, with generally very little alteration in the text of the interviews.

After much contemplation, I elected not to send the emerging analysis to the participants. Various critiques of 'member checks' have been discussed in the literature. Acker, Barry and Esseveld (1983) admitted some reluctance to share their interpretations with some participants who they felt would be upset by their interpretations. Their solution was to not include the participants as active participants in the analysis of the research. Mauthner and Doucet (1998) also highlight the difficulties and dilemmas with returning emerging analysis to participants. They suggest that participants may not wish to become involved in such a way or that the goals, aims and timeframes of the project may not accommodate such an interactive data analysis phase. They also highlight the risk of disagreement between the researcher and participants in the interpretation of the data. Oakley (2000) reinforced this critique and concluded "taking research data back to the researched is an example of a social event rather than a scientific test" (p.66).

As discussed in the following section, I found the data analysis phase to be non-linear and complex, with frequent recycling and juggling of ideas, therefore it was not possible to establish when it would have been appropriate to involve the participants. In addition, I felt I needed to take full authorship and responsibility for the research findings. Stanley (1984) argued that feminist researchers face "the conundrum of how not to undercut, discredit or write-off women's consciousnesses" (p.201) when these differ from their own. She says that at best the researcher can be as aware as possible that interpretation is an exercise of power, that decisions have consequences, and that the researcher is accountable for the conclusions.

In this study many of the midwives interviewed demonstrated that they felt they had a good grounding in 'normal birth' and discussed positively their own personal practice

outcomes. I have no reason to challenge these midwives as I have not examined their practice statistics nor undertaken participant observations as a data collection tool. I do however have the published national figures that demonstrate high intervention rates. Perhaps this group of midwives are an exception. Many talked of a high percentage of the women they attend achieving 'normal' intervention free labours and births. However, as presented in the data chapters they also discussed difficulties in the current environment and a perception that 'other' midwives did not 'achieve' such positive outcomes.

Catalytic validity represents the degree to which the research process reorients, focuses and energizes the participants towards knowing 'reality' in order to transform it (Lather, 1991). Catalytic validity is present in this work. Several midwives made comments of the ways undertaking the interviews made them consider their views and definitions of 'normal birth'. I am confident that the midwives interviewed found the process to be collaborative and that each participant was happy with the degree to which they engaged with the process. Some midwives chose to read and return the transcripts and I received several letters affirming the positive nature of their involvement in the research. All midwife participants were keen to discuss the research process and to receive a summary of findings when I have completed this thesis.

In this section I have considered the issue of trustworthiness and credibility in qualitative research. I attempted to use Lather's (1991) model that includes construct validity, face validity and catalytic validity. Throughout this project I have been mindful of the importance of being open and aware of flaws in the research process and issues of trustworthiness and credibility; I have sought to structure this project based on sound credibility and ethical principles.

In closing this section I present Temple's (1997) solution to the issue of validity in qualitative work. She suggested that feminists should abandon general attempts at validity and rather declare their own hand, while each reader should compare what they read with their own views. This attempt at reflexivity is intended to avoid the problem

of limited academic communities silencing the experience of others by specifying what can constitute proper knowledge (Temple, 1997). Individual researchers however are not isolated from the community, and Alcoff and Potter (1993) claim that the primary agent of validation of knowledge is not the individual researcher but her community. This research will contribute to the body of midwifery knowledge in New Zealand. Midwifery cannot exist in isolation of the health system or the environment in which we practice. Hendry (2001) says that “we need to listen to dissenting voices as well as supporting ones in order to clarify our position (and threats) within our environment” (p.15). This research will be presented to the New Zealand and international midwifery communities.

Having considered methodological issues, I now focus on the method used.

3.5 Research methods

Methods are “the techniques or procedures used to gather and analyse data related to the research question” (Crotty, 1998, p.3). The methods used in this study were semi-structured, in-depth individual interviewing and manual thematic analysis.

3.5.1 Participant recruitment

Purposive sampling was used to invite midwives to participate in this study. Purposive sampling is a deliberately non-random method which aims to select a group of people with particular characteristics (Bowling, 1997). The criteria for participant selection were that the midwife: provided full Lead Maternity Carer midwifery services throughout the pregnancy, labour and birth, and up to six weeks postpartum (i.e. continuity of care) and provided care for women planning both home and hospital birth.

Bowling (1997) addressed the problem of sample size that faces qualitative researchers. She argued for small sample sizes because of the complexity of the data, the time consuming analysis and the aim to gather rich insights rather than statistical information. While there are no clear guidelines about size, a cut off point suggested is, "when the same stories, themes, issues and topics are emerging" (Bowling, 1997, p.338). It very quickly became evident that the stories, themes, issues and topics were consistent between the midwives interviewed, with each midwife reflecting her individual context.

My research proposal identified an intention to interview ten to sixteen participants. I sent letters in October 2001 and February 2002 to the New Zealand College of Midwives regional chair people with a request to distribute information sheets (Appendix A). Overall six letters and forty information sheets were sent out. From these letters I received calls from four participants; the other five participants received information about the study by word of mouth from their colleagues.

Midwives who were interested in the study contacted me by telephone or email after receipt of the information sheet. I arranged to interview all midwives who contacted me. We then arranged a time and place that was convenient for both the participant and myself to meet.

3.5.2 Interviews

I met with each midwife as arranged for one interview. After any questions or clarification were attended to, the consent form was signed (Appendix B) and permission gained to audiotape the interview. Data was then collected via face-to-face semi-structured interviews. A semi-structured qualitative interview is a conversation in which the researcher actively engages "in a dialogue with research participants, using techniques that explore and deconstruct familiar stories", ideas and concepts about the topics and issues under discussion (Grace, 1998, p.116).

During the interviews I asked the midwives to describe themselves and their practice, then moved onto asking a number of open-ended questions around 'normal birth'. I used an interview prompt sheet to ensure congruency between the interviews. Following each interview the questions were reviewed and changed as new ideas and issues arose.

The questions evolved around the day-to-day realities of midwifery practice exploring the various influences and constraints as perceived by the midwife. Interviews had wide flexibility for each participant to address issues that were relevant and important for her specific practice situation. The interview prompt sheet however enabled some focus for our discussion.

Interviews were held with the midwives in a place of their choosing that was private and quiet. As anticipated, interviews took one to two hours each; if possible I arranged two interviews in each centre to manage time and travelling distance effectively.

Following the interviews the audiotapes were transcribed verbatim onto computer disc and printed. My initial intention was to employ a transcriber, however I was able to transcribe all tapes myself. This was beneficial for immersion in the data and a cost saving. Transcripts were returned to participants for accuracy, comment, input or deletion as appropriate. Half of the midwives returned transcripts with very few of the midwives choosing to alter the transcripts or add comments.

Interviewing is a data collection method that allows each participant's voice to be heard within her own context. Semi-structured interviewing has been regarded as synonymous with qualitative research and as quintessentially feminist (Maynard, 1994). Each interview was conducted in a relaxed conversational atmosphere where open dialogue could occur and topics explored as they presented themselves. I felt that the midwives enjoyed the process and enjoyed discussing their midwifery practices.

3.5.2.1 Insider/outsider issues

It is appropriate in undertaking feminist research to be reflective about my position as a midwife interviewing colleagues. As a midwife I am a member of the community I am seeking to study, not an outsider looking in. However I am also an outsider as a postgraduate student and researcher, and a midwife from outside of the region. Kirkman writes that “insider/outsider status has important implications for access to research populations” (2001, p.55) and raises issues related to ethics.

Recognising myself as part of the research process allows me to “look for the tensions and contradictions” that may occur because of my personal positioning or bias (Lather, 1988, p.576). The choices I made in relation to the research were motivated by my interests, and span the choice of research topic to methods and decisions about how to present the findings. As an insider, I have an understanding of the dynamics and relationships in midwifery practice and have personal experience to draw upon; therefore, midwives may have felt more comfortable in sharing information with me. However, I was also mindful that my experience and assumptions may not have matched those of the participants and was careful that the participants did not feel I was in any way judging or criticising their midwifery philosophy or practice in conducting this research. It was my aim that the midwives took the interviews as an opportunity to reflect on practice and I do feel that this aim was achieved.

3.5.3 The Midwives

Interviews were completed with nine midwives from six different regional centers. The participants were all women and all Pakeha (non-Maori). They were aged between 43 and 55 years old. All but one had children. All completed a registered nurse to registered midwife training programme, with programmes ranging between six to eighteen months.

Midwives were on the whole very experienced and had been in self-employed practice for a long time with most midwives being in practice for over fifteen years (five midwives), one midwife had been in practice for eighteen months and three had been practicing between five and seven years.

All work in self-employed midwifery group practices, working with supportive colleagues. Liz reflects the group with this comment:

I'm an independent practitioner I work in a group practice and do total midwifery care (Liz, p.1).

All have a caseload, in line with the New Zealand College of Midwives guidelines, between 30 to 60 women per year and work in urban, semi-urban and rural settings. The midwives work across a variety of birthing/midwifery settings: homebirth, birthing centre, small community based units and secondary and tertiary city hospitals.

Home birth/hospital birth splits ranged from 10% home birth/90% hospital birth to 95% home birth/5% hospital birth. Most midwives attend the majority of births in a hospital environment.

3.5.4 Ethical issues

All research projects require consideration of ethical issues to ensure the rights of participants and clarify the responsibilities of researchers. Prior to commencing this study the research proposal was presented to the Massey University Human Ethics Committee who unconditionally approved the project (HEC: PN Protocol 01/106).

The major ethical principles relating to research participants are the right to informed consent, confidentiality, anonymity, minimizing of harm, truthfulness and social sensitivity (Massey University, 1997). Each of these concepts is discussed in turn. In addition, feminist ethical concerns are considered.

3.5.4.1 Informed consent

Research participants have a right to consent to participate only when they know and understand relevant information about the study (Wilkinson, 2001). Important information includes the identity of the researcher, the purpose and nature of the study, the right to refuse to participate, the right to withdraw at any time, and the measures taken to protect privacy and to ensure anonymity and confidentiality.

Potential participants received an information sheet (Appendix A) inviting them to participate in the study, those willing to participate made contact with me. The information sheet detailed who I am, the aims of the research and what the research involved, including the anticipated involvement of the participant. After discussion, interview participants signed a written consent form (Appendix B). As participation was voluntary, midwives choosing not to participate were free to discard the information sheet and not respond.

3.5.4.2 Privacy and confidentiality

Participants have the right to privacy and to have confidentiality protected. Tolich (2001, p.78) defined confidentiality as “where the researcher can identify a certain person’s response but promises not to make the connection publicly”. In the current study, the names of participants are confidential to myself. During the research process all tapes, discs and transcripts were identified by pseudonym and signed consent forms kept in a separate secure place.

3.5.4.3 Anonymity

A participant is anonymous when responses can not be identified as belonging to that participant (Tolich, 2001). In order to protect anonymity pseudonyms selected by the participants are used throughout the analysis and writing up of the study. In addition, because of New Zealand’s smallness and the small number of midwives practicing in

each town, it may be relatively easy to identify individuals if the region was identified. Therefore the regions selected for study and any identifying information regarding institutions and communities have not been disclosed.

3.5.4.4 Minimizing of harm

Participants have the right not to be harmed as a result of participating in a research study (Bowling, 1997). This requires the researcher to ensure the integrity of the study throughout the process, from planning to publication (Roberts & Taylor, 1998). No physical or psychological harm was anticipated in the current study.

In this type of research however, it is not always possible to anticipate what issues may be uncovered. Participation in the study seemed to be generally positive for the midwives, as it was an opportunity to reflect and talk about their practice. However if any participant became distressed during an interview, I offered that we take a break and that the tape be switched off.

3.5.4.5 Feminist ethical concerns

Feminists have expressed many concerns about the ethical issues involved in research, particularly in relation to research that could be described as unsafe, unjust and oppressive for the participants. For feminist researchers complex ethical issues include the risk of exploitation, the need for empowerment of the participants and the experience of the participants (Carrier, 1997).

Stacey (1988) cautioned feminists to avoid the exploitation of research participants. She argued that because qualitative research depends upon human relationships, engagement and attachment, it places participants at grave risk of manipulation and betrayal by the researcher. Secondly, she argued that that the outcome of the research is primarily for the researcher's purposes, uses the researcher's interpretations and is the researcher's writing.

Reinharz (1992) countered Stacey's views; she believed that relationships formed with research participants are in fact reciprocal. The relationships formed can be constructive and deeply appreciated. While Reinharz (1992) conceded that there is a chance the researcher may not be able to fulfill the needs of all participants; it is an impossible quest for the researcher to be "all things to all people at all times" (p.74). Further she concluded that the feminist researcher is "simply human and is motivated by concern for women, not for their exploitation" (p.75).

Interviewing allowed the midwives' stories and experiences, practice contexts, constructs and knowledge to be illuminated. Semi-structured interviews were chosen to ensure the midwives had the opportunity to reflect and consider the topic of 'normal birth' within their own practice context. The midwives directed the focus of the discussion and talked about what they thought was important relating to each discussion point I raised. I took care to make it a relaxed, conversation atmosphere where topics were explored as they arose. I participated as the researcher, but also as a practising midwife, acknowledging some of the same experiences and frustrations as the participants. I felt that all interviews were a sharing of collegial experiences and proceeded well, participants seemed comfortable and no ethical concerns were expressed.

3.6 Data analysis

Thematic analysis was the method chosen to analyse the transcripts. I elected to avoid the use of qualitative research computer programs such as *NUDist* (QSR, 1995) or *ethnograph* (Siedel, 1992) in order to retain the flexibility and personal input of manual thematic analysis. The emphasis in thematic analysis is on discovering recognizable patterns or themes from the life experiences within the text (Aronson, 1994; Roberts & Taylor, 1998).

Boyatzis (1998, p.4) lists six overlapping or alternative purposes for thematic analysis. Thematic analysis can be used as:

- A way of *seeing*
- A way of *making sense* out of seemingly unrelated material
- A way of *analysing* qualitative information
- A way of *systematically observing* a person, an interaction, a group, a situation, an organisation or a culture
- A way of *converting* qualitative information into quantitative data.

In this study I used thematic analysis to *see, make sense and analyse* the qualitative data collected during the interviews. The outcome of thematic analysis may be a “list of themes; a complex model with themes, indicators, and qualifications that are causally related; or something in between these two forms”. A theme is defined as “a pattern found in the information” (Boyatzis, 1998, p.4). In the current study, thematic analysis revealed themes that explored and made sense of the midwives ideas, views and conflicts around ‘normal birth’.

3.6.1 Audit trail

An audit trail is careful documentation of the research project, with an adequate amount of evidence so that interested parties can reconstruct the process by which the conclusions were reached.

Interviews were transcribed from the audiotapes, creating the raw data for analysis. Transcripts were proofed against the audiotaped interviews and sent to participants for comment, deletion or alteration. Once transcripts were returned any changes were made. Two copies of transcripts were then printed, with each participant having different coloured paper. I retained an intact copy of each transcript, to return too as necessary.

Analysis began with each transcript read as an individual unit to get a sense of each. As I read I jotted down ideas and comments in the margins. Once all transcripts had been read, I read through them again to gain a sense of the data as a whole for some comparison across the nine interviews. There were a total of 159 pages of data. As initial themes or categories emerged, I reread through transcripts to ensure that each transcript had been recycled through each theme and made further notes in the margins. I found many similarities in the transcripts, with some of the same themes being repeated across all participants.

As I wrote all initial themes down and made links between them, broad themes with sub-themes began to emerge. Five initial themes, with around six sub-themes each emerged. These were printed out and an 'envelope' made for each theme. Each transcript was then 'taken to' with a pair of scissors and data units were cut and placed into the relevant envelope. The slips of coloured paper grew as I chopped! As I cut I did some fine-tuning of ideas and duplication of data when ideas/data units fitted into more than one theme. A further theme emerged with several sub-themes during this process. When all transcripts were cut-up I read through each envelope and there was some further rearranging from one envelope to another.

The process was then repeated as I 'cut and pasted' on the computer to move data units from the original transcripts into the now six themes with sub-themes. New ideas, rearranging and further fine-tuning emerged as I worked with the data units. These theme documents were then printed out. At this stage I began to feel swamped under the data as I realised I was still working with over 70 pages of 'raw' data units. The ways in which the emerging themes and ideas overlapped and the complexity of the data somewhat overwhelmed me, with there now being thirty-two sub-themes and six themes. I further worked with the data and rearranged the themes and sub-themes, streamlining down to four themes.

At this time I had a meeting with my research supervisor and after discussion, began a new round of arranging and rearranging of ideas. I entered a period of struggling with

the process and the 'how-to' of the research. At this time I felt I hadn't asked the participants the 'right' questions and that the data would not fulfill the aims of the research question. As a novice researcher I struggled with a way to present the data, what framework to 'hang' the ideas, participants' excerpts and literature from.

I searched the literature for some guidance and found that others too have found the process of data analysis difficult to describe, with a hard-to-delineate 'fuzziness' in the process (Davis-Floyd & Sargent, 1996). Oakley (2000) likened it to asking a centipede to describe how it walks on all legs at once.

I continued working and re-working the data, revisiting the literature and my initial research aims. I read and reread the participants' words; salient themes and patterns emerged, submerged and then re-emerged anew. As I read I became aware of what Carryer (1997) called a degree of boredom, which derived from reading or hearing the same things repeatedly. So I began to 'write' the data chapters, feeling that I was no further ahead with the 'analysis' of the data, but nor was I able to move ahead. It was during this time I became acutely aware of the ways in which I could misrepresent the concepts and ideas shared by the participants by isolating individual words and phrases and taking them out of context of the overall interviews. This was not a comfortable feeling and is discussed below.

Slowly the two data chapters emerged from what felt like confusion. 'Normal birth' exists within the wider midwifery practice and societal context of the midwives. Therefore, during the interviews the midwives and I found that it was not possible to discuss 'normal birth' without a thorough examination of the context. The data chapters reflect this, with the first highlighting the extent to which the context of birth continues to be firmly entrenched in the medical model and the second identifying ways that midwives have adapted to the environment. Many times I returned to the raw interview transcripts and to the literature to search, match and align the participants' words with my interpretations and the literature.

Ramazanoglu and Holland (2002) highlighted that “the process of interpretation can be skilled, creative, reasoned and intuitive, but they argue researchers cannot know for sure whether their connections and meanings can be justified, or what epistemological, ethical and political effects follow” (p.116). The researcher cannot set aside her own language, life and understandings when she produces her interpretations (Smith, 1989).

Throughout this process I worked as a Lead Maternity Carer midwife and reflected on my own practice and how my interpretations of the data ‘fitted’ in my day-to-day reality. In undertaking a qualitative project I was aiming to illuminate and ‘make more familiar’ the reality of midwifery constructions of ‘normal birth’ in midwifery practice. This balance of ‘doing’ midwifery alongside ‘doing’ midwifery research gave me a unique perspective and balance between what I was reading in the literature and the data, and the ‘real world’ of midwifery practice.

3.6.2 Issues arising from data analysis and writing up

During the data analysis and writing up process I struggled as to how to remain ‘true’ to the individual midwife participant and remain true to my own interpretation of the data and making a difference in the current context in relation to midwifery practice. Ribbens and Edwards (1998) acknowledged the ambiguity that arises when we seek to serve an academic audience while also remaining faithful to forms of personal contributions from the participants. The possibility of drowning out, silencing, misunderstanding or misrepresenting particular participant contributions creates a frightening responsibility because the contributions come from real people with real names, faces and lives.

Mauthner and Doucet (1998) highlighted data analysis as a particularly critical site for the issue of reflexivity. It is in the data analysis where the “voices and perspectives of the research respondents are especially vulnerable” (p.138). At the data analysis and writing up stage of the research process I became increasingly uncomfortable with my

‘power as researcher’ to represent or misrepresent the midwives who had so willingly talked with me about their practice reality and their views of ‘normal birth’. During the analysis process as I dissected, cut up, distilled and reduced the midwives’ accounts, I felt that much was lost of the complexity, subtleties and depth of the overall interviews. During the writing up process I interpreted their words and selected extracts for quotation, I felt uncomfortable with becoming a lens or filter, concerned that I was subsuming the midwives’ words into my own views.

I was heartened to find guidance in the literature. Ramazanoglu and Holland (2002) say: “there is a difference between empowering individual research subjects and making any difference to entrenched, institutionalized power relations. Examining similarities and differences in women’s knowledge and experiences, however, can provide some basis for generalization. It is from such (initially limited) generalizations that practical grounds for strategic alliances across difference can be considered, and common aims and interest conceived” (p.120).

In a similar vein, Oakley (2000) suggested that one of the purposes of research is to move beyond individual world-views; she says, “this is its essential difference from fiction” (p.298). Qualitative research includes (usually) more than one ‘case’ for exactly the same reason: that what we seek are patterns, generalities, associations, that help us to understand ‘what is going on’. Individual research participants are usually not in a position either to divulge or to see these patterns (Oakley, 2000).

In further support of my position, Hertz (1997) argued that to make sense of the data collected, “we may draw on the richness of our own experience, particularly if what we are studying we also have experienced” (p.xiii). As I became more embedded in the research process I found each labour and birth I attended as a midwife triggered ideas or confirmed my thinking and related back to the words and stories of the participant midwives. My practice experiences added to the richness of the participants’ interviews and gave me a very real sense of the day-to-day realities of midwifery practice in the current context.

Ramazanoglu and Holland (2002) argued that “the possibility of the researched judging what the researcher has made of them considerably sharpens the problems of conceptualizing and representing ‘others’, and markedly problematizes relationships between researcher and the researched” (p.114). In this study, the research participants are my colleagues and peers, who have a professional interest in my interpretation of the data. My dilemma is to represent the words of the participant midwives in ways that respect the individual midwife participants’ practice and make a difference to the entrenched, institutionalised power relations present in the ‘normal birth’ context. I am acutely aware of my responsibility in interpretation of the data. I agree with Temple (1998), that researchers are accountable for the understandings they produce in translation and interpretation of data processes.

Further, Ramazanoglu and Holland (2002) argued that “researchers are often protected by producing texts for specialist academic consumption that are not intended to be available to non-specialists” (p.114). Again, in the case of this research, the intended audience are the research participants and other colleagues and peers. This being the situation, academic writing in no way ‘protects’ me from collegial critique.

3.6.3 The final ‘themes’

The final themes to emerge from the data analysis journey represent what I believe the nine midwives were saying in the context of the literature and my interpretation of the two. One of the strongest themes to emerge was the participants’ awareness of the tensions and the medicalised nature of the current birthing environment. The first data chapter examines the significant level of medicalisation of the physiological processes of labour and birth and normalisation of intervention and technology. Influencing factors included place of birth, the way in which women have internalised the medicalisation of birthing, the acceptance and expectations of intervention in the labour and birth process, fear in the birthing context, and the ways in which midwifery practice agrees with

medicalisation. The second data chapter goes on to examine the related themes of how midwives are adapting to the medicalised context. The midwives interviewed found a variety of ways to attempt the preservation of 'normal birth' in the medicalised context. These included supporting women's choice to remain outside the system if possible, protecting women from the medically dominated system with the strategies of 'shutting the door' and 'keeping women away', and creating 'new rules' with flexibility to support women's labour and birth experiences. However, constraints and conflicts with these strategies were also highlighted in the analysis.

Acknowledging again that this is my interpretation of the data material, these themes: a medicalised context and adaptation, are an overview rather than the individual stories told in the interviews. Ramazanoglu and Holland (2002) say that it is not possible to neutrally unpack data to discover direct evidence. They further say that what constitute conclusions is an "interaction between your interpretative creativity, the constraining framework of your prior beliefs, and what appears new to you in your data" (p.160). Of course it is possible that different researchers or the participants themselves would reach different conclusions. It is working with the data and making my own interpretations that my power as a researcher is most acute.

3.7 Conclusion

This chapter has discussed both the philosophical underpinnings and the method used in this study. A qualitative approach with feminist underpinnings was selected as the most appropriate for understanding midwives' interpretations and construction of 'normal birth'. This approach allowed for the inclusion of the midwives voices' and for my interpretation of the data collected. A feminist perspective to research refers to research questions that are important to women, are of interest to women and arise from political struggles. In addition, I felt that feminist underpinnings gave me an ethical way of working with the participants, which was respectful and congruent with my own

feminist worldview. Using a qualitative approach allowed me to make thoughtful links with the literature and build upon what is already known about the construction of 'normal birth'.

Semi-structured interviews were chosen to collect data from Lead Maternity Carer midwives and I took care to make it a relaxed, conversation atmosphere where topics were explored as they arose. Interviews ensured that the midwives' stories and experiences, practice contexts and constructs, and knowledge about 'normal birth' were illuminated. Thematic analysis was used as a means of seeing, making sense of and analysing the data collected. Thematic analysis offered flexibility and fluidity, allowing for recognition of patterns or themes in the data and a continual recycling of the data between the interviews, the literature and my own interpretation.

The overall process of conducting this research was done with awareness of ethical and credibility issues. The major ethical principles of the right to informed consent, confidentiality, anonymity, minimizing of harm, truthfulness and social sensitivity, and feminist ethical concerns were considered. The ways that credibility or research trustworthiness has been reached was also addressed.

In the following two chapters the data is presented. Excerpts taken from the interviews with the midwives are framed with relevant literature.

CHAPTER FOUR: Contested context

4.1 Introduction

In Chapter Three I explain and consider the methodology underpinning this study, and the methods used. In this, and the following chapter, I present and discuss the interview material. In both chapters relevant literature is used to frame and enrich excerpts from the participants.

Before proceeding to discuss the themes that emerged from the interview material, I will briefly repeat the aims of this research project. I wanted to explore the assertion that midwifery care ‘enhances and protects the normal process of childbirth’; to find out how Lead Maternity Carer midwives constructed their concept of ‘normal birth’ and to explore the complex influences surrounding midwives understandings of ‘normal birth’. As discussed in the literature review chapter, pregnancy, labour and birth are historically and culturally constructed and contested concepts.

The purpose of this chapter is to demonstrate the contested nature of the current birthing environment and to show that the dominant ideology is based on a deeply entrenched medical model. A number of interrelated aspects have been identified from the interviews and are introduced. In Chapter Five I go on to consider the midwives’ adaptation to the contested environment.

4.2 Contested context

One of the strongest themes to emerge from the interviews was the participants’ awareness of the tensions and the medicalised nature of the environment. Despite midwifery aspirations for professional autonomy, with continuity of care and support for

women's choice there is currently a significant level of medicalisation of the physiological processes of labour and birth and normalisation of intervention and technology. Mary sums this up as she discusses her current practice.

A couple of years ago you probably wouldn't have put the [CTG] monitor on, you would have said no you're alright, these things are okay, counting them off on your fingers. Now you go in and put the monitor on and it's because you want to cover your butt when things go bad. So I think that that influences it because a lot of those women will say that I don't really want that done, I don't want that monitor put on, and so you spend some time talking them into it (Mary, p.9).

The use of electronic foetal monitoring in 'low risk' women is not supported by evidence. According to the British National Institute for Clinical Excellence (NICE) (2001), the evidence "does not support the use of the admission cardiotocography (CTG) in low-risk pregnancy and it is therefore not recommended" (p.4). Further systematic reviews of the randomised controlled trials into electronic foetal monitoring (EFM) have not shown a reduction in perinatal mortality or cerebral palsy, but have demonstrated an increase in maternal intervention rates (such as caesarean section). Despite this evidence there is either written policy or unwritten expectation in New Zealand hospitals that a 20-minute 'admission trace' is carried out on all labouring women and there is a low threshold for the commencement of continuous electronic foetal monitoring, with all its concomitant disadvantages. Liz and Sue both acknowledge that midwives commonly undertake a routine 20-minute admission electronic foetal monitoring.

It is common to do the blood pressure and the pulse because that's the hospital guidelines and temperature. A monitoring for 20-minutes early in labour, and actually some of them come in so early in labour that that's not an issue. But if you've got someone in really pounding labour it's ridiculous to strap them on (Liz, p.15).

Doing CTG monitoring when women go into labour at the hospital, for 20 minutes is normal, common, not natural (Sue, p.16).

Judy strongly feels the pressure to conform to medical protocols due to the power that she perceives the institution holds over her:

It's very frustrating because you, you know what you would like to be doing, but you go in there and you have to practice according to the hospital because otherwise they will remove your access contract and I can't afford for that to happen (Judy, p.4).

Similarly Imogene comments:

Certainly I do feel more bound by protocols and guidelines when I am in a secondary care institution (Imogene, p.9).

Maureen too recognised the way that the medical culture impacts on her midwifery practice:

I've got to pack in all this medical hospital stuff and get away from it. Otherwise I will just be too polluted and too fearful (Maureen, p.18).

She goes on to say:

I know that I am influenced by the medical model, I really am. Because of where I work mostly and the people that I associate with (Maureen, p.19).

Many midwives are discouraged by the medicalisation of birth and experience difficulties in keeping birth 'normal' in the present environment. There are many sophisticated techniques and technologies for surveillance and for inspection, to detect when complications occur, but increasingly to also confirm 'normalcy'. Many have forgotten or lost sight that, "birth works, if you trust it, understand and respect it" (Wickham, 2001, p.73). Maureen sees this:

It [birth] is a normal process, that nature designed us to do and that left alone it works well. And ... it's certainly very clear to me how easily it is effected and medicalised (Maureen, p.20).

Birth is a complex issue however and the use of intervention not simply explained. Many things impact on a woman's labour and birth and on midwifery and medical practice. In reviewing the participants data a number of key areas have emerged which have the potential to impact on a birthing event.

4.2.1 Place of birth

The majority of women in New Zealand give birth in institutions controlled by obstetricians and obstetric policies and protocols, with only a minority giving birth at home (estimated 7 percent¹). The persuasive nature of the medical model can begin to creep into the practice of midwives attending home births too. However, home as the place of birth is a place where a woman has true autonomy and may be more protected from the threat of unnecessary intervention. Judy illustrates the difference between home and hospital midwifery practice when she says:

I alter my practice when I'm doing hospital births. I think that we all do to a certain extent. But I'm very aware that they're watching me and they are auditing notes. Which is fine, I mean they've got to be safe, but they are not supportive of midwifery. Of midwives who practice in the midwifery model. They like midwives to practice according to the medical model and the way they relate to midwifery practice.

In what ways do they change your practice?

They make me a little bit more conservative when I practice in hospital. ... They tie you down; the protocols tie you down too tight (Judy, p.4).

¹ It is difficult to know the exact number of women who give birth at home. No robust national figures are available, however the 2001 Ministry of Health (MOH) Report on Maternity 1999 provided figures for 93% of the babies born in New Zealand hospitals, indicating that nearly 7% were born at home.

The place of birth has the potential to shape the woman's experience, determining who is in control and what interventions are available. At a home birth the attendants are visitors in the cultural context of the family, whereas in hospital it is the woman who must adapt to the hospital context. I asked Lynley about 'normal birth' in the hospital setting. She talked about the benefits of home birth and hints at the contested nature of the environment.

I don't know? I hope that we could have more at home. You're taking women away from an environment which is theirs, so you really have to think that. They are much, much better to be at home, because you are altering too much. You are placing the responsibility somewhere else outside of them. So maybe it can't happen? I'd love to just do home birth, but you have to convince them to have home birth and we're not really in an environment that you can do that. (Lynley, p.16).

Imogene compares her work in a birthing centre and home birth, with attending women in the secondary care unit.

In a secondary care unit, I feel my practice is ... much more bound by the protocols and time frames. And that's where yeah, I do I feel ... more restricted in my practice (Imogene, p.9).

She goes on to further clarify the way in which hospital protocols impinge on her practice:

They do, because I feel much more... for instance, having an active management of third stage I'm much more likely to do in a hospital setting than I would in a home birth setting. Because I know that the protocol says that they recommend strongly that all women have an active management of third stage, and so ... I suppose I don't feel so much that I, I don't know that control is the right word, but in control of things in a hospital, as I do. I feel more confident at home or in the birthing centre (Imogene, p.13).

Various studies have found that there are many more women who would like to plan to birth at home than do. In Norway one survey found that ten percent of respondents claimed that they would like the possibility for home birth, yet Norway has a less than one percent home birth rate (cited in DeVries, Salvesen, Wiegers, & Williams, 2001). A Danish study showed that while 13-15 percent of women planned a home birth, only 1.3% actually gave birth at home (cited in DeVries, Salvesen, Wiegers, & Williams, 2001). In Britain the Expert Maternity Group (Department of Health, 1993) cite one study that found 22 percent of women desire the choice of home birth, yet Britain has a home birth rate of only 2 percent (p.23). Similarly in New Zealand the National Health Committee Review of Maternity Services (1999) found that although 5 percent² of women give birth at home, up to 10 percent would prefer to plan to birth at home if this option was available and supported (p.46).

Olsen and Jewell (2001) concluded that there is 'no evidence in favour of hospital birth for low risk women'. Research shows that women who birth at home or birth in a birthing centre outside of hospital have better outcomes and more women actually desire to plan to birth at home than actually do. In New Zealand 93 percent or more women continue to 'choose' hospital birth. Both Diane and Judy perhaps point to some reasons for this situation:

It would be lovely in an ideal world to have those women come to you who are already converted, but I guess our job is to convert some others as well.

And that's hard

I think it's hard because the medical model is so strong in our culture (Judy, p.12).

Certainly the partner can influence a woman who is quite committed to having a home birth and the partner is not. They usually win don't they, and they have a hospital birth, it's quite sad, but it's something that they work out (Diane, p.18).

² As discussed above, it is not possible to find robust figures for the actual number of women in New Zealand birthing at home. The Ministry of Health Report on Maternity 1999 declares a 93% hospital birth rate, therefore a 7% home birth rate, and the National Health Committee Review, in the same year, reports a 5% home birth rate.

Sue is very clear in her view that home is the best setting for birth:

And childbirth just shouldn't be in hospital unless people are very sick. I don't think it should be in hospital. It just wastes too much money, there is way too much money spent and yeah I'm very one eyed about that. I think it's really really silly that we've got hospital births for normal birth (Sue, p.13).

While Imogene summarises this succinctly with the comment:

I think that the place of birth is crucial. The place of birth is crucial to the way that I practice. Yeah. And how I feel about. ... working really. It does. It makes a big difference as to how I practice as a midwife (Imogene, p.13).

Banks (2000) believed that home is the only place that a woman can experience the “true nature of ‘normal’ physiological birth” (p.145). In the hospital environment midwives are more aware of the expectations of the institution and it is more likely that the medical model frames a woman’s birthing experience. Employed midwives are bound to the protocols and policies by the nature of employment, while self-employed midwives sign an access agreement to care for women in hospital. In the hospital setting Banks believed that:

While the woman may be free from unnecessary intervention, it will only be within the framework of the policies and protocols of the hospital. Should her situation transgress the rigid rules, she will inevitably be subject to medicalised childbirth (Banks, 2000, p.5).

Liz points to the hidden or implicit ways that the hospital setting directs her practice in this comment.

I know that when I arrive in there (in hospital) and the room has been prepared for me by the hospital staff, there is a [CTG] monitor by the bed, there's a thermometer on the locker, and the bed is in the middle of the room. And there

is an expectation that the woman will come in and lie down and be monitored. So that's common, just how the room is set up. ... It's amazing what this platform is like when you walk in there. It dominates the whole room; and that's what birth is? Lying on the bed? (Liz, p.15).

The campaign in the 1930s for all births to take place in hospital has been an overwhelming success, despite any evidence to support the move (Tew, 1990). Walsh (2002) argued that research in the United Kingdom shows base hospitals to be associated with more birth interventions, more maternal morbidity, less 'normal birth', more low Apgar scores, birth asphyxia, and birth trauma. Further, they are more expensive and women are less satisfied. In conclusion, Walsh believed that midwives have an ethical obligation to inform women about the possibility of adverse effects in many hospitals.

Despite these findings, many women believe hospital to be more appropriate and the 'safest' place to give birth to their babies. Many are unaware of the dangers inherent in medically managed birthing. Women have internalised the need for medical surveillance and require confirmation of normalcy.

4.2.2 Women's internalisation of medicalisation

The majority of people 'choose' hospital births as it is no longer accepted that giving birth is a healthy life phase for most people. Societal acceptance that birth should be in a hospital and that the use of technology is desirable has been influenced by obstetricians who convey this message with all their power and authority (Miles, 1991). "The philosophy and practice of manipulating and controlling labour are so firmly entrenched that they have changed our societal view of birth" (Banks, 2000, p.106). Judy readily identifies the influence of women's expectation in her practice:

Oh woman can influence it, in terms of what their expectations are and sometimes you'll get up to the end stages of the pregnancy and you realise that actually the woman and you are like opposite ends of the room really. So then

sometimes you just have to. You can't go on and insist that she follow a midwifery model if she's really not there. So you have to just acquiesce, and I do (Judy, p.5).

Davis-Floyd (1992) in researching American women's experiences of childbirth, found that a significant number of women actually welcomed the medical intervention and technology, that made them feel powerful and that they were full participants in their cultural construct of childbirth. Judy comments:

And some woman you put the CTG on and they stare at it the whole time watching it and when it's ready to come off they don't want it off, they like watching it (Judy, p.10).

Partners and others also influence women's choice as Imogene says:

For instance, if someone's husband says, oh no, we have to go [city] because if anything goes wrong that's where you need to be, and so a lot of women will, that's a really strong influence on them. It's a far stronger influence on them than I can be, and I think society's pressures really. A lot of society pressures really, the media and people talking has a huge amount to do with that (Imogene, p.8).

And Lynley says:

You are looking at the whole social norm too and the network of chatting. And what I believe is normal, which is allowing the woman to birth, to labour in a place that is the most comfortable and that she is really trusting and she allows it to happen. Versus what the community and society [pause]. We've got a heap of work to do out there because we've changed it so dramatically. And their expectations and I think we are a strong influence on that. But it is the expectations, what the women want. And I hate that because like I don't think women should just, if they request an epidural get it. I don't think that's safe, I don't, it is a medical intervention. It has got huge connotations (Lynley, p.13).

In New Zealand most women have their babies in a hospital, they have pregnancy monitored by ultrasound scan with an average of three scans per pregnancy (Campbell, 2002) and labour monitored by electronic foetal monitoring. They have epidural anaesthesia (22.8 percent) to reduce pain and have either direct assistance (31.4 percent) (Ministry of Health, 2001) or directed pushing/coaching to give birth to their babies. It is therefore not surprising that most women come to believe that the use of these technologies and interventions **are necessary** to reduce the risk of harm to themselves and their babies during the labour and birthing process.

The myth of obstetric care being based on sound science is widely believed. Thomas (2000) suggested that in reality only fifteen percent of obstetric practices are based on research evidence and that the majority of practice is based on ritual, tradition and untested theory. Enkin (1994) supported this claim arguing that “much of what should be known is not known; the essential research has not been done. Much of what could be known, based on good evidence, is not known by most clinicians; the evidence is voluminous, scattered, and its validity is difficult to assess” (p.13).

When I asked Imogene about her experience of the influences on women’s ability to labour and birth without intervention she says:

I would probably say that mostly it is the women’s choice, that they have wanted interference or that they have accepted interference, for instance ventouse delivery or caesarean section. Some of them have said afterwards, “oh, if I’d really known how to push I think I could have done it, myself” (Imogene, p.9).

In the following chapter the issue of women’s choice in labour and birth is considered in detail. Briefly here I argue that women are immersed in a culture that is increasingly dominated by a medical and technological discourse. Cosslett (1994) supports this assertion, she argued that “subjectivities have been culturally constructed by prevailing discourses and cultural practices” (p.3). Further, health professionals have the power to shape the desires of women, as explained by Devries, Salvesen, Wiegers and Williams (2001, p.260). They proposed that there exists an attitude that says “What my caregiver

offers must be best”, and argued that this reflects a strong trust in individual caregivers. Women ask midwives to support them in making choices and the myth of the ‘expert’ knowing what is best is a seductive myth.

Judy made this observation when I commented on the medicalisation present in the hospital environment.

I know it's horrible. And the women think that they need that quick fix. I don't know. I think that there is no choice here. There are only about three GPs and no private obstetricians, so there is no choice. So you get people approaching midwives who are not really wanting midwives, who think they should have someone else. I think that the element of choice is really important. That there are women who aren't prepared to take responsibility for themselves and that's okay, but I don't want them (Judy, p.11).

Here Judy expresses the difficulty in working with women who have different expectations to the midwife. Sue has also experienced this:

So there is a difficulty, when the woman says one thing but is actually wanting another. And being on top of that stuff is actually quite hard (Sue, p.15).

There are now at least three generations of women whose only experience of birth has been directed by obstetric guidelines, procedures and protocols. As more and more women experience this and the more stories they tell, the more ingrained the medicalisation becomes. Lynley says:

It is the fancy beds, it is the small bedrooms and rooms, it is the moving of women, it is the whole thing that we will make it better for you so we will give you an epidural or we will give you pethidine. And we have to change that; we have to change a whole three generations of thinking, maybe two (Lynley, p.16).

Harding (2000) argued that many of the 'routine' tests and procedures in labour and birth are viewed as not falling within the 'scope' of informed choice. She believed that maternity care is carried out in an environment characterised by technology and protocols, many of which, she argued, have not been adequately scientifically evaluated before being used in practice. Further, she argued many "women have for so long been conditioned to accept 'routine' procedures that it does not occur to them that they may have a choice. Similarly, it does not occur to many practitioners that they should be offering women a choice" (p.76). Some women and midwives accept intervention as a necessary and usual part of pregnancy and birth. Mary sums this up nicely when she says:

[It is] that whole concept of what people perceive as being an acceptable birth and calling it a normal birth (Mary, p.12).

4.2.3 *Interventions acceptable and expected*

The medical model of technology and intervention are seen as an accepted and expected part of having a baby. Our society has expectations about things that are known to happen and women expect them to happen in the course of their labour and birth. For example, lying on the bed:

Women in a semi-reclining position or flat on their back in lithotomy is common. I don't know whether there are many women, midwives who encourage their women too not to be on the bed (Liz, p.16).

Other examples include: artificial rupture of membranes, electronic foetal monitoring:

[It is] common to do the blood pressure and the pulse because that's the hospital guidelines and temperature. A monitoring for 20-minutes early in labour, and actually some of them come in so early in labour that that's not an issue. But if you've got someone in really pounding labour it's ridiculous to strap

them on. But you don't need to be on a bed to monitor anyway, they can sit up you see. Rupturing the membranes is common, epidural is common, active management of third stage is common (Liz, p.15).

Further examples are vaginal examinations, the midwife's presence and examinations that she is 'required' to undertake, in order to confirm or check upon the assumption of normality (Pasveer & Akrich, 2001).

Induction of labour and epidural anaesthesia are also expected and acceptable to some women, Lynley highlights this:

One was a social induction ... you have this family who want this baby to be born and you think, now, do I want to be part of this? So you call an obstetrician and the obstetrician says, yeap sure, which day do you want to do it? So you go along with this thinking, well I don't really think I want to be here, but what can I do? I can't really just leave them I can't just disappear? (Lynley, p.15).

Judy also discusses women's expectations in relation to epidural pain relief:

That's their perception of normal birth, isn't it? ... Some women, in fact I had one woman having her third baby and she'd had two without any pain relief and she insisted on having an epidural for her third. She had the epidural and about half and hour later she delivered. And she waited for that epidural to go in before she actually delivered. Now she said that that was a great birth and who am I to say that it's not? But is it normal? No, it's not. But for her it was fine (Judy, p.8).

Imogene makes the comment:

I think many women see having an epidural as normal, but I don't see that as normal in the process. But I think many women do feel that it is an accepted part of birth (Imogene, p.12).

Lynley alludes to this in her observations.

The thing is it's such a small minority that actually have any difficulty, yet it's made to be the norm.

But do you think that it is a small minority now that has, or perceives that they have difficulty?

I think most, the majority that have something. It's got to be, I mean in Parents Centre classes they go through the complications and they go through this great huge list and it's almost the women are expecting to have them all (Lynley, p.16).

Generations of women and society (including midwives) have lost the notion of non-interference in birth. Women who have had previous children come with expectations that labour and birth can be about 'what they do' to you. As will be further discussed in the next chapter, midwives do 'do' things and bring with them a whole range of attitudes, expectations and responsibilities, as Lynley comments.

I also look at the baggage that a lot of midwives, registered midwives bring along and I wonder whether that is healthy for the women as well. And whether those sort of baggages actually affect that situation and alter it. Coming along to it with what is expected, with things expected (Lynley, p.3).

Many people in society have lost touch with the 'normalcy' of birth, as part of the process of life and have lost faith in their ability to give birth to their babies. Increasingly they are fearful.

4.2.4 Fear in the birthing context

The birthing context is informed by fear and fear is a deep part of pregnancy for some. Fear that something can or will go wrong, that the woman cannot do this, fear of pain, fear of litigation, fear of exposure, public shame and censure, fear of something 'wrong'

with the baby that it will be damaged or not 'normal' (Katz Rothman, 2001). Maureen clearly sees fear present in her practice:

And the fear thing is there the atmosphere of fear through litigation and through, you know the odd person who has had a hard thing to deal with (Maureen, p.6).

Pearse (2000) identified fear as a major hurdle that the midwifery profession is facing. She believed that it is a hurdle that potentially carries considerable risk to the care which women received from midwives.

Fear is a very negative and potentially damaging way to live, as it has the capacity to paralyse us. It robs us of our joy; it takes away our trust of women; it alienates us from our colleagues both medical and midwifery; it makes us defensive and compliant and unchallenging. It also means that we start doing things for the wrong reasons and that can result in harm (Pearse, 2000, p.10).

Mary expresses this idea wonderfully when she explains that:

There is a whole quality of fear creeping into the, into their training, their education. I mean, I know that our midwives that are graduating are being told, "you must go and work in a hospital when you come out of your education", because you need two years experience in a base [hospital], learning all the bloody horrible ways to interfere with women's normal birthing. And I think that those of us out there practising independent midwives have a real responsibility to get those midwives as soon as they graduate and take them under our wing. Otherwise they are going to be turned into fearful practitioners who interfere.
And I think that fear and interference...

Go together. I have a real concern about that. About how they are getting this infiltrated into them, that they, they're not actually good enough when they finish their three year degree, to go out and to practice as independent midwives. That's where they are getting infiltrated. And I feel that that's really, really sad because once they go into hospital and do these graduate programmes, they just, it's like a re-training. They get stuffed up and they become fearful. And

then as you say, you've got this cascade of fear and intervention and interference happening from there on (Mary, p.20).

Symon (2000) found that midwives and obstetricians believed that litigation has caused a rise in defensive practice, which he defined as risk avoidance and risk-reduction strategies. These strategies include increased investigations and interventions such as diagnostic tests, foetal monitoring and caesarean sections. However, he also concluded that changes in practice are almost certainly multi-factorial and that it is hard to isolate the effect of fear of litigation.

Sue would agree with Symon's (2000) conclusions. When I asked her what kinds of things have impeded midwives good intentions, she identified:

Fear mainly and things like that midwife appearing in the media... I think has been a major thing, so that's reinforced the fear and it is very hard to pick actual things out because we are living in an historical moment, which is a fearful moment about birth. So it's really hard to say, you know, what exactly it is because it's actually the culture that we are in.

Umm. Which is fearful and we can't actually stand outside of that (Sue, p.17).

Liz explains the relationship between the medical model and defensive practice:

Sometimes I'm a defensive practitioner, because of, if I'm not seen to be safe by the medical model and I then have to refer women, so especially in management of third stage. ... So defensive practice, if I know that I'm going to have to consult I do ... I may modify how often I do things (Liz, p.6).

Later in the interview Liz adds that intervention in labour and birth is common

Because of people's fear and unfortunately it changes with information, technology etc people have stopped being able to use basic skills. They have come to rely on other skills (Liz, p.15).

Holland (2001) believed that in the New Zealand context “we live in litigious times” (p.17) and midwives are especially aware of this. She argued that high profile cases, reported in the media, along with an increased number of cases being referred for consideration of disciplinary action, have made “us all a bit nervous” (p.17). Mary explains:

I guess the, the degrees of fear that we operate under now because of things like Health and Disability Commissioner. I think we do this, a lot of us, a lot of midwives do have this element of fear creeping into their practice about litigation. So sadly, on occasions, and probably increasingly, your practice is bound by defensive practice really (Mary, p.9).

Cartwright and Thomas (2002) discussing obstetric care in the United States believed it to be carried out in a complicated environment that included “biomedical technologies, corporate interests and an amalgamation of fears and feelings of vulnerability among both ‘patients’ (sic) and practitioners” (p.220). They argued that the most common response to this environment is to create protocols and rituals that are designed to reduce risk, “even in the absence of data supporting their routine use” (p.220). These protocols and rituals have increased intervention in healthy birthing women.

Immersed in the dominant cultural construct of birth, many women no longer fully trust the physiological processes of labour and birth and feel fearful of the process. In dealing with fear and vulnerability women have internalised the medical model and come to believe that birth in a hospital setting with intervention and technology is necessary in order to ensure ‘safety’ in birth, despite a lack of evidence to support their use. The use of medical intervention in birth has become increasingly prevalent in New Zealand and throughout the world.

4.2.5 *Intervention in birth is common*

Downe, McCormick and Beech (2001) looked at procedures carried out during labour and birth in the United Kingdom and argued that 'normal birth' is decreasing rapidly. They found that approximately one third of all women recorded as having a spontaneous or 'normal birth' had experienced induction or acceleration of labour. A finding in this study was that only 16.9 percent of women having their first baby and 30.1 percent of women having a subsequent baby actually experienced a 'normal birth'. They used the Association for Improvements in Maternity Services (AIMS) definition of 'normal birth': "a physiological birth where the baby is delivered vaginally following a labour which has not been altered by technological intervention" (p.4). Women who experienced interventions such as artificial rupture of membranes, induction or acceleration of labour, epidural anaesthesia and episiotomy were specifically excluded, in this definition. Mary discusses how she has seen the same issue happening in the New Zealand context:

The definition of normal birth, particularly where I work in [city] has changed. Now you see them say that they have had X number of normal births, but when you actually sit down and review their data ... they've been induced, they have had syntocinon, they have had an epidural. Sure they pushed the baby out vaginally at the end of all that, but that's then being recorded as a normal birth, and I think that that seriously skews the data and the literature that is coming out from that model of care [shared care]. Because that's certainly not how we in our group, think of a birth as being normal. ...for me it's normal if it hasn't included all those interventions, and yet I guess we are just as guilty as anyone else of saying, hey I had a normal birth today and she may well have been an induction of labour (Mary, p.4).

As discussed in the literature review, Roberts, Tracey and Peat (2000) analysed 171,000 women giving birth in Australia during 1996 and 1997. They found that among healthy women having their first baby in private hospitals only 18 per 100 achieved a vaginal birth without any intervention, compared with 28 per 100 women who were private

patients in a public hospital and 39 per 100 women who were public patients. The findings demonstrate how the birth environment and choice of care provider can influence rates of intervention in healthy birthing women, and showed that the more birth was managed, the more the interventions (epidural, induction or augmentation) accumulated.

In the New Zealand context it is not possible to identify the women who gave birth without any intervention. As discussed above, 93 percent of women have their babies in a hospital; pregnancy is monitored by ultrasound scan, with an average of three scans per pregnancy and labour monitored by electronic foetal monitoring. Epidural anaesthesia used by almost a quarter of women, 22.8 percent, to reduce pain and almost a third will have their baby 'delivered' 20.4 percent by caesarean section and a further 11 percent by operative delivery (forceps or ventouse). Data also shows an induction rate of 27.2 percent and an episiotomy rate of 12.1 percent (Ministry of Health, 2001).

Several of the midwives have experienced the impact of these interventions in practice:

And certainly the practitioners that we see from say [other practice], will proudly say they have had a lot of normal births and you know, we've got something like a 90% epidural rate for primips amongst the practitioners. And they will say that's a normal birth. A normal birth has now become a spontaneous vaginal birth, you know with epidural and syntocinon. And ARM, scalp clip, foetal blood sampling and continuous foetal monitoring (Mary, p.12).

I have come to accept that normal birth involves for some women, an epidural. And that is so many people I meet. [They say] I'm not having any pain "I'll have an epidural". But, I say "tell me what you know about it". And I find out about what she knows about birth [...] and she doesn't know a thing, but she's just listened to her mate (Liz, p.3).

It's common for the membranes to be ruptured, it's common for people to have an epidural. It's common for third stage to be managed actively. It's common to

cut the cord. It's also quite common to check the baby before the Mother has actually breastfeed the baby. Which I think is countering normal bonding. What's another intervention that I've heard that is quite common? Oh, doing CTG monitoring when women go into labour at the hospital, for 20 minutes is normal, common, not natural (Sue, p.16).

Warwick (2001) in her study of 'caseloading' midwives in the United Kingdom found that a range of intervention rates also existed between varying midwifery practices. The midwives working in these practices offered care to all women and had an outcome of caesarean section ranging from 8.5% to 31.7%. She summarised that this demonstrated a range in outcomes between similar models of midwifery care.

Reasons for increased intervention are not always clear, however in some cases there are obvious contributing factors, as Mary explains:

But the interesting thing is when you are looking after a women in spontaneous labour who's un-medicated, and they are making all that wonderful noise that women make when they're having babies. If you come out into the desk area, there is a whole lot of very frightened people sitting at the desk. Who watch your every move, every time you walk past there are eyes following you, and their eyes are saying, "what are you doing to that woman"? And sometimes they will say to you, what, where's she at, what's she doing, what's wrong with her, why hasn't she got an epidural (Mary, p.13).

Further Mary adds:

Our anaesthetists, who we have on call 24 hours a day, so they are there, will lurk around and be wondering why you aren't getting an epidural for this woman. Sometimes they will knock on the door, and say..."I'm going home in half an hour, do you think that you might need the epidural, perhaps I'll do it before I go?" (Mary, p.13).

And Liz, who accesses the same hospital comments:

What worries me is that, I saw someone talking, "I had a nice normal birth", but I know that I watched that midwife arrive, the client wasn't there. The IV trolley and the epidural trolley were outside the room, the woman walked in smiling, "Giddy", and no obvious contractions, from coming in the door to the room, which would have taken two minutes. Looking very unstressed. I saw the anesthetist go in within half an hour, but [the midwife says] she had a lovely normal birth. That was a second baby, I didn't want to ask the circumstances. So that would be client choice. I don't think a lot of midwives now know how to look after a woman in good labour (Liz, p.11).

Throughout the world intervention rates in birth are increasing. More and more women are having labours and births that are coached, controlled and managed. The more that women and society see intervention, the more we accept it and the less we know about the physiological processes of an un-'managed' birth. There are dramatic variations in the care given to women during pregnancy and birth. There are differences from country to country, from community to community, from institution to institution and between caregivers (Enkin, Keirse & Chalmers, 1989). In New Zealand there are significantly different rates of intervention between individual hospitals, indicating differences in practice between institutions and individuals. For example, induction rates vary from 16 to 45 percent, and use of epidural anaesthesia ranging from 10 to 50 percent (Ministry of Health, 2001). While it is obstetricians that carry out the actual procedures it is midwives that initiate the referral for the 70% of women for whom they are the Lead Maternity Carer, therefore it is appropriate for midwives to examine their role in initiating referral.

4.2.6 Pitfalls of referral

Banks (2000) argued that midwives must look at the part they are playing with regard to intervention rates:

While we recently celebrated the end of the first decade of regained autonomy of practice, it is with heavy heart that we hear of more and more women being subjected to highly interventionist labour procedures. Midwives are not the ones performing the surgery for Caesarian sections, or inserting the forceps and epidurals. However, one must look at the part midwives play in performing many of the unnecessary steps in the Cascade of Intervention, which set women up for injurious birthing. Clearly, with the degree of birth injury currently in New Zealand, there are philosophical and behavioural changes required from birth attendants, including midwives, if we are to serve women well (p.214).

I think the story below illustrates the way in which some midwives feel trapped in the system, for example 'I had to refer' for these reasons, when it is a decision that the midwife makes, to refer. This is one way that unnecessary medicalisation contributes to the increasing intervention rates. Diane and I were discussing the ways in which midwives see women restricted or limited in their ability to labour and birth without interference and Diane shared with me this story:

[She was] a 43 year old woman, having her first baby. A very well woman, kept herself lovely and fit and healthy. But because she was of that age I had to refer her and she was in management ...and the specialist knew her. And I don't know whether it was because of that or what, with her having that relationship or the fact that she an older primigravid. But, she had to be induced, soon after 40 weeks, whereas... I know that there is research to say that with older primigravida the placenta slows down a bit. But, we were monitoring things and keeping an eye on things and she was great, no worries with her and I really felt that inducing her was setting her up for failure. She ended up having a wonderful delivery, which I was really pleased about ... she just needed the prostins. And unfortunately, we were going to use the water, but we had to have the good old foetal scalp electrode... She could have had a beautiful normal birth, but she had had a. ... Soon afterwards she was saying I'm going to have another baby, so she's come out with it, how you want her to, she's really happy, but she could have had it better.

So whose decisions were those? To use the scalp clip and to...

The obstetrician's... And that was the other thing too, which made me a bit cross. We'd done the prostins in the morning, and she was coming along quite nicely, and it's six o'clock at night and the obstetrician did the ARM. It's like, thank you very much, you know that's me up. No sort of well let's just see how you go though the night and start again in the morning with ARM, if needed. But no, she did the ARM and went home.

You were up all night?

We were left there, they can't help to. I'm sure she would have done it very well, but having had that referral and having that obstetrician we had to deviate (Diane, p.9).

Here, Diane does not recognise her role in the referral as the first step in the cascade of intervention. She says: 'I had to refer her' explaining that: 'she was in management ... and the specialist knew her' (Diane, p.9).

Other midwives also talked about the ways that an obstetric referral changes the women's options, as Imogene and Mary say:

I'll offer women referrals as per the guidelines, and sometimes they will choose not to have the referral, but I usually offer it to them and most women take it up.

Do you think that restricts their choices?

Yes, because once they see an obstetrician, usually they are not given a choice. Unless they are very strong and highly motivated and really sure about what they want to do. Because, often once they have seen the obstetrician it is confirmed in their minds, or has made the decision in their mind about where they should have their baby and how they should have their baby (Imogene, p.9).

I guess the challenges come when a woman may have something that is under the so-called referral guidelines, something that we need to consult (Mary, p.14).

Maureen says:

I do refer, I believe I refer appropriately but I would talk to the women about it and then someone said, well I don't want to go. And I go, well look, the bottom line is you're the boss, you are in charge of yourself, this is recommended for these reasons. And if you absolutely won't go I need to document that you're not going for these reasons, but no one is going to force you. He's not going to come round and force you up there. But I do work closely with the obstetricians here, cause it's a small place (Maureen, p.12).

Here Maureen explains that 'cause it's a small place' and she works 'closely with the obstetricians' that she does refer according to the guidelines, which are based on medical parameters. Even though Maureen recognises that obstetric referral can alter a woman's course. She says:

It stops being a normal birth the minute you involve an obstetrician in my book. Laughter. Often way back at the referral process too (Maureen, p.15).

Certainly from Diane's story above there does not seem to be a clear indication for referral or intervention and contrary to what Diane believed the induction proceeded. She says:

But, she had to be induced, soon after 40 weeks, ... I know that there is research to say that with older primigravida the placenta slows down a bit. But, we were monitoring things and keeping an eye on things and she was great, no worries with her and I really felt that inducing her was setting her up for failure (Diane, p.9).

The reason she 'had to be induced' was based on a medicalised approach not based on a midwifery approach of individualised assessment of this woman's pregnancy.

As discussed in the following chapter, the midwife strove to get the best outcome possible for the woman.

She ended up having a wonderful delivery, which I was really pleased about and I was really pleased ... she's come out with it you know, how you want her to, she sort of really happy, but she could have had it better (Diane, p.9).

Still this woman received a medically managed style of 'delivery' under midwifery care: an induction at just 40 weeks with prostins and artificial rupture of membranes, and continuous foetal monitoring with a foetal scalp electrode. In addition, the woman was denied her choice of using water during the labour or birth. When: 'she could have had a beautiful normal birth, but she had had a...'. The midwife struggles to find the words to define what it was that this woman experienced.

On reflection, Diane adds:

Yes, and hindsight is an awful thing. If only, you know, we do tend to maybe do too much, too much, too much intervention. And as soon as they are into that referral, you know that that particular Mum is probably going to be probably induced or maybe offered a Caesar, when you wouldn't be talking about it until the labour when you see how things went (Diane, p.10).

As noted in the literature review Guilliland (2002, p.12) commented that the majority of New Zealand women receive an obstetric referral at some stage. She explained that this is because the hospital obstetric protocols and national referral guidelines require midwives to refer. The referral guidelines are broad, covering many possible scenarios. The 'requirement' of referral has the effect of 'heavily medicalising childbirth despite midwives being Lead Maternity Carers (LMCs)'.

When midwifery care does conform to medical parameters and is framed by the medical model, then women will experience medically managed 'deliveries'. Kaufman (2000) argued that midwifery care that follows medical protocols and concepts is not the same as midwifery care that focuses on individual women's uniqueness and trust in the social, sexual, physiological processes of birth. Midwifery care can reflect and mimic medical

care, when the care midwives give is based on following medical protocols, parameters and research. For example in discussing the screening and management of Group B Streptococcus Maureen and Linda say:

I just think wow, I wish I knew more so I could challenge this protocol. But I go to the sessions on it and they put up all the Cochrane Database evidence which looks like what we do is right.

Umm. And so I accept that (Maureen, p.18).

Over things like Group B Strep, things like that ... I find all that quite hard. ... But it's because that's what the policy says. And so I suppose what I say [to the women] is the doctors at the hospital they recommend (Linda, p.13).

In many New Zealand hospitals the protocols are universal screening of Group B Streptococcus (vaginal swab in late pregnancy) and treatment with antibiotics during labour (for women found to be positive). A recent midwifery review (Grigg, 2002) of antenatal screening for Group B Streptococcus failed to support a routine antenatal screening protocol. In summary Grigg says that the:

Information published to date is not convincing of the merits, or the cost and clinical effectiveness of screening in the context of New Zealand – indeed it fails to provide any justification for routine screening. The data also raises serious questions concerning the widespread use of antibiotics. The screening protocol has been a theoretical proposal based on inadequate data and inaccurate decision analyses (2000, p.14).

The midwifery model draws on a wide variety of evidence. Lynley summarises this situation in part with this comment:

I think the medicalisation of birth...is really hard to counter. Because they have the money, they have the yeah, it's that whole scientific world isn't it where they can quantify their research, whereas a lot of stuff I think from a midwifery point of view is intuitive, it's descriptive [...] it doesn't stand up to scientific scrutiny.

So I think we've still got a huge mountain to climb there too, to actually have people that can be recognised in that male dominated sort of kind of world (Lynley, p.5).

Banks (2000) has found that in her contact with midwives from all areas of practice that there are many barriers to practising midwifery. "They may work in geographically isolated communities, with no midwifery colleagues, or in hostile environments where obstetrics overtly (or covertly) predominates over midwifery practice (Banks, 2000, p.5).

Many factors work together, as Imogene explains:

Again, it depends how I feel at the time and it depends how the women feel. If they want to challenge it [medical protocols] or not, I'll go with them. But if they're happy to accept the medical model, it's very hard to go against it. I mean I will challenge it if the women want me to... I will try and encourage them to challenge it, but sometimes it's a matter of.... I suppose that I take perhaps the middle road often and that I'm trying to make it a pleasant experience for them, as pleasant as I possibly can and I possibly take the middle road more than I would. Perhaps if I was in another situation because I feel it becomes too stressful, so I tend to go with the flow. As in go with the protocols.

Medical management of normal labour and birth, putting the drips in, penicillin?
Yeah if that's the recommendation that's what I'll tend to do, and I'll offer it to the women. I'll offer them the choice and give them the options, but they usually will choose, most of them who choose to deliver in the secondary care unit, will choose to have those interventions. I have had a couple of women refuse to have penicillin, or have an IV line put in and that's fine.

So, much of that needs to come from the woman?

Yes it does. I give them the option... I tend to go with what women [want]. I tend to let them lead me with what they want to do. Although I will say, if I don't feel happy doing something or not doing something (Imogene, p.13).

Midwives are working within a medically dominated environment and at times follow medical parameters and protocols because they agree with them or because they can see

no other way forward and so 'acquiesce' and comply or support the medicalisation of labour and birth in well, healthy birthing women. In this way the midwives are acting as agents for the medical model.

4.2.7 Agreeing/acquiescing

Choi (1993) suggested that people decide and act in a given situation based on a model of thinking identified as appropriate for that situation. Further he says that without a model there will be no decision and no action. A situation is uncertain if one cannot identify an appropriate model to associate with it, to make a decision is to resolve uncertainty. Enkin, Keirse and Chalmers (1989) proposed the existence of collective uncertainty "among those who provide care about the effectiveness and safety of many of the elements of care given during pregnancy and childbirth" (p.2). However we all make decisions and take actions when practising midwifery. And as Sue says:

I think it depends where you practice, how you practice as to where your definition starts, you know the boundaries start moving into things that, like epidural. I think a lot of midwives would consider epidural, so long as the birth was vaginal, that it was normal (Sue, p.5).

The medical model is firmly entrenched in our culture, it is therefore not surprising that midwives will feel the pressure to conform to medical expectations and parameters or the 'cultural consensus' (Davis-Floyd & Davis, 1997). In discussing medical practice, Enkin (1994) says "... clinicians often fail to practice what they know to be the most effective form of care, because of the many other factors that tend to motivate and determine their behaviour" (p.13). I believe this comment also applies to midwives, even if they have a strong belief in a midwifery model.

Maureen expresses the variety of influences in relation to physiological management of the third stage of labour:

I don't know it's a bit hard to say specifically why, but probably wanting to have the partner hold the baby or something like that. Convenience I guess, I feel quite guilty saying that. But I certainly would, I try really hard to always wait for it to stop pulsing. And I would probably 90% of the time the cord would be separated, not half of the time, long before the placenta is out. ... I'm doing modified physiological, that's more honest. Modified physiological, with the cord cut before the placenta is out (Maureen, p.14).

This quote from Maureen is also interesting in the context of what else she says in her interview. She is very keen on women birthing at home and in awe of 'home birth' midwives with their knowledge and trust in birth. Her aim is to practice in that manner as she talked about earlier in the interview.

Well now, it sounds very purist, but to me the only normal birth is at home. It really is. A normal home birth and I'm really very purist about it. I'm not saying this is always what happens, but this is my definition. A normal birth is a birth where the woman labours in her own environment, at her own pace, with no vaginal examinations and no intervention at all, unless it is for obvious safety reasons, and endeavoring to be hands off. I'm not saying that always happens, but truly, I've been to many births like that (Maureen, p.4).

When I asked Maureen what interventions she thought were common she identified active management of the third stage of labour and her dilemmas around changing her practice.

Synto for the placenta is common. And I've taken a long time to get it together well with physiological because hardly anyone was doing it and so I didn't have enough kind of resources around. Like people who were around who were knowledgeable enough, to help, to question about it. ... So I'm much more confident now, but any bleeding much would scare me into giving people synto (Maureen, p.12).

In relation to management of the third stage of labour hospital policy supported by medical model research, state universal intervention with active management. However, some midwives with their trust of the birth process, believe that if labour and birth have progressed normally then it is inappropriate to introduce intervention in the third stage of labour. Smythe, Macaulay, Kerins, Schollum and Gunn (1992) examined the beliefs, attitudes and practices of midwives in relation to the third stage of labour and concluded that "there is a wide diversity of practice and beliefs related to the third stage of labour" (p.10). Imogene expresses this diversity:

Birthing at home or in the birthing centre. I usually do a physiological third stage. But if women are in the secondary care unit, I usually do an active management, because those are the women who usually have epidurals and having complicated, more complicated labour and birth (Imogene, p.10).

Further she examines how the awareness of protocols changes her practice:

For instance, having an active management of third stage I'm much more likely to do in a hospital setting than I would in a home birth setting. Because I know that the protocol says that they recommend strongly that all women have an active management of third stage (Imogene, p.13).

Imogene highlights here the strong familiarity all midwives have with medical expectations and parameters. Davis-Floyd and Davis (1997) found that the home birth midwives they interviewed had "in-group jargon filled with technomedical terms, their midwifery bags bulge with technologies and their home birth charts look quite hospital-like, with maternal temperature and blood pressure and fetal heart tones duly recorded at proper intervals" (p.326). All midwives, in the group I interviewed, demonstrated the pressure they feel to conform to the cultural consensus around birth. They must constantly weigh their trust in the process of birth with the consequences of straying too far outside the medical parameters, which are the measures used by many forums in society. As Liz and Sue show with these comments:

The obstetric model is so hard sometimes to ignore and the doctors say that this is my time frame, and I must do it by this time, I must do it by that (Liz, p.8).

I can see the boundaries of my practice of what's normal ... there's the boundary in me that says if the mother's alright and the baby's alright then you can go for as long as you like. There is also the boundary that says that if you are standing up in court because this baby has died or something has happened to the mother, what's going to be seen as being too far to go. So I have ... these blue prints of how things will look from the outside and how they look from the inside. And I keep working those two boundaries so I actually work out what's logically safe to do and what seems like it's going to far. So that I can actually be rational about and can defend what I've done and what I've supported. Yeah. And where I don't think that's defensible, I'll tell the parents that, yeah. *Yeah.*

So it's not a fixed thing, it's movable, but it has to be rational (Sue, p.8).

4.3 Conclusion

In this chapter I have considered the contested nature of the current birthing environment where negotiations and struggles occur. As discussed in the previous chapter, the interviews were participant directed. It quickly became obvious that 'normal birth' exists within the wider midwifery practice and societal context of the midwives. Therefore, during the interviews the midwives and I found that it was not possible to discuss 'normal birth' without a thorough examination of the context. The data chapters reflect this, with this chapter highlighting the extent to which the context of birth continues to be firmly entrenched in a medically dominated environment. Despite dramatic changes to maternity services over the last decade and midwives now being Lead Maternity Carer for over seventy percent of childbearing women, the basic foundations of maternity service in New Zealand are still very much medical and have fundamentally changed very little. In setting out to create a new maternity system that is women-centred and with midwifery autonomy, we have failed to challenge the ruling

hegemony and therefore many of the important issues for maternity services have yet to be addressed. This is demonstrated with increasing normalisation of intervention and technology leading to further medicalisation of the physiological processes of birth.

The participants discussed the context of birth from their practice perspective and analysis highlighted a number of interrelated aspects. Place of birth was identified as important, however the insidious and entrenched nature of medicalised birthing can begin to creep into the practice of midwives at home birth too. All midwives are aware of the fraught nature of the environment and can feel fearful of the consequences of working 'too far' from cultural consensus. In addition, many women and society in general have internalised the medical view of birth as dangerous and are fearful; in this fearful place they accepted and have come to expect medical intervention during the processes of labour and birth. Intervention during labour and birth is now common for many women. Finally I have discussed the ways in which midwifery care can mimic medical care through the process of referral to obstetric services or by midwifery compliance to medicalised parameters.

Medical intervention during labour and birth are prevalent and in this chapter I have demonstrated the increasing complicity of the midwives in supporting the medical model. Smith (1988) said: 'A person is not simply an *actor* who follows ideological scripts, but is also an *agent* who reads them in order to insert him/herself into them – or not'. Cosslett (1994) argued that women make use of, are overwhelmed by or resist the two dominant 'official' stories of childbirth (the medical model and the social or midwifery model). I believe that many midwives make use of and are overwhelmed by the dominant medical discourse of birth and are unable to resist for a wide variety of reasons. As the medical and technological model has gained supremacy in society, it is taken as the 'right' or 'normal' way to 'do birth'.

In the next chapter I consider some ways participants have found to negotiate and balance the contested environment, considering the midwives' adaptations to the medicalised environment.

CHAPTER FIVE:

Midwives' adaptation to the environment

5.1 Introduction

In the previous chapter I considered the strongest theme to emerge from the interview material, the medically dominated nature of the current birthing context. A number of different aspects were identified and considered alongside the literature and participants' words. In the current chapter I go on to consider the midwives' adaptation to the environment and the way the midwives construct 'normal birth'.

As I examined the interview material it was readily apparent that the midwives in this group supported women's choice and promoted the 'normalcy' of labour and birth. However, in the contested environment the midwives commitment and their practice reality did not always neatly fit together. In reality women's choices and the overt and covert pressure to conform to the dominant medical model, among many other influences, come together to inform and direct midwifery practice.

The midwives in this study have found a variety of ways of managing the environment and ways of working with all of the subtleties, nuances and the gray areas present in labour and birth. Agreeing or acquiescing to the entrenched medical model was discussed in the previous chapter. The purpose of this second data chapter is to explore the various ways participants have found to practise midwifery within the environment. Once again the literature frames and adds to the excerpts from participants.

5.2 Adaptation to the environment

Midwifery decision making in serious complications of pregnancy, labour and birth can be fairly clear-cut. Recognition of serious complications and appropriate referral to secondary care are important parts of midwifery practice. When the health of the woman and/or her baby are in question appropriately used medical skills and techniques, synthetic oxytocics, antibiotics, surgery, knowledge and obstetric expertise, can and do save lives.

Decision making with a healthy woman who is well, and within 'normal' medical parameters may also be fairly simple, as Odent says: "giving birth is a physiological process: all one has to do is to learn how not to disturb it" (1999, p.4). This is especially so, if the woman has a strong belief in the normalcy of birth, is clear in her decisions and is motivated and committed to taking responsibility for those decisions. Judy sums this up well.

And I love the women who don't want to use the sonic aid they don't want to have the scanning. All that sort of thing, because these women have, just incredible faith in their ability to grow this baby well and to birth and the confidence in their body (Judy, p.11).

Imogene also supports this idea:

I had to make that decision whether I'd transfer her or not, but she was so determined that she wanted to stay there and she was making progress, and she did achieve that birth. I suppose it's yeah, it's the women really that determine it. And making women strong, and I don't know what is going to make women strong sometimes (Imogene, p.7).

However, in the majority of midwifery practice there are many 'gray areas' and uncertainty where it is the midwife's decisions and actions that can alter the course of the labour and birth experience. Midwives must constantly use a repertoire of skills and

it can be as harmful to do too little as to do too much (Warwick, 2001). It is in these murky gray areas that a midwife makes choices. She can choose to work from a midwifery model with trust and belief in women's inherent ability to labour and birth and a practice philosophy of non-intervention, or choose to work from a medical model underpinned by fear and distrust in the labour and birth process and a philosophy of routine monitoring, testing and intervention. As Diane and Judy discuss there are subtle pressures to conform to medical management:

If we just wait a little bit longer, as long as the baby's fine and the Mum's hanging in there I'd rather just give her that little bit. Even though sometimes an obstetrician will look at what's happened, I mean I didn't have one yesterday, but when you do call them in you do have to fill in the old partogram, and they say like, "this is where you should have called me". It's like ah, shit, you know we've got this sort of straight line for the next three hours [laughter] ... Oh well, we did sort of, ah well. You wear that (Diane, p.16).

Well I still fly by the seat of my pants sometimes. ... I do try and practice research based evidential practice you know that sort of thing, but I also think we practice a lot intuitively. And there are a lot of things that I know are okay that ... you hope like hell your intuition is right.

What about some specific examples?

Just like maybe not referring as soon as perhaps you could or should have according to the protocols. Well I mean nothing terribly unsafe, just, just slightly deviant (Judy, p.5).

With this comment, 'just slightly deviant', Judy demonstrates the norms that control her practice: deviant from what? Deviant from standard practice, which is, she says 'according to the protocols'. Medical practice is often taken as the 'standard' by which midwifery practice is measured. For "when a system of power is thoroughly in command, it has scarcely need to speak itself aloud" (Millett, 1971, p.58).

Similarly Mary says:

We are not on the edge and we aren't on the edge. We all practise in a safe way. We have our kind of bottom lines and we talk to our women about those as well. So that helps, when you have a good working relationship with your specialist medical staff, they will let us go a little bit further than they may let some of the other midwives.

Because they trust you?

They trust that we are going to communicate. They trust that we are not going to go too far over the edge.

Over their edge

Yes, their edge (Mary, p.10).

With this comment Mary hints at the reality of who 'holds power' in the labour and birth process. It is clearly the 'specialist medical staff' who continue to hold the power – 'they will let us go a little bit further' - as it is 'them' who are doing the 'letting'. Neither the women nor the midwife have autonomy in this scenario. However, as discussed in both the previous chapter and the literature review, both the women and the midwife retain their own agency. Neither are simply 'actors' following a prewritten script, women and midwives are also 'agents' who read the ideological scripts and insert themselves (Smith, 1988). In this way midwives 'choose' to conform to medical management.

A further concept that the comments above from Diane, Judy and Mary demonstrate here is what Michalowski (1997) termed disciplinary anxiety. He argued that disciplinary anxiety is characterized by an "uneasy or vague sense that my actual behaviours are being controlled or shaped by others. I experience this concern in the form of anxiety to the extent that the source and/or the effect of this power is unclear" (p.55). Michalowski (1997) further defined disciplinary anxiety as *surveillance anxiety and control anxiety*. He defined surveillance anxiety as the suspicion of being watched, and behaviour being "scrutinized and evaluated by unidentifiable others for unknown purposes" (p.55). Control anxiety is defined as the suspicion that the experiences that are allowed to happen are being consciously shaped by others "to conform to some hidden actor's political goals" (p.55).

These ideas begin to demonstrate how fraught the concept of choice is. However, women's 'choice' is an important factor to consider in this context.

5.2.1 Supporting women's 'choices'

Women's choice is an important part of midwifery care. All parts of the maternity care matrix in New Zealand support women's informed choice. The New Zealand College of Midwives in their code of ethics say that *Midwives uphold each woman's right to free, informed choice and consent throughout her childbirth experience* (2002, p.5). The right to informed choice is part of the rights guaranteed by law in the Code of Health and Disability Services Consumers' Rights. Which say: 6) *Information: you have the right to have your condition explained and be told what your choices are.* And 7) *It's your decision: It is up to you to decide. You can say no or change your mind at any time.* (Ministry of Health, 2002a, p.14). Further as discussed previously, the cornerstone of the New Zealand maternity system, is each woman choosing a Lead Maternity Carer, who is responsible for assessment of needs, planning and ensuring provision of maternity services (Ministry of Health, 2002).

Some midwives work hard to ensure that women have choice as Sue explains:

Being the only person that is taking responsibility [is hard]. And it depends how you make your judgements and give your advice [...]. If it's something that you're really familiar with, it's very easy to take responsibility with. But something new that's cropped up I find that I have to spend a bit of time thinking about what advice I might give. So because the buck stops with you, you have to make a sort of temporary decision about what the choices are that you see as being offered. And then maybe go away and read up and decide what you need to add to the story, so that people can make informed choice. Because I think it's, a down side is that you are expected to know all the answers all the time, and it's really a trap for people that are insecure, because they feel like they need to give advice. Whereas I think it's very important for us to be able to say,

well this is what I understand at the moment, but I will come back to you (Sue, p.3).

Choice however can be seen as a 'slippery' and contested concept. What choices are really available to women in labour and birth? When, as Beniot (2001) argued: "society and culture shape birthing women's desires about what they *want* and the maternity care they *receive*" (p.201). Further, maternity services have been described as suffering from 'cultural inertia', where health professionals steer women towards making decisions which reinforce the *status quo* (Kirkham & Stapleton, 2001). As Imogene has experienced:

Once they [the women] see an obstetrician, usually they are not given a choice. Unless they are very strong and highly motivated and really sure about what they want to do (Imogene, p.12).

Maureen also finds choice rich with subtlety and difficulty in practice, as this comment shows:

I didn't do any home births until I bought my gear. I kept waiting for some one to want one and I'd got gear to borrow, but until I'd actually spent money on buying all my own stuff I didn't get anyone wanting one. So that was very interesting, so it must have been a change in me that must have given them the confidence, or whatever. But in the end it's about the women. It really is. I offer home birth to every woman and I offer the information so that they've got an informed choice to everyone and most of them don't want it. Oh no, no, no, no, I'm not going to have a home birth. When they tell you their history, I say "you've got such a good history there, you know, think about it", ... but I don't want to look as though I'm pushing it. For my benefit, well, there's nothing much in it for me really, excepting the satisfaction (Maureen, p.7).

Liz recalled this situation which provides an example of neither the birthing woman nor the midwife having choice with the introduction of obstetric management.

Often when you consult because you have... a labour that's slowed down or obstructed or whatever... but you still have a hope that you might achieve a vaginal birth ... whereas medical practitioners don't give people hope. ...The registrar or the obstetrician would say, well, if you don't achieve it by this time, we will have to [have a caesarean] whereas we would say, you are making progress. Keep going but we'll perhaps give you some syntocinon it will help your uterus get a bit stronger it has gotten tired. Keep going if you don't get there we'll do something, but keep going. ... So it's often the perception that the woman has of the how hopeless the situation is, and they become helpless. Maybe it's a relief to be helpless because it's such a trial, I don't know. And I have to think whose birth is it, theirs or mine. But I just sometimes think, it's the words that we use, certainly modify the woman's enthusiasm for continuing in labour (Liz, p.8).

Further Liz goes on to say:

Sometimes, I don't believe that an episiotomy is expedient, but that's a choice by the medical practitioner, and apart from ripping the scissors out of the hand it is very hard to stop an episiotomy being done. Even despite a discussion across the woman's body which is really kind of inappropriate (Liz, p.8).

Discussing the introduction of new technology, Katz Rothman (1990) argued that "as 'choices' become available, they all too rapidly become compulsions to 'choose' the socially endorsed alternative" (p.12). This statement equally applies to all other areas of maternity care. Further, for those whose choices meet the social expectation, and agree with what society wants them to want, the experience of choice is very real. But for those who want to make other, alternative choices, the ideology of choice can quickly disappear (Anderson, 2002a).

Sue recalls this practice story in which the woman needed to change midwives in order to have her birthing choices respected:

I've had a wonderful situation where I had a woman who had had a massive, like a life threatening PPH the time before. And the time before that she had had dystocia I think. I got her at 37 weeks, because battle as she might with a normal midwife, a normal birth midwife, she, the midwife, wanted to give her oxytocin. And she really didn't want to have oxytocin. She agreed to go to hospital because of the risks of both shoulder dystocia and PPH. And she was a tiny little thing and she had this huge baby. And she, so she rang me and said, you know I don't want to have oxytocin and I want to have a normal birth. And I said I think you should talk about it [with your midwife]; she said I have talked about it. It was someone I knew quite well. And I said, well, I can't see any reason why you can't have a normal birth or why you have to have oxytocin, that if you understand the risks. She said, I do, I understand them, you know, I've been taking nettle tea and I've done this and I've done that. So I booked her in, well she also had a Buddhist Monk Priest that she wanted in with her. And she had a certain religion where they used to chant and things, so we got in the room and shut the door and the whole room was stripped. They had pictures, mountain scenes; we had an altar, the bed was pushed out of the room, mattress on the floor, an altar. The whole room was transformed by these people with flowers and they sat around chanting and she laboured all night, with her third baby. And she delivered this, I think it was 10lb6oz baby. And she was quite small and it was quite tight and when the baby came out it breathed and I thought oh that's great. And anyway that baby was gray about four hours later, it had never fully expanded, because it had been braced by its arms it was so big, it hadn't fully expanded its lungs, straight after the birth. Even though it had breathed, it hadn't done that properly. It was starting to go gray, so I had to admit it to special care and it had to have positive pressure. It was okay in 24 hours, isn't that amazing (Sue, p.14).

This story also illustrates ways in which women create their own 'space' for birthing their babies within the hospital. This is discussed below.

It takes a lot of courage to look at the cultural consensus, at what we, as women and as midwives, have been taught by our culture, our profession, our training, our parents, our

friends, and our own personal and professional experiences and question and challenge the beliefs and expectations. The referral guidelines in the maternity notice (Ministry of Health, 2002) are just that, guidelines. It is the individual woman who should make her decisions about who will be present and how her birth will proceed. Enkin (1994) said that: “no childbearing woman can entirely shed the responsibility for her choices because she, not the expert, must live with them” (p.21).

However, it does take strength and courage to challenge and to practice outside of the perceived ‘safety’ of the system, and for many women and midwives this is too difficult. Mary expresses this:

You still have an obligation to really well inform your women, so they in fact can make informed decisions... For midwives practising today in this kind of environment, we’ve got to be really well informed. We have to be really up to date in our knowledge. We have to use evidence-based practice and we have to be able to communicate that to our women, because you have the responsibility. If you want to buck the system, the women have to be really well informed about the, the pros and cons of that, so that they can make their own decision about that. And then you can support them. But I guess the scary thing is that even when all that happens, our, our sort of judgmental system can still pick on the midwife. For supporting the woman to, to do something that’s not the accepted common norm (Mary, p.10).

With this comment Mary hints at the strong pressure for the midwife to pressure the woman to make the ‘correct’ choices, based on the cultural consensus. Anderson (2002a) argued that: “One of the major restrictive features of the technocratic paradigm of health care is its intolerance of other ways of thinking. As far as the obstetric team are concerned, there is nothing to discuss; there is no alternative” (p.406). Many midwives are not able to withstand the overt pressure placed on them, to ‘make’ women ‘see’ the right choices to make.

All midwives, even those who attend women in their homes, are under tremendous cultural pressure to "do birth according to medical standards" (Davis-Floyd & Davis, 1997, p.317). But 'doing birth according to medical standards' will in many cases mean using interventions, transferring to hospital or recommending the woman gives birth in hospital, despite the midwife's alternative judgment. Similarly Banks (1998) said, "any midwife will feel the lick of flame as she challenges the status quo" (p.9).

Sue recalls this practice story where an ultrasound scan introduced uncertainty and fear, and effectively removed the woman's choice of birthing at home with her third baby thus altering her experience. This story also highlights the challenges and difficulties in decision making in a medicalised context

I've seen someone have a scan, this is, and I find that scan's are really scary things. Because I've sent someone to have a scan because the baby seemed very big and I've never really known whether I did the right thing or not. And the woman told her that she had never seen a baby that was that big. And she'd had two babies before with me, really straightforwardly. But it completely freaked this woman out and she went in and she came into labour with castor oil and she decided that she wouldn't have a home birth. And then went out of labour and I finished up rupturing the membranes, which I never do when someone's out of labour. But I did it and she had this perfectly lovely hospital birth and in the pool at hospital no problem at all. But she could have done that at home and so that scan was a restriction for me because of what it set up for her and what it set up for me. When someone says to you that it's the biggest baby that they've ever seen...And if you go against that it's completely foolish, but you know, the baby wasn't the biggest baby, you know it was 4.7kg or 4.8kg or something. You know she just squirted it out no problem at all, but had it been a shoulder dystocia and died and we did it at home, I mean I would have been hung, drawn and quartered you know. And you can understand that the parents would have been pissed off with me encouraging them to stay and have a home birth (Sue, p.10).

Further Sue adds:

Advice from other people is very difficult because I think that you have to take it on board and deal with it sort of rationally, but you can't constantly be confident everything is going to be alright, because you don't know (Sue, p.10).

As discussed in the literature review, it is difficult for women to remain outside the system as Murphy-Lawless (1998) argued all women: "must engage with obstetric science in order to give birth". Further she argued that:

Every woman in a developed country is affected by obstetric thinking. She either accepts it because she believes its arguments to be correct and meaningful or because she doesn't know what else to do, or she rejects it and works in opposition to it in order to emerge with meanings around birth which she wants to have (p.229).

It is also difficult for midwives to remain outside the system. The power of obstetric thinking, as discussed by Murphy-Lawless above, is normally invisible; it only becomes visible when resistance is encountered, and then a variety of ways are employed to silence dissent. Midwives are as socially constructed as the women are in the current birthing context. Temple (1997) argued that we "make our social worlds in part by discussing our views, that is intersubjectively, and by locating our individuality within these worlds. Part of the point of discussion and debate is to establish the overlaps and contradictions between accounts and to assess the influences of material and social location on perspective" (p.24).

There are many voices and conversations within midwifery, midwives tell stories to each other all the time. In our language with each other we share meanings and visions, confirm and create our reality of practice. These stories help us to work through and come to terms with significant events and issues. They also help us to receive feedback, receive acknowledgment and recognition from each other on the way we worked in a situation or solved problems, and help us to shape, support and strengthen our professional identity (van der Hulst & van Teijlingen, 2001). Further van der Hulst and van Teijlingen believed that telling stories presents "a picture of the range and scope of

the daily work of the professional. These recollections from practice both *describe* the content of professional work and *shape* its future” (p.166).

If the stories we tell each other support the view that ‘normal’ has now come to include, **for midwives**, a wide range of medical interventions, then what hope have we of educating the women and the community that normal does not include those things. For example, Mary says:

That whole concept of what people perceive as being an acceptable birth and calling it a normal birth. And certainly the practitioners that we see from say [other practice], will proudly say they have had a lot of normal births and you know, we’ve got something like a 90% epidural rate for primips amongst the practitioners. And they will say that’s a normal birth. A normal birth has now become a spontaneous vaginal birth, with epidural and syntocinon. And ARM, scalp clip, foetal blood sampling and continuous foetal monitoring (Mary, p.12).

5.2.1.1 Supporting choices ‘outside’ the boundaries

Some women and some midwives do sustain the belief in the normalcy of birth and, as much as possible, remain outside the dominant medical system. Home as the planned place of birth is perhaps the only place that both the woman and the midwife can retain their autonomy and the only place that one may see ‘normal’ physiology and ‘normal’ emotional, sexual, spiritual and social responses to labour (Banks, 1998). Midwives in this study recognised the importance of supporting women’s choices in this regard. Imogene discusses this with this comment:

If women choose to have a home birth or choose not to have a referral, for whatever reason, yeah, that’s their choice. And I am usually happy to go with it, unless I feel that it, it isn’t. If I don’t feel comfortable about it, I will tell the woman (Imogene, p.9).

Davis-Floyd and Davis (1997) explained that women choosing to birth at home are placing “themselves quite consciously as far out of the reach of the technocratic model as they can get, choosing to give birth in the sanctity and safety of their own homes” (p.316). Imogene agrees that it is the women who are making the decision to remain outside the medical system:

It's the women I suppose, that direct it really. The women that influence me and if they are strong enough to say that that's what they want, I'll support them in what they want to do usually. I've never had the situation where someone has wanted something that I haven't felt comfortable, comfortable doing. I suppose, it is the women that are the biggest influence really (Imogene, p.7).

And Maureen adds:

The women are the major influence ... The things they say, their belief in the normal, their belief in keeping away from ...hospitals is a good option (Maureen, p.7).

All participants support women's choice to birth at home and most would like to attend more home births:

I'd love to just do home birth, but you have to convince them to have home birth and we're not really in an environment that you can do that (Lynley, p.16).

I love nothing more than to be at a normal birth with a woman at home. I want more of those and I'm getting more each year. And I'm converting a few women those are the victories (Mary, p.17).

I mean I would like to do more homebirths, but there is a lot of midwives now that are doing homebirth and I think that that's just kind of diluted it down. And I don't try and insist on them [home birth], I don't, I will very rarely visit a multip in her home if she is in labour. Because if she has expressed a desire to have her

baby in hospital I think that I should honor that and I will meet her at the hospital (Judy, p.5).

Many women, who have constructed their concept of birth based on the dominant cultural construct, value the choice of hospital birth and it is important to recognise this too. Mary says:

I think even though... what we've mentioned before about the whole sort of transferring to hospital is that actually an intervention. If you gotten to the point over the period of time of looking after the woman, and that is her goal, that's where she wants to be, that is her choice, and she's well informed. Then that's where she is going to be and that's okay (Mary, p.13).

A little later in the interview Mary adds:

Physiological normal birth can happen in a hospital, if the woman chooses and she has good strong guardians. It can happen and it does (Mary, p.14).

Women's choice is a cornerstone of maternity care in New Zealand. The midwifery model of care and the participants in the current study are grounded in supporting women's choice. As discussed in this section, choice is however a contested concept. Given the nature of the current environment, many women 'choose' to give birth in the medically dominant hospital setting and the ways that participants identified as supporting this choice while promoting normal birth are now considered.

5.2.2 'Protecting' women - becoming a buffer

Midwifery has claimed to be the 'guardian of 'normal' birth'. However, I believe that women are autonomous adults and only need guardians when they are in a threatened environment and for some reason feel unable to speak for themselves. Banks (2000) concurs when she says: "Guardianship of 'normal' birthing has been the midwife's

catch cry. It has validated her role in maternity care throughout the decades in New Zealand. The need for guardianship exists only in the arena of conflicting paradigms where the Medical and the Midwifery Models of Care meet head on, that is, the hospital system. Guardianship is a paternalistic structure of the stronger (the midwife) protecting the weaker (the labouring woman). It places the woman in a less than autonomous position” (Banks, 2000, p.214).

The previous chapter has clearly established the contested nature of the current environment and therefore the ‘need’ for women to have midwifery ‘guardians’; this section examines the ways in which midwives ‘protect’ women from the system. Mary explains:

If ... that [spontaneous normal birth] is her goal, that's where she wants to be, that is her choice, and she's well informed. Then that's where she is going to be and that's okay. Yes, you can have spontaneous normal birth in hospital, but she has to be guarded and protected. Laughter. By her caregivers to allow that to happen.

Yes

And she has to be strong, as I say if you can get into your room and shut your door (Mary, p.13).

All participants agreed with Mary that it is possible for women to birth in hospital without intervention, despite the difficulties previously discussed. When I asked Diane if women could experience ‘normal birth’ in hospital, she answered:

Absolutely, yes and that's yeah ... I sort of feel like I've done my job then (Diane, p.13).

The attitude and belief system of the midwife is crucial and can be more important than the place of birth. In researching home-like versus conventional institutional settings for birth Hodnett (2002) concluded that “there is much stronger evidence to support the need for changes in caregivers’ behaviour than there is to support the need for structural

changes to labour wards” (p.7). This was also a finding in the Ontario Women’s Health Council report (2000) that the attitude of caregivers is a critical factor for attaining and maintaining a low caesarean section rate. Diane and Sue both recognise this importance:

I think because I really do believe in normal ... I go in there thinking this woman will go well, I don’t actually go in there thinking shit what’s going to go wrong. The majority of the time, that’s fine (Diane, p.6).

Being in a hospital room. I still think that they can do it, because they’ve decided that they are going to shrink themselves into that space and they do. And they have babies normally and they breastfeed them and go home. I mean I can’t say that that’s not a normal birth. But I think that the potential is there. But you see we’ve got very good rooms in the hospital where you take them and you can shut the door and we’re pretty much on our own. And you have to be able to do that for it to be anything like normal. Shut out the rest of the world and that becomes your home. ... And that’s an attitude that you have yourself that you take with you. That this is a sacred space and it is what you are going to do in this space (Sue, p.13).

The majority of midwives interviewed commented on two specific actions for supporting women in a hospital setting: ‘shutting the door’ and ‘keeping the woman away’.

5.2.2.1 *Shutting the door*

Shutting the door was seen as a way of protecting the women in order that they can achieve ‘normal birth’. Shutting the door was an actual, physical action, but also a symbolic action. This was seen as creating privacy, safety and a way to enable the woman to make the hospital room ‘her own space/place’. Diane and Judy provide good examples of comments made by the majority of participants:

I mean, for a lot of the births that I do up there it’s just the woman and I anyway. We close that door and it’s just, I just try and think that well this is your space. I

don't do a lot different. I mean it's nicer at home, but I actually do, I try and keep it as low key (Diane, p.12).

Ah privacy so that I expect that when I go into the hospital I shut the door and I don't expect anybody to open it unless they knock first and are invited in. ... Just establishing an environment in which the woman feels really relaxed and comfortable and that sometimes takes a lot. Takes a long time of being in the hospital. I try and take out all of the things that I think are not conducive, like the CTG machine, like not always, but sometimes. I try and be as unobtrusive as possible myself, unless I'm needed to do back rubbing and things like that. I try and get members of her family or support people to do that sort of thing... I guess I just try and find, try and get an atmosphere in which the woman feels comfortable and confident for the birth (Judy, p.2).

5.2.2.2 *Keeping women away*

A second theme or action that the midwives undertook was 'keeping women away'. This was again a physical action of keeping the women away by visiting at home in early labour and delaying transfer to the hospital as explained by Liz, Imogene, Lynley and Mary:

I mainly care for my clients in their home until such time as they are getting to the last third of their labour and we come into hospital then (Liz, p.14).

Bringing them [women] in as late as possible in their labour. Laughter. It's really important not to get them there too early. Yeah. To wait until they are really well established in their labour. ...I think that certainly they can achieve a normal birth in hospital (Imogene, p.11).

Taking the woman in later in their labour, which is not always the most comfortable and then giving them time to settle in and then just really trying to make it as quiet and peaceful as possible and letting them labour. ... it's just giving them another place so you can try and allow them to have their baby so

that they can feel safe in it. You know and see progress from there (Lynley, p.16).

We have ... always based our care on keeping women at home as long as possible, even if they are birthing in the hospital. So we still do that, our policy is that when a woman goes into labour, we communicate with them frequently; we visit them at home as often as they require, just to confirm that they are doing okay (Mary, p.11).

A further strategy employed by the midwives was keeping the women away from obstetric management, if possible. These excerpts from Diane and Judy highlight this:

I guess what I try and do, as long as it's safe, I try to keep women away from having to refer, because I know that as soon as I have the obstetrician involved her chance, the woman's chance of a normal birth are less... Because they have their scope of practice and that's where they're operating (Diane, p.16).

I think it's really nice that we've got that autonomy too, you know unless things are going really wrong. It's great that we can work through. Like yesterday's one, the woman got really tired and headachy and sort of got a little bit stuck. And it's like what will I do here, so I stuck up some fluids and, I said that she ... needed to get up and have a good walk around and put some fluids up. And that got her over it. I didn't want to have to call in an obstetrician, I knew she could do it and she did... So she ended up with a lovely birth (Diane, p.13).

Liz explains how she uses the obstetric referral guidelines (Ministry of Health, 2002) in ways that support women. The woman here chooses not to accept obstetric referral during pregnancy and Liz explains how she will 'wear' it if necessary, in this way providing a buffer between the system and the woman's choice:

I also like my clients to be well informed before they go off [for obstetric referral] and they also have a choice to go. And I've had somebody who had had a previous Caesar who did not want to go because of very bad memories of the

hospital. She has had a home birth the second time, which was great. She had had a posterior position the first time, so there was no contraindication pelvis wise, that I could see to her achieving a vaginal birth. So we knew, and I said [to the woman] that you just have to realise when we go in [to hospital], if we have to go in there, they're going to go, "oh, why didn't you come and see us?" You can just say that Liz must have forgotten to refer me. And I will wear it (Liz, p.7).

As I have explored in this section, midwives use different ways and means to provide a buffer between women and the medicalised environment present in the hospital setting. The various ways that have been identified from the interviews include shutting the door to create a private and secure space for the woman's labour to proceed and keeping the woman away, from hospital until transfer is really necessary and from obstetric referral if possible. Anderson (2002) suggested that this may be the 'essence' of midwifery; "doing nothing but guarding a protected space where a woman can labour undisturbed and offering one's watchful presence as an unobtrusive safety net" (p.209). Liz agrees with this comment:

And I think that's the job of the midwife, to keep that space around them so that they are in a safe bubble (Liz, p.10).

5.2.3 Creating a new paradigm

A further adaptation to the environment made by the midwives interviewed is creating new rules or rituals based on their personal beliefs of women's ability to birth their babies. Several strategies used by the midwives emerged from the interview material: working with the uncertainty of birth by creating fluid definitions that support women's labour processes; bringing birth 'back to normal' when possible; or when complications arise ensuring that birth remains 'as normal as possible'. However, as discussed, within the dominant medical environment some issues can arise.

5.2.3.1 *Fluid definitions*

Protecting a space for a woman to labour undisturbed can be seen as part of a midwife's effort to act as 'guardian to 'normal' birth'. The midwifery model in this way 'normalises' individual women's labour processes. In contrast the medical model attempts to pathologise woman's uniqueness as 'deviance' or abnormality.

Medical definitions of 'normal labour' fall within specific parameters, generally based on the 'Friedman Curve' (Friedman, 1955 & 1956). The 'Friedman curve' is part of the partogram, a tool used by many to record 'normal' progress of labour and to assist in decision-making to intervene. The partogram also records foetal heart rate, maternal temperature, pulse and blood pressure, details of vaginal examinations, strength and frequency of contractions, fluid balance, urine analysis and any drugs administered or actions taken (Cassidy, 1993). The 'Friedman Curve' has an expectation of an average of twelve hours for labour, cervical dilation of one centimeter per hour, artificial rupture of membranes at 3 centimeters, one hour pushing for a first baby, delivery of the placenta within one hour, etc (Beischer & Mackay, 1991).

Alternatively, the midwifery model of care recognises the individuality of each woman's experience. In response to 'Friedman's curve' the Midwives Alliance of North America (MANA) have developed the 'MANA curve' which is not a straight line and documents 'plateaus' at various centimeters of dilatation (Daviss, Johnson & Gaskin, 2002). They have generally answered the practical question, 'so how long is too long at any given centimeter even by midwife standards?' by replying, 'when the baby is no longer liking it or the mother, father, and midwife are all fed up' (Daviss, Johnson & Gaskin, 2002). The New Zealand College of Midwives (2002) Midwives Handbook for Practice recognises "the individuality of each woman's pregnancy and childbirth experience" (p.36). In this way "Midwifery practice defines 'normal' on a one-to-one basis with women" (New Zealand College of Midwives, p.36). As illustrated by Liz, Lynley and Mary:

So labour is just very different for different woman and it's just really being patient, not doing too much and not being able to promise them anything. I don't do times, no times nothing. If I say, "it won't be long" they get sick of that. [so I say] "this is not too long" (Lynley, p.8).

I think that I can last a lot longer [than other midwives] because I have seen so many people achieve, with time. I don't think that there is a rush in labour. I don't have a Friedman's curve timeline in my practice (Liz, p.9).

We don't have routines. We don't routinely do anything to anybody. Every woman starts her labour at this point and goes to that point and there are things that we may or may not use along the way. We don't really have standard interventions (Mary, p.10).

Diane shared this story which taught her a lesson in trusting women's unique processes:

I remember ...one young woman having her first baby that was a really good lesson to me for not doing anything. She changed midwives at 18 weeks and came to me, a very different sort of woman, really out sort of out there, she'd been on the drugs and done all the wrong things ...becoming pregnant just changed her. She'd had a really tough time a year before then, she was raped really badly ... It was like oh god, I knew what second stage was going to be like. And all she needed was lots of knowledge and to take some control and when she went into labour she mucked around, she mucked around, mucked around. I spent a whole day at home with her and then brought her into hospital and then she went off the boil. And I thought what do I do? What do I do? And I thought, no, if I call, if I call in an obstetrician, it will be ARM, synto. Baby's fine, Mum's fine and I gave her some pethidine and she had a six-hour sleep. And she had the most wonderful waterbirth, and she just brought that baby up into her arms and said, "I've been waiting for you all of my life". And it just totally changed her; she's just a different woman. You know it was such and I got this most amazing letter from her, which I will just treasure. It was such a good lesson, to just sit back and just believe. So long as Mum's fine and baby's fine, just wait (Diane, p.14).

Banks (2001) explained:

In the depth and breadth of women's experiences of childbirth defining normality is not just problematic ~ it is impossible. Just as the meaning of midwife (with woman) is defined in the singular, practice of the midwife's art and science must be tailored to the individual woman. Any attempt to alter the unique focus of midwifery practice needs to be examined to expose who benefits when midwifery is contained and distinct boundaries are set as to when women 'require' medical intervention (2001, p.35).

Sue discusses the individuality of the process:

It [natural birth] needs to be re-framed, so that people understand what natural is... It's not a rigidly determined thing. It's something that involves judgement, it involves process. It's processing with women and that is a really vague thing to transmit to people (Sue, p.17).

Definitions, such as medical parameters, that confine and limit, introduce boundaries and rules and fail to allow for women's individual experience of labour and birth. In the midwifery model, more appropriate, fluid definitions of birth allow for the uniqueness of individual women's expression and experiences, with room for birth as complex and multi-layered. At times labour and birth are defined by medical parameters as 'abnormal' or high risk, for example, vaginal birth after caesarean section (VBAC), 'postdates' or 'prolonged' labours, or do not proceed without alteration or intervention. At these times, midwives continue to have a vital role to play.

5.2.3.2 *Returning birth to 'normal'*

Davis-Floyd and Davis (1997) argued that the medical model of care has deconstructed labour and then reconstructed it to fit narrow and abstract parameters. In this way medicine reshapes labour to 'fit', by using medical intervention. In contrast Davis-Floyd and Davis found that the home birth midwives they interviewed continually redraw the parameters of

normal, expanding the definitions to allow for the wide range of experiences. In this way labour is “a meaningful expression of the birthing woman's uniqueness, to be understood on its own terms” (p.335). They quote ‘Maggie’, a home birth midwife who says:

What I resolved for me is that where birth is not normal, part of a midwife's job is to return it to normal. For example, in the case of a VBAC, which is regarded medically as high risk and almost universally by midwives as not high risk, what we're doing in that case is returning birth to normal. And when we go four, five, six hours of pushing, we are also returning birth to normal, a normal that says if the woman pushes for three hours and she's exhausted, then she can take a rest, and maybe in a couple of hours, she'll get her strength up, and then she'll be able to push again--she will get her baby out. When we do things like that, we're returning birth to normal. (Davis-Floyd & Davis, 1997, p.335)

Similarly Lynley hints at the subtleties involved in keeping birth normal or returning birth to normal with this excerpt.

And I think that we have lost that patience too in that we've had so many times put on us, you know particularly that time around when women are starting to sense that something is different and it is changing, being patient then. Some women go to sleep then, they might curl up and have a sleep for a couple of hours, you know what's the matter with that. You know, there's nothing, there is no pressure coming on the baby. It's safe, it's inside its mothers body, so why, why push on it (Lynley, p.10).

Common practice is to ‘diagnose’ full dilatation as soon as possible and then direct the woman to start pushing. Often there is a lot of ‘busyness’ at this time of labour, with high expectations and anticipation, as Diane and Lynley have found with other midwives.

I'm not a great one to say push, push push and all this sort of stuff. You know, its like, women know what to do, most of the time. But there are times when you do have to get in there and be a bit of a, yeah, coach them along (Diane, p.13).

Sometimes in [city] you might get called to help out another midwife's births. And they've got these fancy new electric beds; they must have cost them. And I wouldn't have believed that a woman could give birth on them, the bottom of the bed just yeah. This woman was just so precariously balanced, I would not have been able to see myself giving birth like that, I just could not have felt that I could do what I needed to do, because if I let go I would have been on the floor. It was kind of odd; I like seeing how others work and the coaching of pushing?

So you think other midwives, other practitioners have different definitions than you?

Oh, totally. Totally, like to me I think of, now I'm being quite fractious here I know, but to me full dilation, fully dilated is when you see the baby's head fill the perineum. Laughter. Until then it's just, you go by what they are telling you, if they are telling you they don't want to push, well you say, don't. You'll know you will not be able to do anything about it. And I think that we have lost that patience too in that we've had so many times put on us (Lynley, p.9).

Many participants discussed the importance of fluid definitions of time frames in labour. Sue demonstrates with this comment:

Yeah, a normal labour is, is an event that people just participate in themselves, you know the woman and the husband, or the partner, whatever. Or the friend, or whoever it is, works together and it takes as long as it takes. So long as it doesn't seem to be obstructed or there doesn't seem to be a major problem and the woman's physiologically okay and the baby's okay. ... I have to actually be responsible for making sure that the baby is okay and that the mother is okay. Which is simple things, simple enough things to do, and she delivers where she is comfortable and she doesn't bleed excessively (Sue, p.7).

Birth often does not proceed without alteration or intervention, as has been extensively discussed, in the current environment. Participants discussed ways of making birth 'as normal as possible' for the women, in spite of the use of medical intervention.

5.2.3.3 As '*normal as possible*'

Earl, Gibson, Isa, McAra-Couper, McGregor and Thwaites (2002) presented a conference paper that brings to the fore some issues around practice for 'core' midwives in New Zealand. 'Core' midwives are employed by a hospital/District Health Board and generally work on rostered shifts, providing midwifery care for women with obstetric or general practitioner Lead Maternity Carers, and 24 hour 'inpatient' care. Earl et al. (2002) argued that secondary midwifery care does exist and that it needs to be named, explored and discussed, so that roles and boundaries can be more clearly defined. They believe that "clarification of the role and responsibility of 'core' midwives will lead to recognition of the place that they have as practitioners who enable birth *to remain as normal as possible* even when it does become complicated" (p.30, emphasis added).

Imogene identifies an increased role in providing secondary care as a Lead Maternity Care midwife, which she identifies as 'abnormal' midwifery care.

I have begun to offer that service. I will go with them to [city] if they want me to. ...there are still some midwives that choose not to do that. And I suppose that is a decision that I made that I wanted to provide that midwifery care. So I suppose that because I've done that I've now gone into the realms of abnormal much more. Providing continuity of care makes you provide abnormal midwifery care (Imogene, p.6).

Mary described a woman's birth story with the outcome of a 'normal' birth. This woman experienced multiple obstetric referrals in pregnancy and an induction of labour. Mary was pleased with the end result, for the woman, as she explains:

So I feel like I've actually worked well with her to achieve what she wanted to achieve. While it was potentially a high-risk situation. ...[I] protected her to have a normal birth, even though it was induced. It could have gotten worse, you know. It could have been a lot worse for her. *Umm*.

They would have had monitors and scalp clips and God knows what else (Mary, p.16).

Maureen hints at the difficulties in defining her role when working with women who have additional complications of pregnancy. She finds it hard to define the boundaries between what is normal and not normal in those situations.

If people have pre-eclampsia or something, sure, I've got to keep a watch on them, I do need to do their blood pressure and I do need to be pretty much involved with an obstetrician throughout their labour. That is quite different, but I still believe, within those constraints, they can still do quite well, and still have a vaginal birth, ... what becomes normal and not normal within that sort of stuff and that's quite hard (Maureen, p.14).

A number of the participants found it difficult to identify clear boundaries, discussing both epidural anaesthesia and induction of labour as clinical areas in which the boundaries become 'murky', where women can experience a 'normal' birth, but with the additional assistance. In these situations Imogene, Diane and Maureen are hinting at keeping birth as normal as possible, under the circumstances:

It's difficult. Because, who defines normal birth and is it a normal birth because they have had an epidural on board, plus syntocinon, but they have eventually pushed their baby out. Yeah.

Would you consider that a normal birth?

Probably not, because it is an assisted birth. I would probably, I probably wouldn't call it a normal birth no because it has been assisted, it has been interfered with. The actual passage of the baby is normal, but the labour is not normal. And that is where the dilemma comes of course (Imogene, p.11).

Epidurals you pay a price for those. But there are times that as you know, it's either the epidural or a Caesar. And the epidural's good.

And so if a woman has an epidural, has an induction, ...and then she pushes the baby out, would you consider that a normal birth?

No, it's still not real. It's something else. It's not an assisted birth, but I'd put that down as intervention.

I think most midwives would actually.

Yeah. I don't know. The only time when I, like an induction, is the woman has had prostins and she has gone ahead from there then I would call it normal. But if she's had prostins and ARM, I'd class it as an induction and particularly if you go onto synto, then you're very much. ... 'Cause some of them all they need is a sniff and you're away, and that's really good because you can still use water and stuff like that. You know, as pain relief. Once you really going to get that labour augmented then you need to continue monitoring it (Diane, p.14).

And epidurals are sometimes great for women's pain, but they totally, your body forgets about how to do what it is meant to do. Not totally, but often. Because if it's one that the woman still has good mobility, like I've had people on their hands and knees with epidural, still having a normal vaginal birth (Maureen, p.16).

As discussed in the literature review, Gould (2000) undertook a concept analysis of 'normal labour' which revealed that her midwifery colleagues were enmeshed within the medical model of childbirth. She believed it is the underlying medical culture which has led to a paradox where many midwives "may believe natural childbirth to be normal but do not really believe that normal childbirth has to be natural" (p.420). In discussion with her colleagues Gould found they defined 'normal labour' as a 'purely physiological event with no intervention', they then went on to explain the many interventions used, but they did not necessarily believe that the intervention put the woman into the realms of 'abnormal labour'. Gould summarised with her belief that midwives have been "coerced into accepting the medical profession's measurable parameters of normal labour as defining factors" (p.420). As discussed earlier, the ways in which midwives have come to accept medical parameters have also been identified in the interviews, Liz provides a further example:

Normal is unassisted by anything but the woman and the support she's got around. Yeah, that is my bottom line (Liz, p.3).

But sharing a birth story later in the interview, she says:

They [the family] didn't want to, but she went to all the specialists ... and we ended up having a lovely normal birth... via an epidural. She'd been in labour; we induced her at 38 weeks for maternal distress (Liz, p.10).

Mary also demonstrates the way that midwives have come to accept medical intervention as a 'normal' part of birth:

I guess we are just as guilty as anyone else of saying "hey I had a normal birth today" and she may well have been an induction of labour. So in my kind of heart, I know that normal birth is defined as physiological birth, where there is no intervention, there is no time pressures and the woman just gets on and does it. ... when I look back over my last six months worth of statistics, I say I've had 85% normal births, when I look further down the line at my statistics, I've had 43% induction (Mary, p.5).

Can something remain 'as normal as possible'? Or does this demonstrate a lack of clarity around the way intervention and medicalisation alters the normal physiological processes of labour and birth? Or does this suggest a fluid understanding of 'normal birth'. I believe there is a subtle difference between bringing birth 'back to normal' as outlined in the previous section and seeing a birth 'as normal as possible' here with the dangers of internalising and accepting the medical intervention. This confirms Banks' (2000) argument that we have a fallacy of 'normal birth' existing in the New Zealand maternity system, or as Mary says: that whole concept of what people perceive as being an acceptable birth and calling it a normal birth (p.12). Liz muses on our discussion at the end of her interview:

Yes, what's normal? I never challenge, ... challenged that. I mean even when I read your script I heard in my mind yes, normal birth I've got normal birth. But some of my normal births have not been a normal labour. They've been a

spontaneous, a vaginal birth with assistance of some sort of thing either an induction, and/or an epidural... umm, it makes you think (Liz, p.17).

5.2.3.4 Dangers inherent in adaptation

Within the process of 'bringing it back to normal' we need to have critical reflection and awareness. It is all too easy to start believing in 'the masters tools' (Lorde, 1984) when you are using them. There are inherent dangers of this approach, the more you use the 'masters tools' the more you come to believe in their efficiency and power and come to internally normalise medical processes around birthing. Judy hints at this when she says:

Well, it doesn't have to be a straightforward normal labour and birth to be great.

Yeap

I can just drive home and think if, if you've got a live healthy mother and baby at the end of it and a satisfied mother and a wonderful welcome to this new life. Yeah no, it doesn't have to be normal too to be fantastic. But of course that's an added bonus if it is. I mean especially if she's a previous section or something like that and has had a wonderful normal vaginal birth and the woman's really pleased she's managed to achieve it. It might have been really difficult to achieve, even if she's had an epidural. Very rarely will I come home feeling fantastic if it's been a forceps or a ventouse or yeah a caesarean (Judy, p.9).

Research on women's views on midwifery care in labour consistently shows the importance of supportive care (McCourt & Percival, 2000). Hodnett (2001) concluded that continuous support during labour has a number of benefits for women and their babies, without harmful effects. In another review, Hodnett (2000) found consistent and clear benefits of continuity of care by midwives, with high levels of maternal satisfaction. Midwives can and do make the labour and birth process more comfortable and 'nicer' for women with supportive care and continuity. Murphy-Lawless (2000) however warned of the "Laura Ashley flowered curtain approach" (p.343), with nice surroundings and support, but no real change in the underlying medical protocols.

Within the continuity of care relationship women may have an increased chance to retain their honour and dignity and to be supported in their process. However, if medical intervention is the primary part of the process it will always be a medically managed process, not the woman's process.

As a profession I believe we need to increase our vigilance and challenge ourselves, asking from what basis am I making this decision or taking this action. Some midwives have an awareness of the contested context in which they operate and attempt to honour the woman's process and work with a midwifery model, to keep birth 'normal' or to return birth to 'normal', or 'as normal as possible' within the constraints. But we also need a very real and acute awareness of when normal physiology is undermined and problematised by medicalisation and midwifery action and an awareness of when unnecessary intervention is normalised by midwifery actions influenced by the dominant medical and technocratic culture.

5.3 Conclusion

This second data chapter has explored some ways in which the midwives interviewed manage the medically dominant environment. As I examined the interview material it was readily apparent that the midwives in this group supported women's choice and promoted the 'normalcy' of labour and birth. However what was also clearly illustrated was the way that midwives have been unable to resist taking up the medical construction of labour and birth to some degree.

All parts of the maternity care matrix in New Zealand support women's informed choice and women's choice is an important part of midwifery care. However, as discussed, choice can be a 'slippery' concept. What choices are really available to women in labour and birth? In many situations neither the birthing woman nor the midwife have choice with overt and covert obstetric expectations and management. All midwives,

even those who attend women in their homes, are under tremendous cultural pressure to "do birth according to medical standards" (Davis-Floyd & Davis, 1997, p.317). But 'doing birth according to medical standards' will in many cases mean using interventions, transferring to hospital or recommending the woman gives birth in hospital, despite the midwife's alternative judgment.

Some women and midwives do sustain the belief in the normalcy of birth and, as much as possible, remain outside the dominant medical system. Midwives in this study recognised the importance of supporting women's choices in this regard. All participants support women's choice to birth at home and most would like to attend more home births. However, it was also clear from the interviews that physiological 'normal birth' without intervention can and does happen within a hospital environment. The attitude and belief system of the women's caregiver was highlighted as being more important than the place of birth.

The majority of midwives interviewed commented on two specific actions for supporting women in a hospital setting: 'shutting the door' and 'keeping the woman away'. Shutting the door was an actual physical action as well as a more symbolic way of ensuring the woman had her own private space in which to labour and give birth. Midwives used 'keeping women away' as an actual physical action by visiting women at home in early labour and delaying transfer to the hospital and by avoiding obstetric referral if possible. Other strategies used by the midwives emerged from the interview material: working with the uncertainty of birth by creating fluid definitions that support women's labour processes; bringing birth 'back to normal' when possible; or when complications arise and ensuring that birth remains 'as normal as possible'.

In this chapter and the preceding chapter I have presented the interview material from the midwives framed by relevant literature. In the following and final discussion chapter I discuss the insights and understandings that have emerged from the research.

CHAPTER SIX:

Discussion and concluding statements

6.1 Introduction

In the previous two chapters I presented the data from the interviews with the nine midwife participants. In this, the final chapter, I discuss the insights and understandings that have emerged from the research and consider some implications for the midwifery profession. The limitations of this study are identified and finally I offer some concluding comments.

This was a small qualitative study and as with all such work no claim to generalisability is being made. The process of undertaking this research, including the participants' interviews, a foray into the literature and reflection on my own midwifery practice, has generated my thoughts and ideas discussed here. When I began this thesis I had no concept of where the process would lead me and certainly my ideas have developed throughout the journey. My initial focus was on midwives' construction of 'normal birth', however I have found that it was not possible to focus on 'normal birth' without looking at the wider context within which birth takes place.

During the process of undertaking this work, I have come to see midwifery practice and the cultural construction of birth with greater clarity. I feel I have a deeper understanding and renewed awareness of the multiple and competing influences on practice. I concur with England and Horowitz (1998, p.152) when they say:

No single decision, no one doctor [midwife], and no mother is solely responsibility for a birth outcome. It's over-simplified to blame or praise any individual or isolated event for how a birth turns out. Our challenge is to live with ambiguity.

In presenting this thesis and subsequent publications it is anticipated that readers may also gain increased understanding. I argue that the concept of 'normal birth' is increasingly fragile and subject to formidable challenge. I can now see and feel more acutely medicalised boundaries and expectations; they can be overwhelming in midwifery practice, in all settings. Whether in a totally medicalised setting or in a woman's home, as a Lead Maternity Care midwife, I am constantly aware when I am supporting a woman to move to the edge or outside of those boundaries. It is difficult on a daily basis to be on what Davis-Floyd and Davis (1997) termed "the ragged edge far outside of the safety net of cultural consensus" (p.336). It is true when Skinner (1999) says "midwifery of its very being fronts up against the medical model on a daily basis" (p.16).

Even when **I know** that birth is a normal life process and that the majority of women have all that they need within themselves to grow, nurture and give birth to their babies, and when there is midwifery evidence and/or belief to support my advice and actions, practising from a midwifery model remains a difficult task. I argue in this thesis that our cultural construction of labour and birth continue to remain deeply entrenched in the medical model and that a medical model is being continually reconstructed by midwives and women as well as by medical practitioners. The medical model is the default mode: it is always present and expected to happen unless it is actively contended. This is verified by the 'cultural fallacy' that exists around normal birthing. It is not possible to identify if 'normal births' are actually happening in our current environment, as the official figures do not identify the women who have given birth without recourse to surgical, technological or pharmacological interventions. This silence in itself may send a message about what society 'values' and what is held as important. What the figures do reveal is that more and more women are experiencing medical procedures during their labour and birthing processes (Ministry of Health, 2001).

This discussion chapter explores my interpretations and insights from this research. I revisit the contested nature of the context and cultural construction of labour and birth,

including re-examining some specific clinical examples. Initially however it would be useful to revisit the aims and research approach of the current study.

6.1.1 The aims revisited

The aim of this thesis was to explore the assertion that midwifery care ‘enhances and protects the normal process of childbirth’ (New Zealand College of Midwives, 1993, p.7). I aimed to explore the meaning of ‘normal birth’ in Lead Maternity Care midwifery practice in the current New Zealand context and to understand the complex influences surrounding midwives’ construction of ‘normal birth’.

This study was undertaken in a qualitative framework, with feminist underpinnings. I have presented the interview material with my analysis using relevant literature to frame and explore the participants’ interviews. This weaving together of the literature and the interviews from the midwives is my ‘take’ on the data collected. Another researcher operating within their own framework may find a different interpretation. I acknowledge that these are my conclusions and accept accountability for the understandings produced in this work and my interpretation of the data.

As previously noted, Sandelowski (2000) explained that the summaries from qualitative descriptive studies may produce “working concepts, hypotheses, and thematic moments for future ... study, or themselves contain early versions of them” (p.339). With this in mind I have aimed for my qualitative interpretations to “illuminate and provide a vicarious experience by making the familiar more familiar (eliciting the often-cited shock of recognition), making the familiar strange, and/or by revealing what is hidden” (Sandelowski, 1995, p.372).

6.2 Cultural construction

The healthy life processes of labour and birth have continued to become increasingly medicalised and technologicalised through surveillance and control, despite the efforts of women's groups and midwifery groups. Contributing and ongoing factors include active management of labour since the 1950s and 1960s, rising caesarean section rates since the 1970s, routine use of ultrasound since the 1980s and 'evidence-based' care since the 1990s and thereafter. Johanson, Newburn and Macfarlane (2002) argued that 'normal birth' has become too medicalised and link this to beliefs held about birth, the implementation of 'evidence based practice' and team work.

Claiming that midwifery practice and women's birthing is subjugated and constructed within the medical model of birth is by no means a new idea. The medical model or technocratic model of medicine has been discussed in the childbirth literature extensively for the last 30 years (Arney, 1982; Banks, 2000; Davis-Floyd, 1994; Ehrenreich & English, 1973; Katz Rothman, 1982 & 1990; Papps & Olssen, 1997; Rooks, 1999). Women and midwives have mounted serious challenges to the dominance of the scientific 'management' of pregnancy and birth, working to break down and challenge the existing paradigm and re-establish a strong and dynamic body of knowledge that is unique to the culture of midwifery. What is significant about this research is that I have attempted to explore the notion of 'normal birth' in the one place where I would have most expected to find it alive and well. By interviewing this particular group of midwives I have gone to the very place where it could be expected that the role of guardian of 'normal birth' would be very much in evidence. I have found this to be only partially the case.

Despite considerable gains with the 2002 Maternity Notice (Ministry of Health, 2002), the medical model of birth remains more supported by the legal and political institutions of society. There are numerous examples in practice where there is a divergence of opinion between midwifery and medical 'management'. As discussed in the data chapters, often the medical worldview is held to be the 'correct' version of truth to

which midwives must answer. The referral guidelines are one way in which the medical world-view is sanctioned in the New Zealand context.

6.2.1 Referral Guidelines

As noted in both the literature review and Chapter Four, the majority of women in New Zealand receive an obstetric referral at some stage during their maternity experience. Guilliland (2002) believed that the 'requirement' of referral has the effect of "heavily medicalising childbirth despite midwives being Lead Maternity Carers" (p.12). The majority of midwives in the current study stated that they 'follow the guidelines' and use them to frame their practice. The referral guidelines identify clinical reasons that warrant a consultation with a specialist and are included as part of the 2002 Maternity Notice (Ministry of Health, 2002).

The referral guidelines have developed and evolved, beginning with the *Report of the Committee of Inquiry into Maternity Services* in 1937. Since then various versions have been published in 1982, 1989 and 1997 (Banks, 2000). Initially the 'risk list' or referral criteria were developed without input from midwives or consumers. The latest, 2002, version of the guidelines have had extensive New Zealand College of Midwives participation, however, "in some situations they still represent a compromise position for midwifery" (Midwifery News, 2002, p.6).

Banks (2000) argued that irrespective of the means by which these guidelines are introduced, the whole premise is fundamentally flawed. She argued that "the wide range of variation, which occurs in the healthy experience of childbirth is too large, for a single, uniform definitions of 'normality', which can then be used to define 'abnormality'" (p.84). Further, as there is no agreed definition of 'normal' pregnancy and birth, how is it possible to predict abnormality or 'risk'? Wagner (1994, p.99) clarifies further:

Logically, the abnormal cannot be identified without a clear scientific definition of the variations of the normal. Obstetrics lacks this because the risk concept implies that all pregnancy and birth is risky and therefore no pregnancy or birth can be considered normal until it is over. In other words one cannot claim both the ability to separate normal from abnormal during pregnancy and the inability to determine normality until after birth.

Importantly the guidelines suggest that the woman must be involved in all discussions and decision-making is a three way process, between the Lead Maternity Carer, the woman and the specialist. In reality this three way decision-making is difficult. The New Zealand College of Midwives state that “specialists cannot automatically assume responsibility for care just because they have been consulted” (Midwifery News, 2002, p.6). However, as discussed by the midwives in this study, once a specialist is involved in the care of a woman it is very difficult to retain a focus on a woman-centred physiological birthing process. In a recent ‘O&G’ (the Journal of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists), Ekeroma (2002, p.112) says:

Midwives now provide total care for women in pregnancy and childbirth. However, *they are required* to refer patients (sic) with defined conditions to obstetricians using referral guidelines that were developed by a team consisting of general practitioners, midwives and obstetricians. The guidelines are one of the major challenges to emerge from the reforms as some midwives care for high-risk patients (emphasis added).

6.2.2 Clinical examples

The medical attitude of ‘assuming responsibility’ is evident in many medical policies and practices despite at times a lack of evidence to support their position. There are many examples of medical management and policy that are not backed by convincing evidence, yet dissenting voices remain a minority in our medically entrenched society.

For example, as discussed in the data chapters, there is overwhelming evidence for turning away from base hospitals and returning birth to locally based midwife-led care and home birth (Enkin, Keirse & Chalmers, 1989). Yet, the move to centralised base hospitals continues.

In addition, various concerns have been raised regarding the ‘evidence’ on which practice continues to be based. Anderson (2002) argued that “virtually the entire canon of research literature has been conducted on women giving birth in hospital, which we are now beginning to understand distorts the physiological process of giving birth” (p.207). Katz-Rothman (1990, p.5) adds to this discussion:

I have come to see that it is not that birth is ‘managed’ the way it is because of what we know about birth. Rather, what we know about birth has been determined by the way it is managed. And the way childbirth has been managed has been based on the underlying assumptions, beliefs and ideologies that inform medicine as a profession.

Here I will very briefly revisit two specific clinical examples of ‘routine’ practices that are not supported by evidence.

6.2.2.1 Electronic Foetal Monitoring

As discussed in Chapter Four, the routine use of electronic foetal monitoring during the labours of healthy women is common, but not supported by evidence. Systemic reviews of electronic foetal monitoring have shown no reduction in perinatal mortality or cerebral palsy. Electronic foetal monitoring has not been shown to reduce low apgar scores or rates of baby admissions to special care units (NICE, 2001). The outcomes of electronic foetal monitoring, however, include prolonging labour by restricting a woman’s movement during labour, increased stress and anxiety, discomfort and an assumption of the sick role. The primary risk from electronic foetal monitoring is an increased risk of caesarean section or operative vaginal delivery (NICE, 2001).

Major reviews of the evidence concluded that electronic foetal monitoring should be reserved for high-risk pregnancies (Thacker, Stroup & Chang, 2002). Yet, as discussed by the midwives in this study, it is 'common' that on arrival in hospital for all women, a routine admission monitoring is carried out. Many hospitals have written policy that details a routine electronic foetal monitoring (MidCentral Health, 2002). I concur with Johanson, Newburn and Macfarlane (2002) who argued that the use of inappropriate electronic foetal monitoring is an example of the extent and pervasiveness of medicalised practice.

I believe that each 'small' procedure carried out, such as electronic foetal monitoring, can have far-reaching significance. It has become 'normal' in both medical practice and midwifery practice to routinely undertake electronic foetal monitoring. This is one way of undermining women's belief that labour is a normal process for their babies and themselves. Routine use of this technology clearly gives women the message that labour is 'risky', and therefore surveillance is necessary. The focus is taken away from the woman and her process and placed with the 'machine' and/or the person who has control of the machine and interpreting the output of the machine.

6.2.2.2 Time Frames

The use of arbitrary time frames also places the process of a woman's labour outside of herself and onto some external measure of 'normality'. As discussed in the literature review and Chapter Five, many of the expectations of how a woman's labour will progress continue to be based on Friedman's research conducted in the 1950s and O'Driscoll's work of the 1970s onwards. O'Driscoll advocated a system of management which included early 'diagnosis' of labour, routine amniotomy within one hour of admission to hospital, liberal use of high doses of oxytocin for acceleration of labour and active obstetric participation. O'Driscoll promised women that labour would take no longer than twelve hours. He called his system *Active Management of Labour* (O'Driscoll & Meagher, 1986). Murphy-Lawless (1998) believed that "O'Driscoll's definition of normal labour has passed into general obstetric texts and midwifery texts

alike as an ontological truth, where the first stage of labour lasts up to but no more than ten hours” (p.212).

Opponents of active management of labour argue that O’Driscoll’s framework was not based on a randomised control trial and therefore is not ‘evidenced based’; further, oxytocin augmentation and rupturing the membranes artificially makes labour more painful. Therefore women are more likely to require epidural anaesthesia, with all the concomitant risks of electronic foetal monitoring, reduction in mobility, increase in instrumental delivery and caesarean section. Oxytocin augmentation has been identified as a salient factor in infant brain damage, intrapartum foetal deaths and uterine rupture (O’Connor, 2001). In addition, this cascade of intervention (Inch, 1982) has been associated with postnatal depression (Oakley, 1992).

Active management of labour takes a women-centred process and makes it a medically led time-oriented process. The MANA curve was introduced in the previous chapter as one midwifery response to active management. Daviss, Johnson and Gaskin (2002) challenged the assumption that time is of primary importance in labour and present their MANA curve; it does not have a straight line, rather it demonstrates women’s individual variations and plateaus during labour.

6.3 Midwifery response

As discussed in Chapter Five, the midwives in this study used a variety of means to resist or adapt to the medicalised birth context. The midwives in this group provided a ‘buffer’ between women and the medicalised environment present in the hospital setting. This included physically shutting the door to create a private and secure space for the woman to labour and the symbolic act of ‘shutting out’ the medicalised expectations. Midwives also ‘kept women away’ from the hospital by supporting home birth or for women planning to give birth in hospital, until transfer was really necessary, recognising

that leaving home is one of the biggest interventions. Midwives avoided obstetric referral if possible, although as discussed this is difficult in the current climate with the 'referral guidelines' taken as a framework for midwifery practice and seen as a 'requirement' by the obstetric 'team'.

Leap (2000) proposed that our expertise as midwives is with our ability to "watch, to listen and to respond to any given situation with all of our senses". Midwives in this study worked with the uncertainty of birth by creating new paradigms with fluid definitions that support women's labour processes; by bringing birth 'back to normal'; and ensuring that birth remains 'as normal as possible', although some difficulty with this idea was also highlighted.

Many authors argue for the social or midwifery model of care with woman centred care, informed choice and consent, autonomy and continuity of care (Wagner, 1986 & 1994; Rooks, 1999; Banks, 2000; Walsh & Newburn, 2002) as a way to resist and challenge the hegemony of the medical model of care. A number of writers have discussed midwifery responses and these will be discussed.

New Zealand midwives have had professional autonomy for over a decade, with the legislative changes in 1990¹. Since the introduction of the Lead Maternity Care system in 1996², women have been the primary focus of maternity services and have the option of continuity of midwifery care. In the year 2000 seventy one percent of New Zealand women chose a midwife as their Lead Maternity Carer (Ministry of Health, 2001). And, with the introduction of the Health and Disabilities Act in 1994³, informed choice and consent are legally the means by which decisions are made in health care services. Still our rates of surgical, technological and pharmacological interventions continue to increase.

¹ Nurses Amendment Act 1990

² Notice issued pursuant to section 51 of the Health and Disability Services Act 1993 concerning the provision of maternity service 1996

³ Health and Disability Commissioner Act 1994

On one level I can see the huge improvements that have taken place in maternity services and progress in the way that women are treated; with more respect and understanding from their caregivers. In New Zealand we have created a midwifery-led, women-centred maternity service that Ekeroma (2002) stated is evidence based. Various national reviews (National Health Committee, 1998) have demonstrated the satisfaction that women experience with the current maternity services. The 1998 report on Maternity found that more than 86 per cent of women were satisfied with their care. This report showed that maternal and perinatal morbidity and mortality were either the same or better since midwifery-led care was introduced. Midwives have also found job satisfaction higher through providing full continuity of care (Guilliland, 2001). The participants of this study expressed their satisfaction with working with women and providing full midwifery care.

Although I acknowledge the huge changes, on another level, I recognise and draw attention to how ineffectual these changes have been in challenging the fundamental basis of maternity services. I believe that we have created a new maternity system that is women-centred, but fails to challenge the dominant hegemony, and is therefore doomed to disappointment and failure. I draw on Shaw (2002) for support, in writing a review of the recent midwifery conference, she highlighted the partnership focus between midwives and women underlying the philosophy and ethics of midwifery in New Zealand, but noted that: "our national system still fosters a medical-focused 'birth culture'" (Shaw, 2002, p.18). More strongly, Black (2002) argued that:

More and more midwives are aligning with the medical pathway... [and] women are supporting the intervention pathway as never before. ... Compliant medically motivated midwives have failed to see the bigger picture. They have failed to recognise the part they play in the erosion of the midwife/woman wise way and in the development of another mound in the uneven playing field of how women come to 'choose' (more accurately – are directed to choose) their midwifery care (p.26).

The current study also raises serious challenges to the adequacy of the partnership model as a means to 'enhance and protect the normal process of childbirth'. If the midwifery profession is going to seriously challenge the medicalisation of birth, I believe we need to engage in a radical critique of midwifery practice, alongside further development of continuity of care and the partnership model. The partnership model is now considered further.

6.3.1 Partnership

Under the New Zealand midwifery model of care 'partnership' is a key concept. In this model "the midwife acknowledges the woman's sovereignty in her own life and respects the decisions she makes for her childbearing experience. The midwife has a responsibility to share all the available information with the woman and to respect her values and beliefs" (New Zealand College of Midwives website, 2002). In this thesis I argue that partnership does not adequately address the subtle and overt ways that the whole pregnancy and childbirth process have been appropriated and medicalised in western society.

Pairman (1999) argued that by midwives "taking hold of our own power we begin to understand childbirth in new ways" (p.10). She suggested that these new understandings challenge the right of medicine to define and control childbirth, offering instead an alternative model that arises from women's experiences. This "new understanding returns control of childbirth to the woman and her family and to the community" (p.10). Further, Pairman (1999) found in her research that the women wanted midwifery care based on trust, respect, equality and openness. "The women wanted to be actively involved in their care, to take responsibility for themselves and to be in control of their childbirth experience" (Pairman, 1999, p.11).

This argument however fails to address the ways that women themselves have been colonised by the dominant medical model. As discussed in Chapter Five, the dominant medicalised ideology and practices have culturally constructed women's choices. Although midwives may disagree with many medically based practices, we find the women requesting and expecting these medical interventions. At a recent New Zealand College of Midwives conference Beatrijs Smulders, a Dutch midwifery spokesperson, said that Dutch midwives believed that choice is an illusion based on fear and insecurity (Midwifery News, 2002). As discussed by Davis-Floyd (1992) medical interventions may help the women to feel powerful and help them to feel they are fully participating in their culture. In failing to challenge how women's subjectivities are historically and socially constructed midwifery is in danger of passive legitimization of the dominant medicalised ideology.

I agree with Skinner (1999) that partnership can leave both the woman and the midwife extremely exposed. She addressed the differing knowledge bases of the midwife and the woman and argued that in her experience women do not necessarily want partnership and control, and that informed consent is not always possible. Skinner (1999) believed that the partnership model does not make explicit "the extent of the enormous power imbalance between midwife and mother" (p.15). Further, Skinner (1999) wrote:

The fact is though that many mothers do not understand the nature of what is being challenged and that they are often going against the medical model by undertaking care by a midwife. What in effect often happens is that the mothers are still functioning with the assumptions of patriarchy and the medical model absolutely unchallenged while at the same time exploring the realities of midwifery care and appreciating the extras it provides (p.16).

As discussed in Chapter Two the medical model of birth continues to be more supported by the political and legal institutions of our society. Daellenbach (1999) argued that the concept of partnership is one of the resources that midwives and consumer activists can use in challenging the dominance of the medical model and in "establishing more credibility for midwifery" (p.23). I believe that in the New Zealand context partnership

between the midwifery profession and consumer organisations has been extremely effective and powerful. The development and ongoing commitment to partnership at a political level is crucial.

However, I conclude that the partnership model at a practice level has not substantially countered the medically dominated experience of pregnancy, labour and birth for the vast majority of women in New Zealand. The partnership model is a way in which both the women and midwives actively collude in supporting the medical model, frequently in unrecognised ways. As noted in Chapter Two, Anderson (2002) argued that in the United Kingdom context “in terms of supremacy, little has changed: it is clear that the obstetricians remain the ultimate policy and decision-makers” (p.407). I believe the same applies in the New Zealand context. Further, the entrenched nature of the medical perspective operates in hidden and subtle ways meaning that it is at times hard to even recognise.

DeVries, Benoit, van Teijlingen and Wrede (2001) argued that those who wish to change the way maternity care is organised, must pay attention to all of the forces that combine to create care systems and explore the conditions that allow and promote effective reform. Midwives are in a unique position to take a greater role in promoting and protecting ‘normalcy’ in labour and birth. I agree with Pairman (1999) when she says: “The only reason the midwife is involved with the woman is because she brings professional knowledge and skills of childbirth. The bottom line is the well being of the woman and her baby” (p.10). However, I believe that as midwives we need to cease from ‘proving’ our model in the medical discourse and move onto the real work of articulating and authoritatively claiming our own midwifery worldview.

6.3.2 Midwives’ subjectivities

As discussed in Chapter Five, midwives are ‘situated actors’, which means that we are active participants in the process of meaning creation (Hertz, 1997). How midwives

construct 'reality' or their own subjectivities is a complex interplay between cultural, social and historical circumstances. Corbett (1992) argued that subjectivity is "produced by, and productive of, cultural and material practices" (p.5). Further, subjectivity is an ongoing process: "It is not constructed, once and for all, at some locatable point in the individual's history; rather, it is a continuous process of production and transformation. Subjectivity, like gender, is a 'doing' rather than a being" (Robinson, 1991, p.11).

Wickham (2001) identified a variety of sources of midwifery evidence including experience, women, intuition, spirituality, practice, history, insight, physiology, reflection, research, philosophy (p.s24). Medical parameters and expectations are a further source of midwifery evidence and a strong influence on practice. Stapleton, Kirkham, Thomas and Curtis (2002) outlined strategies that midwives adopt in order to juggle a variety of competing needs in daily practice. They concluded that midwives use considerable energy to negotiate the needs of the women with the demands of the 'power-holders', the medical and managerial staff. Although this study was carried out in the United Kingdom with employed, shift midwives, they identify familiar strategies. For example they found that the majority of midwives "appeared to 'go with the flow' of obstetric opinion because it made life easier" (p.607).

A further concept that I believe plays an influence in midwifery practice and discussed in Chapter Five is what Michalowski (1997) termed disciplinary anxiety. He argued that disciplinary anxiety is characterized by an "uneasy or vague sense that my actual behaviours are being controlled or shaped by others" (p.55). Michalowski (1997) further defined disciplinary anxiety as *surveillance anxiety and control anxiety*. He defined surveillance anxiety as the suspicion of being watched, and behaviour being "scrutinized and evaluated by unidentifiable others for unknown purposes" (p.55). Control anxiety is defined as the suspicion that the experiences that are allowed to happen are being consciously shaped by others "to conform to some hidden actor's political goals" (p.55).

Stapleton, Kirkham, Thomas and Curtis (2002) found that the midwives in their study who did openly confront the medical dominance “lived in constant fear of reprisal, from both midwifery and obstetrical colleagues” (p.608). This is a similar concept to Fahy (2002) who argued that medical power is normally invisible; “it only becomes visible when resistance is encountered; whereupon rewards, threats and punishments are used in an attempt to gain submission” (p.5). Donley concurs and argued “If submission cannot be achieved through positive willingness to participate in hospital procedures it is usually achieved by veiled intimidation or the threat of dire consequences for non-conformists” (Guilliland, 1999, p.14).

Thus, just as we can never know all of the factors that come together to influence a woman’s birthing experience, we can also never know all of the factors that come together to influence a midwife’s midwifery practice. Midwives are part of a historical time period, members of society and cultural groups, as well as being part of the midwifery profession. It is important however to have an understanding of midwives’ subjectivity and our own agency.

Abrams (1999) argued that agency encompasses both self-definition and self-direction. Drawing from Abrams’ (1999) work, I believe that each midwife, in seeking agency, must firstly become aware of the ways that her practice is defined, constructed and shaped by medically dominated norms. In this way, as Abrams (1999) argued “developing this awareness does not permit her to transcend these socially conditioned visions of self, but it allows her greater room in which to affirm, reinterpret, resist or partially replace them” (p.819).

Further, there is a “political dimension to this process of recognizing and reflecting on the influence of social norms” (Abrams, 1999, p.819). Exploring how midwives construct their sense of themselves, their own subjectivities, how those subjectivities are shaped by and shape the reality of midwifery practice and women’s birthing experiences, opens a space for midwives to understand and challenge the complexities of medical dominance.

6.3.3 Postmodern midwife

A number of experienced midwifery writers and researchers (Anderson, 2002; Banks, 2000; Davis-Floyd & Davis, 1997; Katz Rothman, 2001; Leap, 2000) have identified 'postmodern' midwives or midwifery 'ways of being' that do not subscribe to any one metanarrative, but rather midwives who are able to negotiate the tensions and are comfortable with fluidity and ambiguity. This group of midwifery theorists has helped articulate my own views and I argue that these writers demonstrate that the 'midwifery model' is not secondary to the obstetric/medical model. Medicalisation and medical dominance, with its narrow focus on pathology, has made invisible many parts of midwifery; however, midwifery knowledge, skills and expertise are unique, far broader than, and distinct from medical knowledge.

American writers Davis-Floyd and Davis (1997) identified 'postmodern' midwives who are "educated, articulate, organized, political, and highly conscious of both their cultural uniqueness and their global importance" (p.320). These midwives are equally comfortable working between "the whiz-bang technologies of biomedicine to the holistic philosophy and 'of service to women' ethos of homebirth midwifery" (Davis-Floyd & Davis, 1997, p.320). Postmodern midwives are self-consciously engaged in "the most radical of cultural critiques" (p.320).

In the United Kingdom, Leap (2000) argued that our belief in a woman's inherent ability to be her own and her baby's expert should underpin all of our midwifery actions and responses. She warned of midwives 'doing things' and suggested "the less we do, the more we give" (p.3). In this way midwives can avoid dependency and enable women to maximise their own potential.

Anderson (2002) built on Leap's ideas with the concept of 'intelligent inactivity'. Intelligent inactivity is knowing when to sit quietly and patiently and recognising when to act. Interventions need to be recognised as such and their risks and benefits thoughtfully assessed in each individual situation, but there is a time and place for

everything. "The challenge is to articulate how we make judgements as to when each intervention is appropriate, so we learn to make timely interventions in this beautifully balanced physiological process - but only when necessary" (p.209). Anderson (2002, p.201) further says:

The post-modern midwife sits and knits patiently, but can also site an intravenous line or perform a McRobert's manoeuvre if needed. The glory of post-modern midwifery is that we can use all the different healing modalities and embrace the three levels of intervention as and when we need to. The holistic paradigm of midwifery care has no hesitation in utilising science and technology when it is genuinely at the service of the individual.

A related model is presented by Banks (2000) who identified the scientific, heroic and wise woman traditions of healing. Banks argued that the wise woman midwife does not support unnecessary intervention and that "if intervention becomes necessary, she [the wise woman midwife] will always start with the least interventionist step that is appropriate for effective resolution of a problem" (2000, p.141). Banks believed that midwives know that "giving birth is an experience full of high emotions or deep disappointments (Banks, 2000, p.3). Katz Rothman (2001), I believe, strengthens and supports these ideas when she says:

Midwives know that birth, like life itself, comes with no guarantees. A belief in the health and normalcy of pregnancy and birth is not to be confused with a fantastical expectation of all 'jolly' pregnancies, happy healthy babies, well-adjusted mothers, and eternal happiness. Critics of midwifery often fail to understand this, confusing the midwives' conviction about the "naturalness" and physiological" and "healthy" nature of pregnancy with a naïve "Pollyannaish" expectation of happy endings (p.191).

Smulders (2002) adds to this discussion with her message from the recent Dunedin conference. She discussed the importance of a strong birthing culture and an acceptance that you can not improve on a 'normal birth', but you can spoil it with medicalisation.

She says: "If you just protect normal pregnant women from medicalisation then 80 per cent of the births will be normal" (Midwifery News, 2002, p.6).

As a political and informed group of women, midwives are in a unique position to play a far greater role in the promotion of 'normal birth' than we currently undertake. In presenting this research my intention is to stimulate debate and contribute to midwifery knowledge. By 'giving voice' and by 'speaking out' I challenge the ways in which midwives' current construction of 'normal birth', based on medical parameters, restricts and limits women's ability to labour and birth without technological, pharmacological or surgical interventions. Medical power operates most effectively with the cooperation of the midwife and the submission of the childbearing woman (Fahy, 2002).

6.3.4 'Normal birth' – midwives (re) construction

Kirkham (1996) suggested that midwives are only given status within a very tightly controlled medical system. I strongly urge midwives to re-examine the ways that their midwifery decisions, actions and words are based on a hidden or subtle acceptance of the medical model and to work to construct a strong midwifery system. As discussed, our ways of working and interacting with each other and with women help to determine and create our reality. In order to re-gain and re-frame birth from a place of strength it is an urgent task to find new ways to 'tear down the master's house' (Lorde, 1984). For we as women and as midwives have too much to lose if we continue to support the march of medicine and technology. In a context in which a feminist social commentator (Coney, 2001) can proclaim that by the year 2010 around half of all women will choose a caesarean birth, midwifery's task is urgent. Stapleton, Kirkham, Thomas and Curtis (2002) proposed that "explicit strategies are needed to achieve massive cultural change" (p.610), before it is too late.

Davis-Floyd and Mather (2002) argued that midwives have a unique opportunity to weave many elements together to create the best obstetrical/midwifery system the world has ever seen. They say:

More information than ever is available from scientific studies that inform us about the physiology of birth and the kinds of care that truly support women to give birth. ... *And it has been scientifically shown that the most powerful determinant of a woman's birth outcome is the ideology of her practitioner* (p.506, emphasis added).

I argue that it is crucial for the midwifery profession to establish clarity and challenge around midwives' role in the increasing intervention rates and see a way through the subtleties, nuances and gray areas. I agree with Anderson (2002) when she suggested that in our quest to understand physiological birth we need to 'deconstruct' midwifery interventions that distract from the woman's process and may lead to medical intervention. Banks (2000) concurs and argued that examining routine practice "provides a challenge for birth attendants to examine their role in supporting the medicalised birth industry" (p.4).

Further, I argue that midwives need a radical shift in thinking and conceptualising to challenge each other and our selves and stand by our midwifery knowledge in more open and authoritative ways. Perhaps we would be wise to consider the messages of black feminist theorist Audre Lorde. She argued that if we use the tools of the 'patriarchy' to examine that same patriarchy it means that only the most narrow perimeters of change are possible and allowable (Lorde, 1984). Further, she argued for "learning how to take our differences and make them strengths. *For the master's tools will never dismantle the master's house.* They may allow us temporarily to beat him at his own game, but they will never enable us to bring about genuine change (Lorde, 1984, p.112, emphasis in original). She goes on to say "...an old and primary tool of all oppressors (is) to keep the oppressed occupied with the master's concern" (p.113).

6.4 Putting me in again

I began this journey with a burning question. I wanted to make sense of what I could see and hear happening in midwifery practice: the daily taken for granted and normalised existence of pharmacological, technological and medicalised intervention in the midwifery practices and labours and births of well, healthy women. I questioned why, when seventy percent of New Zealand women have a midwife Lead Maternity Carer, are intervention rates continuing to increase? Just like Earl, Gibson, Isa, McAra-Couper, McGregor, and Thwaites (2002, p.32) I found myself asking: *If our model of midwifery in New Zealand is so good why are the caesarean section and intervention rates still going up?*

I end this thesis journey in some ways feeling more disillusioned, while in others ways I have a greater understanding and more personal conviction in my own practice to resist the dominant hegemony. Birth is a normal physiological process, if only we can trust it and trust it enough to resist the ever strengthening pressure to medicalise every aspect of the process. Labour is hard work, but doable. As Wickham (2001) wrote, "Birth works; if you trust, understand and respect it" (p.73).

6.5 Limitations

In Chapter One I declared my own personal and professional interest in 'normal birth' and my positioning as a direct entry midwife and a self-employed Lead Maternity Care midwife, with a commitment to home birth. I do so again as my own commitment to working with women who choose to remain as "far out of the reach of the technocratic model as they can" (Davis-Floyd & Davis, 1997, p.316), will have influenced the research process and interpretations. However, this positioning also gives me a unique perspective in terms of critiquing some taken-for-granted aspects of midwifery practice

and should not preclude my participation in contributing to a midwifery construction of birth in our current context.

This was a small study involving nine Lead Maternity Care midwives and myself as the researcher. I used purposive sampling that deliberately selected a group of midwives with particular characteristics. Therefore, it is not generalisable to all midwives or all practice contexts. The midwives involved in this study were Pakeha/non-Maori midwives. Maori midwives and midwives from other cultures may experience the environment from a different cultural perspective and experience different cultural constraints. All midwives involved in this study worked in settings that were within a one hour drive of a secondary or tertiary care centre. Midwives who practice in more remote settings may also have a different perspective.

However, all midwives are practising within a similar societal context and work under the same legislative system. This study does provide one perspective and some insights into the construction of 'normal birth' and the multiple influences and constraints that midwives experience in supporting women to achieve birth without intervention in today's environment.

6.6 Concluding Statement

This thesis does not seek to provide definitive answers to the issues that it has highlighted. Rather it is my intention to stimulate debate and contribute to the growing recognition that midwives, in a rejection of the "prevailing hegemony of the technocratic model of childbirth... are now seeking a deeper understanding of that elusive phenomenon: the normal birth process" (Anderson, 2002, p.207). By being more acutely aware of the overt and subtle ways in which the medical ideology frames our practice and continues to operate, we can seek ways in which to challenge, resist and reframe our practice. Further, I wish to stimulate debate regarding the role partnership is

playing in achieving the goal of enhancing and protecting 'normal birth'. I believe that the midwifery profession needs to examine what we have learned and continue to build on it in order to confront contemporary medicalisation.

The midwives in this study are political, experienced and articulate midwives; all except one have been in practice for a long time. They are all working in self-employment providing continuity of midwifery care and actively work in a women-centred midwifery model. They all support women to birth at home, if this is the woman's choice. Some have worked throughout the changes in the maternity services in New Zealand. They all participate in an annual Midwifery Standards Review process and are on the whole active members of the New Zealand College of Midwives. Even these strong politically aware midwives experience difficulties in standing outside of the powerful medicalised discourse evident in the current New Zealand context.

Over the last thirty years maternity services have been transformed. Women are no longer isolated from their partners and families in sterile and frightening hospitals with detached impersonal strangers. Midwives are no longer legally under the supervision of the medical profession. The passage of the Nurses Amendment Act in 1990 and the introduction of the Lead Maternity Care system in 1996 have transformed the experiences of women during pregnancy, labour and birth and the working lives of midwives. The majority of women can and do choose who will provide professional maternity services during the whole maternity episode and will know the professional who will be present during labour and birth. Some women are able to make choices throughout the pregnancy and birthing journey. Midwives can choose to be self-employed or employed, and have professional autonomy. They have the legal right and the knowledge, skills and expertise to provide a complete service to women throughout the childbearing journey.

The majority of women are nevertheless still giving birth to their babies within a system that is framed by the ideology and culture of the medical model, despite the aspirations and hopes for midwifery autonomy. This is demonstrated by the majority of women

choosing to birth away from their homes in the hospital setting and by the increasing use of technological, surgical and pharmacological interventions used during pregnancy, labour and birth. Midwifery practice is still framed by medical power, protocols and expectations. This is demonstrated by the legal and societal expectations that midwives will conform to the referral guidelines and the medical and technological procedures of pregnancy, labour and birth, and by the 'disciplinary anxiety' experienced by midwives.

Midwives are legally practitioners in their own right, however the degree of autonomy midwives claim depends on how we perceive ourselves within our environment. Midwives are subjected to competing discourses and conflicting ideologies that affect the way that we practice. Since 1990 in New Zealand, some midwives have demonstrated how easily autonomous practice can create its own power base which mimics medicine's behaviour and which can interfere with women's right to information and choices about childbirth (Guilliland, 1999).

I have argued in this thesis that both women and midwives continue to be active participants in recreating and supporting the dominant medical model of pregnancy, labour and birth. While the midwifery model does impact on the care given and received, the dominating presence in maternity services is that of the medical model. The medical model continues to be taken as the 'truth' in institutional and legal settings and is more socially sanctioned in subtle and complex ways.

In the same way that society is currently debating the issue of 'social caesarean' I believe we also have an urgent responsibility to debate more actively the issue of hospital birth and medically managed 'deliveries'. If we, as midwives, truly believe our philosophy of enhancing and protecting the normal process of childbirth (New Zealand College of Midwives, 2002), then we must seriously address the issue of taking women away from their homes and into an environment that can be 'unsafe' for the process of labour and birth.

However, given the overwhelming success of the move to hospitals for births and the clear finding that it is caregiver, not place that remains the most important factor, midwifery must also continue to work to change the culture of hospitals. In order to be 'actively promoting and protecting women's wellness' (New Zealand College of Midwives, 2002, p.3) we must draw a line in the sand regarding many of the technological, pharmacological and surgical interventions used for the majority of childbearing women in this country. A radical critique is needed to examine interventions including the overt procedures such as routine obstetric referral, routine ultrasound scanning, routine electronic fetal monitoring, and an acceptance of epidural anaesthesia for 'normal' labour pain. Midwives also need to examine the more insidious 'silent' interventions such as compliance to medical time frames and active management of labour, directed pushing, routine use of 'alternative' therapies and the many other actions that undermine the belief that the majority of women have everything within to give birth to their babies. In addition, we need to comprehend how it is that the medical model continues to dominate women's birthing experiences despite a substantive lack of evidence to support its position.

I finish with the words of the *Tao Te Ching*, written over 2,500 years ago (in Heider, 1986) that ring true for me:

The wise leader does not intervene unnecessarily. The leader's presence is felt, but often the group runs itself.

Remember that you are facilitating another person's process. It is not your process. Do not intrude. Do not control. Do not force your own needs and insights into the foreground.

If you do not trust a person's process, that person will not trust you.

Imagine that you are a midwife: you are assisting at someone else's birth. Do good without show or fuss. Facilitate what is happening rather than what you think ought to be happening. If you must take the lead, lead so that the mother is helped, yet still free and in charge.

When the baby is born, the mother will rightly say, 'We did it ourselves!'

APPENDIX A: Research Information Sheet

Hello/Kia Ora

Hi, my name is Sue Crabtree and I am a practicing midwife. I am also a student working towards a Master of Arts degree at Massey University and I am seeking some LMC Midwives to participate in some midwifery research with me.

The research is looking at meanings of normal birth in midwifery practice. I am interested in exploring with you how you define normal birth in your practice situation, exploring the complex influences and constraints.

Participation would involve one interview with me (the researcher) which will take one to two hours, in a place and time that we agree on. With your consent this interview will be audiotaped, if needed you may ask to have the tape recorder turned off at any time.

When the interview has been transcribed (by myself or a typist, who will not have any personal information about you), I will return the typed interview to you to read and you can make any changes you feel more accurately reflect your meaning. At this time you can delete any material that you may wish to.

No personal evaluation of your practice is involved. We will be discussing your views on your practice and your own reflections. In this type of research it is not always possible to anticipate what issues may be uncovered. Participation in this study may be positive as it may allow reflection on positive aspects of your practice. It may also lead to feelings of discomfort as it may uncover aspects of your practice you were unaware of and may be uncomfortable with. At any stage of the interview we can take a break and turn the tape off and, if appropriate, we can discuss ways in which you can seek support for the issue at hand.

If you wish to discontinue your involvement you are free to do so up until the time edited transcripts are returned. At this point, once your data has been amalgamated with other participants, it is impossible to remove your individual contribution.

All audiotapes will be returned to you at the end of the study or destroyed if you wish. Following completion of the thesis transcripts and computer discs will be stored in a secure locked filing cabinet for five years, which is Massey University's policy and then destroyed.

In the final writing up of the thesis you will not be identifiable by name or in any other way, you may like to choose your own pseudonym. A summary of the final report will be sent to you. I believe that this study will have positive benefits for midwives by increasing our knowledge of the constraints and influences on LMC midwifery practice. It will contribute to the growing body of knowledge on the unique model of midwifery that continues to develop in New Zealand.

In summary, you have the right:

- to decline to participate;
- to refuse to answer any particular questions;
- to withdraw from the study up until you have returned your edited transcript;

- to ask any questions about the study at any time during participation;
- to provide information on the understanding that your name will not be used;
- to be given access to a summary of the findings of the study when it is concluded.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 01/106. If you have any questions or concerns about this study please contact myself or my research supervisor at Massey University who is Professor Jenny Carryer, School of Health Sciences, and she can be contacted at Massey University (06) 350 5799 ext. 7719, or at MidCentral Health, (06) 350 9143.

If you are an LMC midwife who practices across all midwifery settings, including home, community and hospital, and are willing to spend an hour or so talking with me about your experiences of normal labour and birth, please contact me.

Please contact me to volunteer or for further information at home on ([REDACTED]) or on my mobile [REDACTED] or email me on [REDACTED]

Thank you very much for your time reading this information and I look forward to your response.

Sue Crabtree
Midwife/Researcher

APPENDIX B: Consent form

Definitions of normal birth for Lead Maternity Carer (LMC) Midwives practicing in Aotearoa/New Zealand

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 understand I have the right to withdraw from the study up until the time I have returned my edited transcript and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission. The information will be used only for this research and publications arising from this research project.

I agree/do not agree to the interview being audio taped.

I also understand that I have the right to ask for the audiotape to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed by participant: _____

Name: _____

Signed by _____

Date: _____

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