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**'BEING SAFE'
IN CHILDBIRTH:
A hermeneutic interpretation of the narratives
of women and practitioners**

Elizabeth Smythe

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**School of Health Sciences
Massey University
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ABSTRACT

This study uncovers the meaning of 'being safe' related to the experience of childbirth, from the perspectives of practitioners (midwives and doctors), and women. It is informed by the philosophies of Heidegger and Gadamer. Stories and thoughts of the participants are offered to uncover the taken-for-granted nature of the experience of 'being safe' and to expose possible meanings in a new way.

The findings of this thesis are that 'being safe' dwells in vulnerability. There are possibilities of unsafety that are beyond human or technological control. There is however a distinctive spirit of practice that promotes safe care. It brings wisdom of learning and experience, alertness to the situation of 'now', and anticipation of problems that might arise. Relationships matter to the provision of safe care. Those that seek mutual understanding and that remain open and dialogical are more likely to anticipate concerns or find problems at their first showing. The setting in which practice is experienced impacts on safety, having the potential to erode or sabotage, to protect or enhance. Any questions asked in hindsight about the meaning of safety need to consider what possibilities, if any, existed for creating safe care, and what other factors influenced the situation to undermine the best intentions of those directly involved.

The study concludes by drawing attention to four worldviews which bring conflicting meanings of 'being safe'. The findings of this study show, however, that in the experience of 'being human' there is a common understanding of what it means to be safe in childbirth that reaches beyond the boundaries of worldviews. Where there is a willingness between those involved to find the shared understanding of 'being safe' that overrides the conflicting worldviews, safety is more likely to be achieved. For practitioners, to be safe is a lifetime's struggle. For women, 'being safe' can never be assumed, or taken as a sure promise. 'Being safe' will always be complex, will always be vulnerable, will always be close to danger.

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POINTS OF CLARIFICATION

Writing style

This thesis takes a hermeneutic approach recognising that I am the author in dialogue with you the reader. I have tried always to make it clear when another voice is offered by the customs of referencing, following the style set out in the Publication Manual of the American Psychological Association (1994). Italics are used for the voices of participants and also for the voice of poets. In chapter ten I have chosen to use italics to highlight the questions that have arisen from this study.

Ending each chapter

When I came to the finish of writing each chapter I let my mind, that was full of the notions of the chapter, yield to the freedom of poetry. It seemed in keeping with the spirit of interpretive phenomenology. The poetry becomes the dwelling place of the tentative new insights. It reveals the connections. It leaves open the questions not yet answered. It tries to speak the language where the meaning arrives at a new place.

Naming the participants

I have broken from the custom of referring to participants by a pseudonym. I experienced a reluctance to call these people by names which were not their own. I have referenced the practitioners' stories with an alphabetical letter representing the order in which I interviewed them. I have not referenced the woman's stories at all. This is to protect their anonymity by preventing the reader from piecing together the stories from the same woman, with the chance that they might then identify her or her practitioner. I believe that the data moves beyond the story of a particular woman, to become a story that might belong to any woman. In seeking to bridge the dialectic tension of a story being both unique and universal it seems there is no longer a need to cling to pseudo-identity. The consequence of not referencing stories with names is that I have no name to bring to the discussion. Therefore, I ask you to accept that 'this woman', 'this doctor' or 'this midwife' always refers to the participant whose data is the focus of the discussion.

The meaning of words

It is important that I clarify the meaning I give to key words in this study. 'Childbirth' is used to encompass the whole of the experience from conception to the early days of the mother/baby experience. 'Practice' is similarly used as an umbrella term encompassing the work of midwives, doctors, and any other health professionals. 'Practitioner' is used to refer to both midwives and doctors. 'The practice setting' refers to any place where maternity care is offered. 'Woman' is used to identify a woman who is, or has been, a consumer of the maternity services. I have deliberately chosen broad defining terms to facilitate an openness. Specifying holds the danger of creating barriers, of not letting us see where commonness lies.

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CHAPTER ONE: BEGINNING IN THE MIDST

We had the experience but missed the meaning

T.S. Eliot, *The Dry Salvages*, Four Quartets

The focus of this study is 'being safe' in relation to childbirth. Some have had the experience of 'being safe', in their role as practitioners in the maternity services. Others have had the experience of 'being safe' as a person who has given birth. We all share the knowing that 'being safe' matters. Practitioners call their practice 'safe'. Women expect their experience to be 'safe'. We all assume that what we know and think and do is 'safe', therefore 'being safe' is a taken-for-granted assumption. This study takes its beginning by asking 'even though we have had the experience, could it be that we have missed the meaning?' It seeks to bring this taken-for-granted background practice to the fore, and give it voice by asking the question "what is the meaning of being safe?"

There are two main perspectives to the question asked: what is the meaning of 'being safe' for the woman who is pregnant, or in labour, or has a new baby?; and, what is the meaning of 'being safe' for the midwife or doctor involved in the care of a woman and her baby through her childbirth experience? Is there a straight forward answer to each of these questions? Is there a common answer? Are there many possible answers? Are the answers known and able to be articulated by those who would call themselves safe, or is 'being safe' more an embodied experience? Is 'being safe' more apparent in its vulnerability, and in its absence? Is safety taken-for-granted until a situation arises that is seen to be unsafe?

Beginning to uncover the meaning of 'being safe'

The dictionary is a place where the meaning of words is explained, with the understanding that that meaning is the one that is valid for that time and place. I sought the biggest dictionary I could find, *The Oxford English Dictionary* (1970), and in Volume IX found two and a half pages of the smallest print, describing the meaning of the word 'safe'. It comes from the Latin *salvus* meaning uninjured, entire, healthy. In Greek, safe has the meaning of 'whole'. As I ponder on those early meanings, I wonder if we have lost something of that essence of wholeness in our everyday use of the word. This authoritative dictionary then moves on to offer a choice of meanings of more recent times: to be free

from hurt or damage; to be in sound health, well, whole; to be spiritually whole; to be mentally or morally sound or safe; to keep safe or intact, without hurt or prejudice to; to be not exposed to danger, not liable to be harmed or lost, to be secure. The dictionary definition tells me that 'safe' may refer to a place or a thing; that it may be of an action, procedure, undertaking, or a plan free from risk, guaranteed against failure. There are reminders of the other words safe is commonly linked to: 'safe and sound', safe-conduct, safeguard, safe keeping, 'it is safe to say', to be 'on the safe side', safe passage, to be in safe hands. It is with awe that I recognise the enormity of meaning encompassed in those four small letters. A midwife in this study who is closely involved in the politics of practice, with a gleam in her eye said: "well 'safe', it's a four letter word, isn't it?".

The meaning of 'safe' is complex. When it is linked to the notion of 'being safe', of living out the meaning through thinking, doing, feeling, experiencing, its complexity sinks even deeper into the unknown. Lewis (1945) in his satirical novel *That Hideous Strength* captures a sense of the challenge of trying to be safe:

My dear young friend, the golden rule is very simple. There are only two errors which would be fatal ... On the one hand, anything like a lack of initiative or enterprise would be disastrous. On the other hand, the slightest approach to unauthorised action - anything which suggested that you were assuming a liberty of decision which ... is not really yours - might have consequences from which even I could not protect you. But as long as you keep quite clear of these two extremes, there is no reason (speaking unofficially) why you should not be perfectly safe (p.310).

It is a metaphor of walking a tightrope, where the meaning of 'what is safe?' is held by two opposing powers. There are those who say 'you must **act** without permission', and those who say 'you must **do nothing** without permission'. One cancels out the other. Being safe on one hand, is being unsafe on the other hand. The to and fro is a place of enormous vulnerability.

Shakespeare adds his wisdom to the complexity:

I speak of peace, while covert enmity,
under the smile of safety, wounds the world
(King Henry IV, Part 2)

We are reminded that all may not be what it seems to be. What is giving the appearance of safety may be an illusion. It may not be safe at all.

The Bible places the notion of safety in the hands of God. Take the example of the story of Daniel thrown into a pit filled with lions (Daniel 6:11-24, Good News Bible). The King who reluctantly carried out his order did so with the words, “May your God, whom you serve so loyally, rescue you” (v.16). The next morning, the King found Daniel had not been hurt at all for God had sent his angel to shut the mouth of the lions. The King then had all those who had falsely accused Daniel thrown into the same pit. “Before they even reached the bottom of the pit, the lions pounced on them and broke all their bones” (v.24, Good News Bible). It is the paradox of safety. What is known to be unsafe, is safe in this story in the hands of God. It is beyond the understanding of mere humans. It is built on trust, and faith.

Safety is shown as a complex phenomenon. It is situated and enmeshed in political power. It seems as though it may be won or it may be lost. Making safe decisions can be perplexing because of the possibilities of both winning and losing. There is also a kind of safety that is mysterious and unpredictable, beyond rational explanation. This study will take on the pursuit of uncovering the complexity of ‘being safe’, of seeking the meaning of ‘being safe’ in the context of the New Zealand Maternity Services.

The impetus for this study

In 1992 I was asked by an obstetrician colleague if I was planning to attend an interdisciplinary conference *Birth in the 21st Century*. He commented, “there is no mention of safety”. I attended that conference with his comment in the front of my mind. Two international speakers, Janet Balaskas and Yehudi Gordon discussed their practices related to water birth. While I was excited by the new possibilities they offered me, I was disturbed by a sense that when they discussed their “just wait and see what happens” (1992, p.57) approach to the baby in the first few minutes of life, they were moving beyond my bounds of ‘being safe’. The legal case of the death of a one day old baby in Australia (Mair, 1992, p.144) further disturbed me. The midwives had not been able to hear the fetal heart in labour in the 37 minutes prior to the delivery. At birth, the baby showed no signs of visible life. Resuscitation began with the establishment of a heart rate of 100 but with no spontaneous breathing. The baby was oxygenated with positive airway pressure. It was given ‘rescue remedy’, a homoeopathic treatment, and a crystal was placed on its chest. It was two and a half hours before the midwives asked the father if they wanted to send the baby to hospital. He consulted with his wife, who “expressed a preference for the baby to

be kept at home and wait” (p.144). Four and a half hours after birth, when the baby’s colour began to deteriorate and there were no neurological responses, the midwife finally informed the mother that her baby should be taken to hospital. The baby died in hospital two and a half hours later. I listened to this story in stunned disbelief. How could these midwives stand by and do so little when this baby’s life was in the balance? How could they acquiesce so passively to the inappropriate choices of the parents? How could they take the risk that alternative, natural remedies would be as effective as skilled medical assistance? How could they let so much time go by without recognising the seriousness of this situation? How could they let this baby take the road to death?

My biggest concern was that sitting in the front two rows at the conference presentation, hanging on their every word, were student midwives. I was one of their teachers. What messages were they taking from this conference about the meaning of being safe? On the one hand the key-note speakers were encouraging a ‘wait and see’ approach to resuscitation, while on the other hand, the tragic consequences of such practice had been laid before us. The contradictory voices argued the romance of the natural unfolding of life against the negligence of not recognising danger. Would these students, in their vulnerability due to their lack of experience, be persuaded towards unsafe practice? Yet what was safe, and what was unsafe? How did I know that my beliefs about ‘being safe’ were safe? I had watched other practitioners ‘wait and see’, and had witnessed that the quiet newborn could establish its own ‘awakening’. Was I the product of the medical model of midwifery education? Was it time for me to be more open to other ways of ‘being safe’? Surely all practitioners want to be safe? Could a certain practice, and its opposite practice, both be safe, or is only one safe, and if so, which one? Who determines the one that is safe? Can it be determined in advance, or is safety only ever seen in context and retrospect? Do women and practitioners have the same experiences, understandings and beliefs about what is safe? Do they talk to each other about safety, or do they assume safety is so fundamental that it does not need to be spoken of? How was I, as a teacher, to pass on to students this meaning of ‘being safe’ when I myself seemed to be becoming less and less confident about its meaning and the nature of the experience?

The questions, and the philosophical approach

What then is the meaning of ‘being safe’? I offer these questions to open up the way to uncovering meaning: Is there a shared meaning of ‘being safe’? Do all who seek care from

the maternity services, and all who provide care, understand what it means 'to be safe' in the same way? Do midwives and doctors work from the same meaning? Do hospital midwives and domiciliary midwives have the same meaning? Do women who choose homebirth have a different meaning from those who seek hospital birth? Do women who have had an unsafe outcome with a previous birth see what it means to 'be safe' more clearly than other women? Can safety be almost guaranteed in this age of technological expertise? What prompts women and their families to say they do not feel their care is/was safe? How do practitioners know when practice is unsafe? What are the ways of measuring and monitoring 'being safe'?

Questions of meaning are asked again and again throughout this study. On one level, everyone 'knows' what it means to be safe. One 'knows' that others will understand when they talk about 'being safe', therefore there is no need to say, "this is what I mean by 'being safe' ". Its meaning is taken-for-granted as being understood, just as I take-for-granted that you, the reader, will understand 'my meaning' behind all the words on this page. We could not get on in our shared worlds without a common understanding of the meaning of our shared language. It is in that unspoken sharing that the complexity of meaning rests. It is in the hiddenness of what is not said that the deeper meanings show themselves. It is not the words themselves that do the good, or cause the harm, but the actions, or non-actions, that are brought about by that person's meaning of 'being safe'. The challenge of this study is to describe the phenomenon of 'being safe'. With the nature of a phenomenon in mind, 'being safe' will be sought in what is seen, in what is partly seen, and in what is covered up. Words, with all their limitations, will be used as the vehicles of seeing and telling.

It is important to note that the primary question of this study is a question of 'meaning'. It does not specifically ask 'why is there a need to be safe?', or 'who holds the power?', or 'what is the influence of gender?', or seek to identify the competing discourses, yet it acknowledges that all those questions inform meaning. The primary quest is to uncover the meaning from the common experiences of those involved. I cannot take you by the hand and 'show' you 'being safe' or let you touch it. It is a phenomenon. We are likely to agree that there is such an understanding as 'being safe', and that practitioners want to 'be safe' in their practice, and women want their experience to 'be safe'. The task then is to find the words that give voice to contemporary experiences. By reflection on these experiences, and

interpretation, we come to new possibilities for insight and understanding. This approach is named interpretive phenomenology, and is guided by the philosophy of Heidegger.

This is also a study that examines text to uncover the possible meanings of 'being safe'. The texts have arisen from the written words that have emerged through transcription of conversations about the meaning of 'being safe' with participants, from published scholarly discourse, from historical documents, from the media, and from literature. This broader philosophical approach is named hermeneutics, and is guided by the philosophy of Gadamer. A key tenet of hermeneutics is that before we approach a text we must first be aware of the understandings that we bring with us. Such a process will enable us to be more open to understandings that are different from our own. It is therefore necessary for me, in this beginning chapter, to make explicit my own understandings of 'being safe' in childbirth.

The context I bring to 'questioning'

When I ask the meaning of 'being safe', I am asking questions informed by my own life experiences. I have lived my life through a variety of times and places. I have been influenced in many different ways, all of which inform the manner of my questioning. Let me introduce myself: I was born in New Zealand, the situational context of this study, in 1953, the younger child of two. I grew up playing with dolls, the nearest I got to anything to do with birth or babies. I struggled with the big question of "what will you do when you leave school?" until one day I heard a friend of a friend say she was going nursing. It was a sudden and unexpected decision for me to follow her example, for I had a reputation of fainting at the mere thought of an injection, or the first sight of blood. Somehow, I must have perceived nursing as more than that. Eight years later, as was the custom in those days, I moved on to 'the next step', and achieved midwifery registration. I became a student midwife in awe of both the mystery of birth and the practitioners who seemed to hold enormous powers in directing, controlling, and performing heroic acts.

I saw women give their bodies over to a hospital system that 'knew best' and 'took charge'. I accepted that that was how it was, and busied myself with learning to do likewise. My career as a midwife took me to a busy, base hospital delivery suite serving a lower socio-economic, multi-cultural population. The women who came to the delivery suite brought their own knowing of birth, learnt from generations of women before them. Many of the

midwives who worked there also brought their own personal knowing of birth, rejecting the recent experiences they had suffered, and looking for more woman-centred modes of practice. The doctors I worked with were too busy to concern themselves with what midwives were doing when labour and birth were without complication, but were always willing to offer their support and expertise when there was a problem. There were problems. There were labours that seemed to get stuck, fetal heart rates that made one's own heart sink in fear, and women who just could not push their babies out and, in pain and desperation, begged for help. There were babies who were born with only a flicker of life, or sometimes none at all. There were women who bled, and bled, and bled. The grapevine stories of the 'woman who died in childbirth' were close enough to create an awareness that even in this well equipped, well staffed hospital, women could still die in childbirth.

At the same time, birth just happened. I remember the busy-beyond-belief afternoon duty, when for the first time, I had been left in charge of the whole of the maternity unit with no supervisor to call on. Late in the evening, it seemed there was a minute to draw breath. I walked down the delivery suite to find a family quietly sitting in the dark in one of the small rooms not often used. It was with horror that I remembered them being put there hours earlier in that busy duty. They had been left, unattended and forgotten. Soon after, the woman calmly and beautifully gave birth to her healthy baby. She and her baby, surrounded by her family, had been safe, and were safe. I began to think about this; in relieved hindsight I could see they had not needed 'professional care' to make them safe.

Not long after this experience I relieved the sister-in-charge at a small hospital on Epi Island in Vanuatu for three months. I was called late one evening to a birth. The baby was fine, but I had never seen such thick meconium liquor. Neither had I ever had such inadequate suction to ensure the baby did not inhale any liquor, so risking respiratory distress. Where I came from, this baby would have been transferred to the Neonatal Unit for observation over-night. It suddenly dawned upon me that there was not only no neonatal unit in the hospital, but there were no night staff. All the nurses, and the mother, were going back to their beds. It seemed unsafe to leave this newborn baby unattended. The solution was to carry the baby back to my bedroom, where we could sleep beside one another, in the hope that I would awake to altered breathing sounds. My understanding of 'being safe' had become context specific.

On my return to New Zealand, I became a charge-midwife of the same delivery suite where I had worked earlier. I now needed to re-adjust my understanding of 'being safe' to another set of circumstances. Now I was responsible for ensuring that the practice of others was safe. When a doctor who was new to the unit made a decision I was not happy with, was it safe? When a midwife decided there was too much medical interference going on, and did not ring the doctor to attend the woman, was it safe? When a woman urgently needed a caesarian section, but the doctors were already in theatre doing another urgent operation and there was a half hour delay, was it safe? When a midwife decided a family needed time alone, and went and sat in the tea room while the woman laboured, was it safe? When it was so busy and so short staffed that all there was time for was what 'demanded to be attended to', was it safe? What influence did I have on the safety of the unit while I was in charge? I could ensure the unit was stocked and ready for emergencies (if there was time). I could remind staff of the expected standards of practice. I could offer support and guidance. I could address issues of unsafe practice. There were many times, however, when safety was beyond my control. I could react and respond, but I could not always make it safe.

I moved from hands-on practice to full time university study where I engaged in the reflective thinking of practice. Two years later, I moved into my present role of being a teacher to those who wish to be midwives. In my teaching role I have written many assessment criteria about 'safe practice'. I have stood and declared to the students that 'this is safe practice' and 'this is not safe practice'. I have failed examination questions for what I considered unsafe answers. I have deliberated with my colleagues, as gatekeepers, over whether a student was safe enough to be allowed to sit her examination for registration. I have lived with the notion of 'being safe' as one who supposedly knows the truth about such things. I now ask 'but what is truth?' The students I teach are quick to mimic my response to the questions they ask. They say the beginning of every answer is 'it depends'. My own uncertainty about the meaning of 'being safe' opens up many possibilities of what could be safe, and equally so, heightens the awareness of what may not be safe.

I believe that birth can be perfectly safe, but may not be safe. I have never been pregnant, or given birth myself, so I can only know what I know from my role as midwife. I remember some years ago inviting an esteemed colleague to talk to the midwifery students. She told them it was time we took the fear out of birth. Yes, I thought, it is time that we learnt to trust the normality of birth. As the years have gone by, and I have listened to the

stories of births that have gone wrong, I find myself wondering if we took too much of the fear away. Fear prompts alertness, carefulness, caution. Trust without fear lets whatever is, or isn't happening, happen. That sometimes seems not to be in the best interests of the woman or her baby. I believe there needs to be practices of both trusting and fearing. I recognise the challenge of finding when and how these various practices are used in particular situations.

I have lived out my journey of midwifery through the changing tides of politics. When I was first a midwife, there was always a doctor 'responsible' for each woman's care. I knew the nonsense of this law for it was always the midwife who was 'there' and who dealt with the complications sprung upon them. I knew the contradictions of the new house surgeon having authority in decisions over the experienced midwife. I knew also the wonderful relief of passing over to the experienced obstetrician the problems that were beyond my scope of practice, and valued the trust they invested in the opinions of the midwives they worked with. In 1990, the law changed in New Zealand to allow midwives to practice independently from doctors. By then, I was on the sidelines observing maternity practice in the new political arena through my visits to clinical areas with students, and through my involvement with the College of Midwives. I saw tensions and conflicts emerge between doctors and midwives and between independent midwives and hospital midwives, and wondered how the women felt when at times they seemed to be caught in the crossfire. I celebrate the right of the midwife to practice in her own right, but I am concerned by the inter-professional wrangles that live on. I see the issues of safety being used as a political weapon to stir up fear and mistrust where it has no place. I have had experience of, and know there currently exist, communities of maternity care where individuals respect the right to independence of each person, but, at the same time, value opportunities to offer collegial support and guidance.

I have chosen deliberately to include the voices of women, midwives and doctors in this study, not as oppositional, contrasting voices, but as people who, I believe, share common concerns. I am a midwife, and I know those biases will shine through, but at the same time I have entered this study with the assumption that the meaning of 'being safe' is as important morally and ethically to doctors as it is to midwives. I do not claim that midwives know better. I am not judging doctors against midwives. I simply recognise that they are together in the business of 'being safe' within the maternity services. I invite the

reader to also identify their own background, their own prejudices, and in doing so to be open to seeing others in a new way.

DESCRIBING THE CONTEXT OF THE STUDY

I make the assumption that 'being safe' is complexly entwined with the society of its time and place. The practices surrounding childbirth have been described by Crouch and Manderson (1993) as a social metaphor. While their sociological analysis focuses on the Australian maternity services, I believe it closely represents what has happened, and is happening, in New Zealand. They point to the paradox of childbirth, that it lies between a distinction of illness and health. They remind us that birth is described as a normal life event, yet they ask, what other perfectly normal event puts the lives of a woman and her infant at risk? They describe the era of modernity in childbirth, from the late 1940s post-war 'baby boom' times, as one where childbirth made the transition from a natural process to an illness-state. It became "a 'medical problem', achieved through the imposed supremacy of scientific knowledge and through unnecessary, but coercively legitimated interventions" (p.60). They talk of the discontent that arose in the late 1960s through alternative movements which rejected science and technology and sought to return to "folksy, earthy and quasi-mystical practices" (p.61). They tell of a return to the notion of 'natural' childbirth, which encompasses the belief that the woman herself is an active participant in all that happens, and in all plans. They point to the discarding of a unified system of beliefs and values, with women now claiming their right to their own experience of birth as a significant rite of passage. The focus has shifted from the outcome to the process. Women now have upon them the expectation that they will be able to proudly declare they had a 'good birth'. This post-modern era is super-imposed upon the beliefs and values from the era of modernity, where birth was viewed as a 'medical problem'. Crouch and Manderson talk of the resulting tensions, clashes of belief systems, disagreements, anxieties, and disappointments. There is no longer a standardised routine management of childbirth. Women and practitioners are faced with many options, many choices, many possibilities.

Influences on changing expectations

Bunkle (1994) notes that the contemporary women's health movement in New Zealand, which includes childbirth, has its influences in: the call by women to have their interests included in scientific practice (feminist empiricism); the argument for notions of gendered

knowledge (feminist standpoint epistemology); and in the New Age alternative health movement. As an example of the new feminist critique she tells of the rise in awareness that problems in birth may not necessarily be solved by technology, but rather may arise from technological interference, thereby bringing the safety of technology in to question and to doubt. She talks of the rise in value of “woman’s interior knowingness” (p.228), thereby undermining the belief that safety rests with the knowledge of the practitioner. She describes the New Age practices which value “relatedness, connection and dynamic process” (p.231), which favour minimal intervention, and which promote individualistic ‘choice’ and personal growth.

At the same time, Bunkle uncovers how these beliefs and practices may influence the health care experience. She sees a tendency to romanticise the past, to falsely universalise the experience of one woman, and to adopt an extreme idealism. For example, natural birth is celebrated as the only ‘good birth’ forgetting that if some women and babies did not have access to caesarean birth they would die. She sees the New Age perspective as carrying with it the belief that perfection can be achieved, and illness avoided, at the choice of the individual. The implication that follows is that if things do not go as hoped, it is the fault of the woman who did not exercise the choice that would have led to the perfect outcome. In other words, if a woman chooses a homebirth, but ends up in hospital with an epidural and a forceps delivery, then it is her own fault for not believing in her capability to birth at home.

Bunkle, having described the feminist suspicion of institutional care, alerts us as to how the state, in New Zealand, has fostered such suspicion in its economic drive for deinstitutionalisation. She points to the paradox of language such as “individual freedom of choice, responsibility and autonomy” (p.234) advocated by feminist consumer groups, which is, at the same time, utilised in the market model of the New Right. The feminist suspicions of institutional care have been reinterpreted as the ‘right’ (ie. requirement) for consumers to take responsibility for their own care in their own home. Coney (1997) points us to the changes to the New Zealand state funding of postnatal care that have led to the situation where women now feel pressured into leaving the postnatal ward within 48 hours of birth. The overcrowding of postnatal wards, driven by economics, further provokes the woman to rush home. While women have sought to reclaim the home as a place of safe, nurturing care, it has now been thrust upon them. It seems that it is of no concern to those

who control policy and resources, that a woman and her new baby may be discharged to a place of no care, of no support, of no nurturing.

Individualising birth

The maternity services arose from the tacit and explicit support given by people and policies, the professions, the technological advances, the resources invested in them, and the expectations society placed upon the services. Where once every maternity hospital seemed to be a replica of every other, and every woman told the same story of 'going in, being prepped for labour (shave, enema, shower), labouring alone, birthing in lithotomy position, staying in the postnatal ward for ten days, and then going home', now each woman is encouraged to plan her own experience, and to make her own choices from a smorgasbord of options.

An Australian publication, revised for the New Zealand market, entitled *Childbirth Choices* (Bennett, Etherington & Hewson, 1993), describes its aim as giving women the same right to participate in their birth experience as they would of having their wishes incorporated if they employed an architect to design their home. It is the signal of a transition from professional control to consumer control. Cole (1996), writing to advise New Zealand women on their current choices of maternity care, recalls the days when "about the only choice you got to make was how soon to visit your family doctor after you thought you were pregnant" (p.18). Now, a woman must first choose what type of person she will have for her Lead Maternity Carer (LMC). She may simply award the maternity hospital the right to provide, and claim funding for, her care, or she may consider the many other choices. She may have a midwife, or a midwifery service, a general practitioner, an obstetrician or shared care (but only if her LMC is prepared to work co-operatively with another practitioner, and share the funding). Cole suggests that in making this decision, she needs to find out about their qualifications and experience, their basic beliefs about birth (eg. regarding pain relief), how many visits they include, how they will attend in labour, what back-up arrangements they make when they are off-duty, how big a caseload they carry, what is their intervention rate, who would they refer to if there were complications, what emergency equipment they carry if a homebirth is planned, and how they have their practice reviewed. The woman is expected to be an active participant in care from the very outset of choosing the practitioner that she considers will offer her safe and acceptable care.

The woman is expected to have identified her own beliefs and values about birth. The woman is warned that different practitioners practice in different ways.

There is no longer a standardised procedure to follow. There are instead seemingly limitless possibilities of care. The information booklet made available to women in July 1996 by the Regional Health Authorities entitled *Expecting a special delivery* offers women a checklist from which they can prepare their care plan. Under twelve headings there are at least seventy three aspects of care the woman is expected to plan for. They allow her to make decisions about pregnancy and birthing aspects that were once very much under the control of the practitioner, for example, routine laboratory tests, vaginal examinations, episiotomy. These choices are offered in an era where modernity and post-modernity co-exist, where some practitioners are likely to consider their own practice as unsafe if the woman refuses them the right to perform assessments and practices that they believe are essential to safe care. An example of the reluctance of practitioners to hand over choice is seen in an English audit of maternity care which revealed that half the women felt they had not participated in the decision that resulted in their episiotomy (Robinson, 1997). Practitioners might well argue that while a woman has the right to express her preference to avoid an episiotomy, neither they nor the woman can know for sure that that is a safe decision until the moment arises. Involving the woman in the decision at the time may mean the opportunity to do an episiotomy is lost as the perineum takes matters into its own hands by tearing. Decision making as embodied practice is now being taken into a new mode of pre-agreed decisions between woman and practitioner. While it is possible to consider 'what if situations' there is the possibility that pre-decided plans will not be the best plan for what actually happens, but may be the plan that is acted out.

At the same time, it is an era where many women may be reluctant to take on the responsibility of deciding, being caught in the cross fire of contradictory discourses. Legat (1997) states: "The midwives have sets of figures, statistics and studies to prove that their model has best outcomes for women and babies; above all, they argue, it is *safe*. Doctors can produce the paper work to prove just the opposite" (p.77). Choice does not, therefore, necessarily signify safety. It may rather signal tension, confusion, anxiety and disagreement. It may persuade women and/or practitioners into inappropriate choices. It has taken away the grand narrative that decrees what is safe care. It has placed the meaning of safe into the arena of politics and vested interests. It has resulted in the formation of such

action groups as Parents for Safe Birth, which arose from members' own experiences of unsafe births prompting them "to lobby to protect other families from being unwittingly exposed to dangerous birth practices" (Access, 1996). As women and their families take on the challenge of being responsible for their own decision making through the childbirth experience, they no longer invest midwives and doctors with unquestioned trust.

Smith (1996), an American Professor of Political Science, makes this comment:

For a variety of reasons, the ideas that have sustained men and women in the modern age seem to have become less compelling in our post-age. Modern ideas seem to be on a more or less gentle, slippery slide to a loss of persuasiveness, but the novel ideas seem reluctant to announce themselves. In the interim, things are not quite right -who does not sense it? Wherever we turn there is a cacophony of voices. Everything seems strangely adrift yet strangely unchanging ... Intensification, fragmentation, cacophony of voices, and the monotony of constant, circling, changeless change. Who does not see it? (p.5-6).

Who does not see the novelty and paradox that show up here in the maternity services? Ironically, standards for care, are immersed in novelty for its own sake, and in ideas that seem to multiply beyond our ability to count them. As the 'trusted' ideas of the modern era slide away, the cacophony of voices offer new novelties. It is perhaps the listening consumer who first senses that things are strangely adrift, that things are not quite right, but in the whirl of constant, circling, changeless change who dares to announce that all is far from 'being safe'.

What of the midwives and doctors?

While consumers of the maternity services are voicing their right to choice and participation amidst the cacophony of voices, how are the professions responding? In 1990 New Zealand Midwives won the legal status to provide care in their own right. Previously all women had to be under the supervision of a medical practitioner. At the newly formed College of Midwives Conference in August, 1990, anticipating the forthcoming right to independence, the President, Karen Guilliland, told the midwifery profession that "their status will always principally be dependent on providing a service that women want and with which they feel safe" (p.3). She went on to acknowledge, in accordance with the earlier analysis of Bunkle, that "consumerism and feminism are the cornerstones to midwifery philosophy" (p.4). Midwifery did not simply decide it was time for a change.

The forces of change were within society itself. Midwifery both shapes and is shaped by these forces.

Guilliland's address at this 1990 Conference was followed by the Rt. Hon. Helen Clark, then Deputy Prime Minister and Minister of Health, who had introduced the Nurses Amendment Bill to Parliament, which was very shortly to be passed. She talked of the submissions to the Bill, many supporting the importance of women having birthing choices, and the recognition of birth as a natural process. There were other submissions, however, that expressed concerns about "the adequacy of midwifery training and accountability" (p.3). She stated her own view that "the safety of the woman and baby are of paramount interest" and added "I know that that view is strongly shared by the College of Midwives. Nothing in the proposed changes is detrimental to mother and child. Indeed the converse may well be argued" (p.4). She went on to encourage midwives to recognise the important role they had in educating the public about "the increasing choices women have in childbirth and how midwives can make a difference" (p.8).

Six years later, Helen Clark again addressed the College of Midwives Conference:

Midwifery has faced huge challenges in New Zealand as in other Western countries. Had the dominant forces in the medical profession had their way in this country, midwives would have been permanently subjugated. Their places would have been as doctors' handmaidens, forever working under medical supervision - and never, never having the self-confidence and high self-esteem which comes from being independent practitioners. Fortunately that was not to be. Irrepressible spirits kept the cause of independence and autonomy alive. Joan Donley and her sisters dared to think the unthinkable and the unthinkable became the possible, then the desirable, then the inevitable. When legislation for autonomy went through Parliament it was passed unanimously. It was a change whose time had come. It was a change desired not only by midwives, but also by women. It opened up the possibility of continuity of care by midwives - through pregnancy, labour, birth and the postnatal period. ... Pregnancy and childbirth could be experienced for what it is meant to be - a normal, healthy experience for healthy women (1996, p.8).

Helen Clark facilitated the safe passage which enabled the midwifery profession to once again become practitioners in their own right. She did so to facilitate what some women saw as their safe option to natural birth. She herself considered it possible that midwifery care could be safer than medical care. She describes the strength of the belief of the medical profession that midwives would never be competent enough to provide safe care in

their own right. She captures the huge transition of beliefs that society has travelled through, from independent practice being unthinkable to finally being inevitable. Is it that midwives were once not safe enough to be given such responsibility, and now they are, or have they always been safe to practice on their own responsibility, but are now perceived to have the right to legal status which confirms this?

What have been the influences on changing perceptions? Is it again feminism, consumerism, and the New Age alternatives that have brought about the change in the recognised safety of midwives? Midwives as women, and many as consumers themselves, were caught up in the same changing insights and values as their consumer partners. There has been a reaction to 'technologicalisation' of reproduction and childbirth which Sutton (1996) suggests has covertly changed the role of the midwife and the control of childbirth "from being woman centred to being technology centred" (p.35). The medical profession, on the other hand, is still embedded in male dominance, comes from an established mode of practice where advice is expected to be accepted, and bases practice on scientific truths. Kelleher, Gabe & Williams (1994) talk, however, of the challenges the medical profession face. Their autonomy has been taken over by commercial business management. They find themselves working with colleagues (nurses and midwives) who have made a transition from doctor's handmaiden, to making their first commitment to 'patient centred care'. They face competition from complementary medicine. They find themselves increasingly being sued for medical negligence. Their attitudes and behaviours are frequently exposed to the public by the media. Self-help groups of consumers are much more active in their challenges to care, and new groups of feminist health workers (eg. midwives) have developed alternative analyses challenging the hegemony of the medical model. The challenge is described as being "not only ethical but epistemological" (Kelleher et al., 1994, p.xix). It is a challenge to the very foundations of all that has represented the medical profession for so long. The pendulum of 'perceived total control' is swinging. Consumers now, for example, expect total control over their own fertility through fertility clinics, even to the extent of demanding the control of the sex of the baby (Sawicki, 1991).

Within these changing times is a story where there was once a body (mainly men) who held the knowledge, power and resources of health care. All other people, be they health professionals or patients, were subservient to them. Those 'other people', however, have been through a re-awakening, and have decided that indeed they have knowledge, power

and resources of their own. They have boldly claimed them, thus creating new dangers as well as possibilities. They have moved on to new understandings, new modes of practice, new, more economical forms of resources. They delight in their freedom, yet at times they still need the skills and resources of the medical profession. Meanwhile, the medical profession has been struggling to adjust to their once powerful voice that is now ignored. They are struggling to adjust to being instructed on how to manage care by bureaucrats, struggling to adjust to the fact that other practitioners are achieving equal outcomes at a much cheaper cost, struggling to adjust to being questioned by the media, and struggling to adjust to having to stand by and watch as a client takes their fee to another health worker. What is worse, at the end of the day when the patient has developed serious complications, the doctor is then called upon to sort it out. Sharpe (1997) tells of a woman who had had a previous caesarian section, and had planned a homebirth. She was transferred to hospital care, where a decision was made to do an urgent caesarian section. He says, "I feel that secondary care practitioners are very vulnerable when having to deal with such cases" (p.154). Is the vulnerability of the medical experts just about the lack of input they are able to have in preceding care, or is it also about the fact that this woman, probably against medical advice (if she sought it in the first place), was able to reject both medical care, and an institutional setting for birth?

Birth is not an unproblematic experience for all women. The obstetricians still have a vital role to play. A document from the Joint Regional Health Authority Maternity Project (1997) has been released after three years of negotiation with midwives, general practitioners, obstetricians and paediatricians. It lays down clear guidelines as to when the Lead Maternity Carer 'may' recommend that a consultation with a specialist is warranted, when they 'must' recommend such a consultation, and when they must recommend that her care 'be transferred'. The consensus decisions of these descriptions of safe care have not been arrived at easily, nor is it yet certain they have been accepted by those involved in negotiations. They are now published with the promise that they will be reviewed after one year. These referral guidelines perhaps ensure that vested interests do not cloud the fundamental physiological pathology that may accompany the childbirth experience. They give back to the obstetrician the security that there are times when their input is imperative. It is to the credit of the medical profession that they have been party to negotiations which have reached an agreement that there are also times when their input is not required at all.

The winds of change bring more than a ruffling of the leaves on the trees. They have prompted and persuaded the realignment of structures of care.

Translating the times into a philosophical approach

In a new era, with new responsibilities and new expectations, New Zealand midwives have claimed a new model of care. The notions of partnership, continuity of care, and protecting the normal process of childbirth were adopted by the New Zealand College of Midwives, and became central tenets in their Code of Ethics within the Midwives Handbook of Practice (1993). Guilliland and Pairman, then the National Co-ordinator, and the President of the College of Midwives respectively, presented their articulation of the model for midwifery practice at the 1994 National College of Midwives Conference. It was later widely disseminated by publication in the College of Midwives Journal, which is received by all College members, and published as a Monograph by Victoria University in 1995. They described such a partnership between the woman and the midwife as both an ethical stance and a standard for care (Guilliland & Pairman, 1994, p.5). Underpinning their model were philosophies of birth being a normal life event, midwifery being woman-centred, and the need for individual negotiation, equality, shared responsibility and empowerment. The model assumed that continuity of caregiver was fundamental for such a partnership to develop. This model was a declaration to midwives and to women that the midwife did not necessarily know best. It signalled the requirement to offer choice to women, and, in doing so, to share with them the responsibility of deciding which choice would be safe. It gave the woman the power to decide on the management of a situation, even if the midwife did not think that was the safest option. It placed safety into the arena of possibilities.

In 1995, Page, an English Professor of Midwifery Practice, visited New Zealand. In an article reflecting on her impressions she states "The value of respect for the individual permeates everything, becoming an explicit searching for a work of partnership between women and midwives" (1996a, p.89). Partnership permeates the New Zealand College of Midwives Handbook of Practice. Partnership is a dominant philosophical base in Midwifery Curricula, for example the Auckland Institute of Technology, Bachelor of Health Science (Midwifery) programme. Partnership is incorporated in the structure of the College of Midwives, where consumers have equal voting rights on the National Committee. Partnership, with consumers having shared governance of midwifery matters, is a resolution that New Zealand Midwives took to the International Congress of Midwives

in 1993 and again in 1996. The notion of midwives sharing power with consumers is gaining support, but has not yet been fully accepted by the global community of midwifery (Guilliland & Pairman, 1996).

For all that partnership has become the catch-cry of the times, there are those who suggest it is not so simple. Fleming (1995) in her research on the nature of the midwife-woman partnership found that the wider system of socio-political domination disempowered the relationship. Midwives were seen to comply with practices deemed necessary by the medical profession, to protect themselves from the wrath of the power holders. That is, they were not always empowering the woman to choose freely from the options available. On the other hand, a midwife in Fleming's study told of her uncomfortable experiences of working with a woman when "everything was on **her** terms" (p.148). She told the story about a woman who was three weeks overdue and, despite consultant advice, insisted on having a homebirth where she was attended by midwives who were there despite their advice. The midwife reflected:

I actually had to go and see her afterwards to get rid of that awful feeling that we had acted counter to what our philosophy is. I also couldn't see any other way around it because I truly believed that it wasn't safe for her and I documented page after page with all the things that were explained and still she kept to her plan and I said "I have to say that I admired you." Because I did. In the event the baby was not that overdue.

(Fiona, in Fleming, 1995, p.149)

The reality of the tension of partnership is uncovered in this reflection. Midwives do have their bottom lines, when they truly believe a decision made by the woman is unsafe. The woman, in this era of being encouraged to trust her inner knowing, despite explanations, despite consultant advice, clung to her own decision. Is this still partnership, or has it disintegrated to custodial care by reluctant custodians? Lauchland (1996), reflecting on the impact the partnership model has had on New Zealand midwifery, arrives at the conclusion that "more questions surround partnership in clinical practice than have been answered" (p.26). Partnership, at bottom line, is a shift in who has the ultimate power over the decisions of care from the midwife to the woman. The tension of this shift becomes apparent when conflict over power involves bottom line safety.

The partnership model of midwifery brings its own language, which is apparent within this study. The choice of words rests on the assumption that the partnership is between the

'woman' and the 'midwife'. The word 'woman' encompasses her baby, confirming the approach that the baby belongs to the woman, not to the midwife. The word woman also implies an inclusion of whoever she would name as 'family'. Some would argue that such language makes the father of the baby invisible. Midwives working from this model are quick to assure them that they are not invisible once the woman brings them to share the relationship with the midwife. It is empowering the woman in her own choices, in a world where family relationships may be complex. Some would say it is disempowering the rights of both the baby and the father. I suggest the language is the swing of the pendulum from the era where the rights of the woman were often undermined by the practitioner's assumption of their own rights to decide who mattered most. I choose to follow the language of the partnership model in this thesis, for it is currently the dominant discourse within midwifery in New Zealand.

What of the places of birth?

In 1989 at the Congress of British Obstetricians and Gynaecologists, Professor Liggins, from New Zealand, predicted that within the next decade most births would take place in a more 'homely' environment with care provided by mainly non-medical staff (Wane, 1989). He challenged the assumption that all women should, and would, choose to give birth in hospitals designed specifically to deal with every high risk situation, in a forum renowned for opposition to homebirth. Here was the realisation that the changes to the maternity services would be consumer driven, whether the obstetricians approved or not. It signalled an era of choice in all things, including the place of birth.

In 1997 a paper was published in the New Zealand Medical Journal entitled *Homebirth in New Zealand 1973-93: incidence and mortality*, authored by three pro-homebirth medical practitioners and a consumer (Gulbransen, Hilton, Mackay & Cox). It is an analysis of 9776 New Zealand homebirths over a span of 21 years. The perinatal mortality rate of 2.97 was not significantly different from a comparison group of low risk women from National Women's Hospital (a large, high-tech, teaching hospital), and was lower than the New Zealand rates of that period. It was recognised that some women who would be considered high risk still choose to deliver at home because they "often feel safer at home with continuity of care provided by known and trusted care giver(s), better social support and confidentiality in their own homes" (p.89). In other words, these women have a much broader understanding of what 'being safe' means to them. It is more than just their

physical well-being. The conclusion of this study was that “homebirth was a safe and increasingly popular, though minor, option for New Zealand women” (p.87).

At the other end of the continuum from homebirth, New Zealand offers in its main centres level three obstetric units with the expertise, technology and resources to provide the full range of current obstetric and neonatal practice. The units have registrars on site 24 hours a day and consultants on call. They have laboratory services available around the clock. Any woman within a defined geographical range can choose these units as their place of birth. Women outside the area would require referral.

Spanning the continuum are a range of services. Women in rural areas may have access to a birthing unit such as the one at Wellsford. It is described as being more like a motel than a medical building. Women must bring their own support people in with them to look after them. The midwife or doctor will attend only to responsibilities within their professional roles, and will leave the woman and her new baby alone in the unit under the care of her support people. The average length of stay is about one day after the birth (Coast to Coast Courier, 1997). If a complication should arise the woman will be transferred to the nearest appropriate Obstetric Unit, in this case over an hour’s drive away.

Within a city there are usually other options of care for women. For example, in Auckland there are small units such as Botany Downs and Papakura Maternity Units which are staffed by midwives. Women may choose to receive all care from these midwives, or book under an independent midwife or doctor who will attend her in labour at this hospital, and visit postnatally. These units are designed for low risk women and carry only the technology needed for emergency situations. There is, for example, no epidural service and no on-call obstetrician or paediatrician. The woman/baby must be transferred to another hospital to receive these services. The minimal possibilities of intervention in these small level one units ensure that the normal processes of birth are protected as a part of everyday practice. Any woman in the area may choose to birth in such a unit, but may be advised not to if she is recognised as being at risk of complications. The question arises ‘what is a risk?’ Some would suggest that being a primigravida is a risk. Others would argue that the best chance a primigravida has for a good birth is to be removed from possibilities of interference.

A second level of hospital exists (eg. North Shore), where there are on-call obstetricians and paediatricians. They may not actually be on site, but they will come in response to a phone call. There are facilities to perform caesarian section but there is no neonatal unit. In other words, most complications can be dealt with here, although there may still be a need for transfer to the level three unit, and there may be a time delay in the arrival of the expert practitioner. These hospitals serve all women in the locality, and take referrals from the outlying rural areas.

It seems that for the identified high risk woman, there is only one choice of care, the level three obstetric unit. For the low risk woman, while there are many possibilities of care, her choice is likely to be directed by whatever service is accessible. Not all women will have geographic access to a level one birthing unit. Not all women will appreciate that there are limitations to the level two unit that they assume is equipped to do anything. It seems that where a woman lives is a strong determinant of choice. Not all women have easy access to epidural services. Not all woman have access to hospital-provided postnatal care. Does this make their birth experience less safe? It is to be remembered that some women purposefully choose to avoid hospital care in their quest for safety.

The correlation between a safe place of birth and the level of technology and expertise available is again a complex one. Hielmann (1995) states “When it comes to the issue of safety, there is so far no scientific documentation concluding that high-tech birth is safer for most women, rather to the contrary” (p.260). Olsen (1997) states that a meta analysis of best observational studies related to the safety of homebirth

revealed no significant difference in perinatal mortality between home and hospital birth. Thus no empirical evidence supports the claim that hospital births are a safer option than planned homebirth backed up by a modern hospital system for selected pregnant women. The analyses also revealed significantly and consistently increased morbidity and intervention rates in the hospital group. Furthermore, perinatal deaths occurred in both planned home and planned hospital births. Thus it cannot be claimed that hospital birth is safe for all babies, nor can it be claimed that planned homebirth is safe for all babies (p.9-10).

Macfarlane (1997) critiques Oslen’s analysis on the grounds that it does not consider the complex differences there may be in what constitutes a homebirth, and what constitutes a hospital birth. As in New Zealand, there may be a huge difference in accessibility from home to emergency care between city and rural areas, and a huge difference in resources

and expertise between a rural birthing centre (nevertheless designated as a hospital) and a high-tech city teaching hospital. Differences bring their own uniqueness, which may or may not promote safe care.

The global trends of the western world

The debate about what makes childbirth safe rages throughout the western world. Wagner (1988) in his testimony before the United States Commission to Prevent Infant Mortality said:

Every single country in the European Region with perinatal and infant mortality rates lower than the United States uses midwives as the principal and only birth attendant for at least 70% of all births...This fact alone should dispel any notions that obstetricians are safer than midwives as birth attendants at uncomplicated births... There is also evidence that a strong independent midwifery profession is an important counterbalance to the obstetrical profession in preventing excessive intervention in the normal birth process (p.7).

Oakley and Houd (1990) in reviewing the maternity services of Europe, agree that there needs to be a return to mother-midwife relationships, with the mother being the central person in the process of care; that there should be continuity of care that is community based, fully utilising the skills of midwives; that women should have choice in childbirth; and that care should cause no harm. They do, however, caution midwives to be wary in their drive to uphold the profession of midwifery, for they see professionhood almost as a contradiction in terms. They see it leading to obedience of medical rules, and control of clients. They say that “the idea of the midwife as ‘being with woman’ has nothing whatsoever to do with the modern notion of a profession” (p.166). They encourage the expression of a new model of care. It seems that New Zealand is heeding these calls, although Cole (1994) would suggest that some New Zealand midwives are mimicking the model of practice of their medical colleagues.

In Britain, an Expert Maternity Group was called upon in 1993 to review policy on maternity care. It followed vigorous debate over the notions that “every mother should be encouraged to have her baby in a maternity unit where emergency facilities are available” [1984 Maternity Services Advisory Committee] and “the conclusion that the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety” [1992 Health Select Committee] (Report for the Expert Maternity Group, 1993, p.1). The focus of this expert maternity group was the belief that maternity care must be woman

centred. They identified key components as: services recognising the unique characteristics of the population they serve; women being involved in choice of practitioner and in the planning of care; women having access to a named local midwife; obstetricians being the lead professional when the pregnancy is more complicated; community based antenatal care; women being given information, with opportunities for discussion to enable them to make their own decisions; known care givers; supportive hospital environments; appropriate postnatal support. Page (1996b) who was a member of this expert group makes this comment in an address to midwives:

We cannot blame any particular group for the current state of the maternity services. In many ways the systems simply reflect the norms of the times. Assembly line systems, where the woman passes through the hands of a number of carers (frequently as many as 40), may seem efficient. An emphasis on the acute care hospital as the place for caring for women in pregnancy and birth reflects a commonly-held faith in the hospital as a place of safety and healing. Yet the hospital holds its own dangers and may actually do harm (p.248-9).

It is one thing for a group of experts to lay claim to the vision of the future. It is another to shake and change the traditions of practice, especially when the hospital is enshrouded with the myth of absolute safety. Nevertheless, Jackson & Cowl (1997) four years on from this report say the achievements gained from professionals working together to achieve the philosophy of woman centred care have exceeded their expectations.

Tensions and conflicts

It was naive to suppose that a global trend to re-instating the midwife as the appropriate care-giver in low risk birth would simply be allowed to happen. The return of the midwife to prominence has resulted in the obstetricians' loss of territory, loss of power, loss of income, and loss of opportunities for learning about normal birth. For some, this has been a loss worth battling for. Wagner (1995) states his belief that there is a global witch-hunt in progress with accusations about dangerous maternity practices. He sees it as a struggle for control of the maternity services with the key underlying issues being "money, power, sex, and choice" (p.1020). He notes from his involvement in twenty legal cases of maternity malpractice, 70% of the accused were midwives, and 85% were women. The thing they all shared in common was their move away from what was considered to be mainstream practice. He compares one unpreventable death, from the caseload of a homebirth practitioner, as negating "years of impeccable standards" (p.1020) while a death of a

hospital practitioner's client may be reviewed behind closed doors, but will not come to the attention of public or legal authorities.

Battles for power are not new. Willis (1983) tells of a case cited in the Australian Medical Journal of 1864 where a midwife was charged with manslaughter following the death of a mother. He cites the report: "In her evidence, she said she had sent for the surgeon when she realised the birth was going to be difficult, but he had refused to come because he was not guaranteed payment". He tells us "she was none the less culpable" (p.103). It raises questions about whose 'safety' took priority, and whose interests the power-holders of society protected. Those same questions are still being asked.

The context of 'being safe'

When I was student midwife in the late 1970s, in the era of modernity, there was seldom any question about the context of safe care. The authority of the medical profession, submissively supported by the midwifery profession, deemed what was safe. Written policies and procedures ensured that safety was enacted at all times. I remember reading a policy advising the midwife that if the parents did not want their baby to have the routine Vitamin K injection after birth, they were to remove the baby to the nursery, and give it out of the parents' sight and knowing. I look back on such memories with horror and shame, and it is within those memories that I realise how huge the changes have been in the past twenty years.

It is now a time of paradox and endless choices. The medical profession have lost their power and control over patients and over midwives, yet they still retain power and control for they have the skills to remove the baby from the womb, possibly saving the lives of mother and child. Midwives have gained legal permission to practice on their own, yet they are influenced at every turn by the power of those they may need to refer to, by the model of care they are expected to enact, and by the woman herself. Women and their families have never had so much choice, yet at the same time they have never had so much confusion about what may or may not be safe, and have never had so little choice when at the end of the day funding determines the limits of the care they may or may not have. It is a time when hospital care is called unsafe by some, and safe by others, and homebirth safe by some, and unsafe by others. Others see the possibilities of both being safe and unsafe. It is a time when the advances of science and technology are snubbed by some for the

remedies of by-gone ages. It is perhaps a time of chaos, yet it is a time of opportunity. It is certainly a time when the question of 'what is the meaning of being safe?' needs to be explored.

They came to the world
and looked around them
seeking to understand
seeking to make sense
and found there was none.

The loud voices of authority
declared the answers were theirs.
It was observed however
that their garments of power
were becoming tattered,
and their accustomed expectation
of wealth and esteem
had become
a bewildering
uncertainty.

The voices of the new wave
were enthusiastic
and bold
and had new answers that returned to old ways.
They offered choice,
yet it seemed they had limits of what they could do,
however far they pushed the boundaries
How demoralising it was,
when they could do no more,
to have to seek help
from those who had held them captive
for so long.

The recipients looked bemused, confused, and perplexed.
They sort of wanted to be in charge themselves,
but there was so much to understand about it all,
and whose understanding should they believe?
The new wave 'promised, encouraged, and empowered'
The authority 'declared, cautioned, and decided'
Yet both were absolutely sure they were 'safe'.
How hard it was to know.

An old woman sat watching
her eyes speaking of the wisdom of her travails
To think, she sighed,
between them all they have so much
so many possibilities,
such skill,
such understanding,
yet they don't really understand at all
they haven't grasped 'what matters'.

CHAPTER TWO: THE HISTORY OF 'BEING SAFE'

Hermeneutics guides us in an understanding that the past goes ahead yet comes to meet us. The past both informs us and is the lens of the present. Therefore, to come to understand the meaning of 'being safe' we need to first go back to the past, to find and examine the meanings from the legacies of the generations of women and practitioners that have gone before us. We need to ask 'how was 'being safe' then'? How do the documented experiences show the meaning of 'being safe'? What were the influences? How does the past add to our understanding of the meaning of 'being safe' today? This chapter is a collection of snapshots, each offering its own perspective on the meaning of 'being safe'. It takes its beginning in 19th century colonial New Zealand, and in keeping with an album of photographs, wends its way through the generations. It includes snapshots of both child-bearing women and the people who offered them 'safe' care.

Childbirth in Colonial New Zealand

Birth in 19th century colonial New Zealand took place in an era before there was access to formalised professional maternity care, before there was life-saving technology, before there was any expectation that birth should be safe. The letters of those times enable us to see 'being safe' as it is in itself.

For some women childbirth was an everyday, uncomplicated event. Sarah Greenwood wrote this letter to her physician husband, in 1845, on the birth of her 10th child:

I was first warned of the coming event about 6 on Tuesday evening and at 12 precisely the young lady made her appearance after giving me (if possible) still less trouble than her predecessors. I was very comfortably attended by Mesdames Hogan and Bere; the former lady remains with me ... She is delighted to be paid in old clothes, and I to save the cash. She is an active body with a most desirable passion for scrubbing and scouring... Of course I am longing to see you but thank God that I am so perfectly well that I do not require any assistance in the medical way.

(Porter & MacDonald, 1996, p.348)

For others, however, the awareness of the possibility of death seems to be integral to the experience. This 1864 letter speaks of the understanding that pregnancy may lead to death :

I daily expect the birth of my 4th son and I always have a feeling (perhaps it is only a habit), that it is well to put my house in order and do what is well before the time comes, when it may be too late. Why do men make such a marvel of people being cheerful and brave in the face of the guillotine when so often, as a soul is born into the world, we poor women meet a greater pain and almost as great a danger as the guillotine with a pleasant unconcern, and up to the last moment finish up all our small affairs and wind up the several threads of our lives as methodically as if we were preparing for an expected entertainment.

(Porter & MacDonald, 1996, p.358)

Dying in childbirth was not just something that happened to other women. It was something that could happen to any woman, with any birth. It was a fear real enough for women to prepare for its possible happening, yet at the same time, as this letter seems to suggest, preparing for the danger was acted out with a 'pleasant unconcern'. Another woman comments :

But one can never forget how many poor women have been full of hope and reasonable expectations of happiness whilst the Angel of Death was waiting for them close at hand (Porter & MacDonald, 1996, p.359).

These women were also full of hope that their baby would live:

We had a little stranger since I wrote last time, a bonnie little girl ... but she only lived a quarter of an hour. I just heard her cry once and then, as the nurse said nothing about her, I asked if she was dead for I felt as if she was but I suppose she was afraid to tell me. [The nurse] said 'the baby was all right', but in my own mind I knew better and when Peter came into the room I asked him as I knew he would not deceive me. I felt as if I durst not look much at the little pet for I did so long to keep her. When they had laid her on a box in the bedroom she looked just like waxwork (Porter & MacDonald, 1996, p.364).

For many women, their faith and belief in God was their security and helped them to understand. There was little they could do themselves, and there was little effective help to call on, to offer them any sense of security between life and death. This is the comment from a 31 year old woman expecting her first child:

I let myself plan for the near and far future, but I am not at all sure that I shall see either. I don't feel in the least despondent, however, but I know I

am not very young and that next month must bring its risk. I cannot but trust and pray that the Almighty may spare the child for Arthur if he sees fit to take me away (Porter & MacDonald, 1996, p.353).

The women talk fondly and respectfully about the women they called on for assistance. This letter of 1868, written by the mother-in-law, told of a woman who in the midst of her childbirth experience became very sick and had a violent fit. The husband went for Mrs Dickey, the neighbour two miles away, and then for the doctor:

The doctor came and gave her laudanum to stay the sickness. He said the fits were not at all uncommon and if she got some sleep she would be all right. He was going to Patea but would come and see her the next day. Mrs Dickey promised to stay with us. The doctor had not been long gone when we were sure what was going to happen. Mrs Dickey said never mind we shall do very well, and so she did. No doctor I believe could have done better. Harriet was very ill for about four hours and all the time to the very last her husband supported and soothed her. Indeed I don't know what we should have done without him. Mrs Dickey is such a nice Scotch woman ... she says she has often been similarly situated. She is the mother of a large family ... And so we have got on first rate without either doctor or nurse (Porter & MacDonald, 1996, p.363).

By today's standards, this woman was acutely ill and would receive expert attention in a high technology unit. Instead, she was left by the doctor to make her own recovery through rest. She was attended by her family and by a neighbour, who had a presence, born of experience, of knowing what to do. The woman recovered.

Not all women, however, recovered. This letter is written by a husband, in 1864:

Then came what Dr Rawson describes as a 'nervous fever incidental to childbirth' from which she seemed slowly but steadily recovering till Thursday last when there came a sudden change. On Friday night she passed many hours in cruel pain and on Saturday at 6pm she breathed her last.

About an hour before her death she seemed to be aware for the first time that she was to die. Both hearing and sight were so much obscure and she could just dimly articulate the words Mother and husband. She turned her poor weary head and parched lips many times, first to Aunt and then to me to kiss us... These were the last indications of consciousness. (Porter & MacDonald, 1996, p.360).

It is as we read, and watch the life of this woman drain from her, that the helplessness of the doctor and the family become apparent to us. All they could do was give a diagnosis to the condition, and offer comfort and love while they awaited her death. They had no knowledge, skills or technology to turn the situation around. Unsafety claimed them and trapped them. There was no escape from death. Birth was constitutively dangerous.

The loud voice that echoes in these letters is that childbirth might lead to the death of the mother or her baby. It was a possibility in every birth. Only God could protect and save. The doctor and the women who offered care did what they could, but it was most often only the woman's own body that could win the fight to survive. Being safe and staying safe was a cause for celebration and thanksgiving.

The coming of safety

Why is it that a century later being safe and staying safe are considered the right of every woman? Why is it that the possibility of death is seldom even thought about, let alone discussed with relatives and friends? From where has this confidence in the safety of birth arisen?

Significant changes in the twentieth century have impacted greatly on the maternity services. There have been changes in education, technology, institutionalisation, professionalisation, and in the conditions of living (Arney, 1982; Donley, 1986; Dye, 1980; Fildes, Marks & Marlands, 1992; Gordon, 1956; Mein Smith, 1986; Willis, 1983). The possibilities of health, of protecting against harm, and of rescuing from death, have made dramatic advances. Accompanying these advances, however, have been political struggles for power and control: struggles which have involved the change from birth seen as a normal life event to birth seen as a pathological, medicalised event; and the taking away of the governance of birth from women and families. The intention of making birth safer has perhaps often been accompanied by consequences which, at the same time, have made birth less safe. To understand these changes it is important to go back to their beginnings.

Establishing safe practitioners

Colonial New Zealand women in childbirth called upon the services of neighbouring women or of midwives (who had been trained by other midwives, or by the local doctor) (Donley, 1986, p.27). In 1904 (following the Nurses Act of 1901) New Zealand passed the Midwives Registration Act (Donley, 1986, p.29). At the same time, St Helens Hospitals were established for the dual purpose of providing safe maternity care for the wives of working men, and a place where midwives could receive training (while providing free service). In a Manifesto to the people of New Zealand in 1904, the Rt. Hon. R.J. Seddon talked about the Midwives Act:

How much infantile mortality and debility, and how much unnecessary maternal suffering is due to unskilful midwifery is known only fully by the medical profession. and this act provides for a system of registration which will prevent this waste of life and health (Printed as a poster, obtained from ex-St Helens midwife).

In 1907 the Inspector-General of Hospitals, Dr Duncan MacGregor made the following statement in his report to parliament:

With the passing of the Midwives Registration Act the day of the dirty, ignorant, careless woman who has brought death or ill-health to many mothers and babies will soon end. After 1907, every woman who undertakes the responsibility of a midwife will have to show that she is competent to do so (Appendix to the Journals of the House of Representatives, 1906, cited in Papps & Olssen, 1997, p.98).

In these two statements we have the beginnings of the professionalisation and control of the safety of childbirth by the state, the sense of the unquestionable safety of the knowledge and practice of doctors, and the assumption that the high maternal and fetal death rates of the time were all due to dirty, ignorant and careless practice by untrained women. The government now made it an offence for a neighbour to support another woman in her labour and birth. It was the government who now passed down to its midwifery training schools, under medical control, the right of deciding who was to be deemed competent to act as a midwife. It was also the government who, in 1911, prosecuted eight untrained women for acting as midwives, who were, in turn, convicted and fined for this offence (Appendix to the Journals of the House of Representatives,

1911, p.79). Being safe was no longer a matter of choice for the woman and her family; it was a matter of government decree.

Defining and controlling safe care

By the end of the 19th century there was grave concern in government about the steadily declining birth rate of the white immigrant population (Donley,1986). In making recommendations for “improvement in confinement conditions, midwifery practice and hospital accommodation” (Donley, 1986, p.32) the government took on the responsibility for defining safe care. In 1921 a special committee was set up by the Board of Health “to consider and report on the question of the deaths of mothers in connection with childbirth” (AJHR, 1921, p.1). The Committee had before it statistics demonstrating that a death rate of 3.93 per 1,000 in 1880, had risen to 6.84 per 1,000 in 1913. The principal causes of death were listed as puerperal septicaemia, puerperal albuminuria and convulsions, puerperal haemorrhage, and accidents of pregnancy and labour. Of the 157 deaths in 1913, 57 had been from septicaemia. It was the committee’s opinion that deaths from sepsis were largely preventable, and thus they devoted special attention to this dominant cause. Their understanding of its occurrence was that deaths from septicaemia were due to the abnormal virulence of organisms and the diminished resistance of individuals. Further, they believed other contributory causes were that confinements were taking place in unsuitable, unhealthy places, and that there was an unduly large use of instruments and other operative measures at delivery. Their recommendations to increase the safety of birth were: to acquire more accurate information on death certificates, to investigate every maternal death and every case of puerperal sepsis, and to demand quarterly returns from every maternity hospital specifically in relation to elevated temperatures. Further monitoring would be maintained by strict and regular inspection of private maternity hospitals. It was stated that there should be attendance during confinement of a reliable and highly trained midwifery nurse, who would have gained through her training, a thorough knowledge of asepsis. The medical profession was admonished for its lack of knowledge of asepsis, and for its excessive use of instruments in midwifery practice. At the same time, the profession was encouraged to enhance the status of obstetrics by the creation of a

professorship. Finally, the use of antenatal clinics was recommended to enable the medical man to detect abnormalities, and, as a consequence, avert dangerous complications. The report concluded with the statement: "Childbirth is a normal physiological process, and to the healthy woman in healthy surroundings is attended with very small risk" (AJHR, 1921, p.4).

The meaning of 'being safe' in the 1920s seems to be that women were safe, most of the time, but when they were not safe, they were at risk of death. The responsibility for safety had been transferred by the beginning of this century from the family to the government. The government could only be responsible, however, if it knew what was happening, and so had laid down rules and policies to ensure safety was maintained. 'Being safe', therefore, involved the Board of Health setting the standards of safe practice, monitoring that those standards were met, and investigating, with the power to terminate practice, when death or disease occurred.

Women and their families were encouraged by this 1921 Board of Health committee to believe that the doctor knew best. Indeed in the report, "patients and their friends" are rebuked for bringing undue pressure on the doctor to "expedite the course of labour by the use of forceps" (p.3). Safety had become both professionalised and bureaucratised. Those who attended women were under the governance of their professional training, of their employer, and of the policies and standards set by government. A midwife employed in a hospital was readily controlled. A doctor, independent in his practice, was freer to practice however he pleased. The Department of Health had set itself the task of defining safe care, advising about safe practices, monitoring for unsafe practice, and investigating death. 'Being safe' was now a notion enshrined in bureaucracy.

Safety is more than knowing about asepsis

Significant numbers of women in the 1920s were still dying in childbirth from sepsis. There was by this time understanding about the preventative action of aseptic techniques. It is not surprising that those carrying the burden of responsibility should do

everything in their power to introduce and maintain aseptic conditions. At the same time, the question needs to be asked 'why was the rate of puerperal sepsis so high?'

An inquiry into six deaths in the Kelvin Maternity Hospital in Auckland between July and November 1923, found that five of these had been caused by puerperal sepsis (AJHR, 1924). While there was no direct common mode of transference evident in these cases, apart from the bath-sink room in which bed pans and other utensils were washed for all patients, the solution deemed to be the most safe was to close the hospital to allow for complete disinfection. In other words, it was likely that it was the hospital itself that was unsafe. The very institution that was upheld as enhancing safety was in fact taking women to death. The commissioners of the report declared that the Health Department, because of under-staffing, and the inconvenient timing of reports, had not maintained adequate inspection of this hospital. They drew attention to a series of doctors who assumed that the hospital was a safe place to send their patients, never questioning the possible risk of infection. They described the position of the maternity patient as pitiable. "The safeguards she imagined she had do not exist" (AJHR, 1924, p.17). This story reminds us that the assumption of 'safety', whether it rests on scientific knowledge or traditions of practice, must always be kept open and problematic.

There is the strong possibility that if these women who died in the Kelvin Maternity hospital had given birth at home, as it is likely their mothers had done, they would not have died. It was the quest for safer care, ironically, that took them to their death. Within this report is the paradox that the intentions of safe practice actually resulted in unsafe conditions. The doctors were charged with insufficient and inaccurate diagnosis, with having a reluctance to suspect puerperal fever, with causing regrettable delay, and with not always making prompt use of bacterial examination. The Auckland District Health Office, having been notified of puerperal sepsis was accused of "extraordinary languor" (AJHR, 1924, p.11). The nurses were excused on the grounds that "we have no right to expect of a trained nurse the scientific knowledge necessary to question the diagnosis of a doctor" (p.13). The possibility that there had been "a conspiracy of silence between Matron and the medical practitioners, or between the medical

practitioners themselves, to conceal or suppress information which might be detrimental to one or other of them” or “that one or more medical practitioners were financially interested in this hospital” (p.16) was examined. The report stated “there was no evidence indicating any ground for that suspicion” (p.16). Does that mean it did not happen, or does that mean the evidence of it happening was not uncovered? It is nevertheless a reminder that the safety of mothers may not always be the number one concern of the practitioners involved in their care. The practitioners’ own personal safety in terms of on-going employment and status may take precedence over patient well-being. The Commission states: “Expectant mothers should not be deluded into a sense of security, ...when the security in fact does not exist” (p.15). Safety may be a facade. Everything that seemed to assume women’s safety in childbirth may have been in place, yet childbirth was still unsafe. The Kelvin Maternity Hospital inquiry found numerous breakdowns of safety, of multiple causes. No one person was responsible, yet all practitioners, in their own way, were responsible. ‘Being safe’ is not simply a matter of policies, of inspections, of trained staff. It is a matter of integrity, of alertness, of courage, of happenstance, none of which can be controlled by government or any of its servants.

The sadness of the Kelvin Hospital story is that at every stage there were possibilities for preventing the unsafe situation from occurring, or at least, of recognising the developing unsafeness and acting promptly to reclaim it to safety. Practitioners and health department officials had knowledge and skills, policies and guidelines were there to be followed, back-up safeguards were in place, yet still there was breakdown.

Knowing but not doing

The development of aseptic practice was the new technology of the 1920s. By then, reformers within the Health Department had adopted the belief that sepsis had an exogenous cause. That is, sepsis was understood as an acquired infection that could be communicated by the hands of staff, by vaginal examinations or instrumental deliveries, or passed from one woman to another in a shared environment (Mein Smith, 1986, p.28). From such a notion came precise and detailed recommendations for practice

related to aseptic technique, sterilisation, disinfection, and the closing of hospitals where maternity cases were alongside septic surgical cases (p.63-64). Paget, the Inspector of Maternity Hospitals stated in his 1926 report (AJHR) that the pamphlet setting out a standard aseptic technique for the training of midwives and maternity nurses had already had its effect. He went on, however, to discuss the paradox that doctors seemed to accept standards of asepsis in their maternity work which in surgery they utterly refused to accept. He talked of complaints about the expense and the elaborate and complicated nature of the aseptic technique. He told of those who showed a marked aversion to change from their old habits (p.23). Looking back, it is hard to imagine that it was such a hard battle to convince practitioners that their habits of practice were unsafe, and to persuade them to invest the money required for equipment which would be likely to help prevent death from sepsis. Was it that they did not understand? Was it that they did not believe? Was it that they resisted being told how to practice? Was it that it all seemed too much effort? Was the cost beyond their means, or beyond their willingness? Was the wellbeing of a woman not valued enough for aseptic practice to really matter? Are these same apparent tendencies inherent in practitioners of any generation?

Becoming safe yet being powerless

If 'being safe' is to be measured by statistics, then it became clear that the St Helens Hospitals were the safest places of birth. In 1929 their maternal mortality rate was 2.08 per 1,000. Other maternity hospitals had rates in the 3-4 range, and mixed hospitals had a rate of 8.23 per 1,000 (AJHR, 1930, p.54). St Helens Hospitals strongly upheld the policies of the Department of Health in the culture of their midwifery training schools. This was reflected in every St Helens report to the House of Representatives. The report of the Kettle Commission into Maternity Services (AJHR, 1913, p.12) made recommendations related to student midwives about providing lecture rooms and libraries, and about maintaining discipline, order, decency and cleanliness among officers, pupil nurses and inmates of the institution. The recommendations reflected a culture of training for service, of being told what to think and believe, being taught how

to act, and then being expected to obey. It was the ideal mechanism for transforming methods of practice, and for introducing the medicalisation of birth.

The report of 1909 (AJHR) stated that the last wish of the St Helens trained midwife was “to act in any way independently of or in opposition to the doctor” (p.10). It is an interesting paradox. On the one hand the midwife was being indoctrinated into safe practice through education and the expectation of obedience, while on the other hand, her medical colleagues of those times, who had had no similar education, could decide their own manner of practice. It was the ‘trained’ midwife who knew how to prevent infection, yet she was seen to be under the authority of a doctor who did not necessarily understand or support such ideas. It seems that the status of the medical profession was beyond question in the business of safe maternity care.

Taking on the responsibility of safety

St Helens Hospitals led the way forward in safe maternity care. In 1925 they established antenatal clinics. A 1925 report to the Department of Health written by Dr Gurr (AJHR) describes the duties of the nurse (the midwife is commonly referred to by this title) in charge of the clinic. There were instructions about general hygiene and about how the expectant woman should prepare for herself a sterilised maternity outfit (ie. equipment for birth). There were guidelines on history taking and examination, referring any problems “to the doctor in charge in order to safeguard the mother and her child” (p.34). In describing the work accomplished by these clinics, the Gurr report stated that “the importance of continuous supervision was impressed upon them [the patients] *without in any way alarming them about the ultimate safe issue*” (p.35).

In little more than fifty years the truth about the unsafeness of birth had been taken away from women, and held by the professionals as knowledge not to be disclosed. Nevertheless, it was in the professionals’ interests to create a moderate fear of birth, in order to provoke the woman into handing over her pregnant body to the authority of the hospital. A 1927 AJHR report by Jellet talks of the need for closer co-operation between

medical attendants, patients, and their husbands. He tells of a case of malpresentation resulting in death from shock and states:

Neglect to take advantage of the discovery of the malpresentation at the clinic in this case must be laid at the door of the unfortunate patient, to whom of course it was impossible to fully warn her of her prospective danger; but I have no doubt that had the husband been made fully acquainted of the danger to which his wife was exposed, the delay, caused by her ignorance of the full extent of the danger, and the consequent neglect to seek early help owing to nervousness, could have been avoided (p.32).

Such statements remind us of society at that time where the husband was considered more intelligent, and more able to understand, than his wife. When one considers the attitudes, behaviours and practices evident in this report it is not surprising that they caused this woman such nervousness that she chose not to return to the clinic.

Technology means being safer

In 1925 X-Ray technology was available for use. Its advantages were described as allowing diagnosis of the size and position of the fetus, measurement of the pelvis and recognition of deformities, differentiation of twin pregnancy from hydramnios, and the diagnosing of hydrocephalic and intra-uterine death (AJHR, 1925, p.35). One wonders how much difference this knowledge made to outcomes of care in an era where caesarean section was not a safe option of care. We look back, now knowing the risks of X-Ray. By the 1960s, those children who had had fetal X-Rays pre-birth were shown to have a higher risk of cancer (Papps & Olssen, 1997). At the same time, one can appreciate the wonder and awe such technology brought to both the practitioner and the woman. The practitioner now had access to expert knowledge beyond the reach of the woman/family. The practitioner had new power and with it, new status. They were, however, in complete ignorance that the procedure that they ordered in the quest of safety was perhaps in itself causing what would later develop into life threatening cancer. What was thought to be safe was not safe. What was thought to enhance safety, took away from safety. The practitioners who once appeared to know, are now seen not to have known.

To do or not to do? - that is the question

The report by Paget in the 1925 AJHR document makes a telling statement. He applauds the work of antenatal clinics and of skilled attendance, but, at the same time, reminds his colleagues of the notion of “masterly inactivity” (p.32). Practitioners were in an era where there was a variety of things they could do. They were no doubt proud of their newfound skills and abilities. They had a new sense of being able to take control and to alter the outcomes of situations. Paget’s quiet caution is a reminder that sometimes a situation is best left untampered with, that the practitioner is best employed by doing nothing. Being safe is a paradox between doing and not doing, and knowing which to do when.

Jellet’s report of 1927 declares his horror at reported forceps rates of over 50%, rising as high as 70% in one hospital. He compares them with English figures as low as 2.38%.

He comments:

It is impossible for the officers of the Health Department to tell a qualified medical man that he conducts his midwifery cases improperly; but if a medical man runs counter to accepted opinion, then it is open to him to come forward and justify his practices. To do this he must establish four points: First, that he has a low mortality; secondly that he has a low morbidity; thirdly, that the examination of the pelvic organs some weeks after labour, as carried out by a competent examiner, reveals as normal a condition as is found after spontaneous delivery; fourthly, that the result to the infants so delivered is good. If he can do all these things then it is possible to say to him that in his hands the forceps has not as yet done harm; but it is necessary to add that he is setting a bad example to his less-skilled neighbour, and that he is running increased risks of being associated with an epidemic of sepsis in his own hospital (AJHR, 1927, p.29).

Jellet strongly implies his preference for non-interference with normal birth. He identifies the many possible harmful consequences, yet, in keeping with his time, does not move on to consider the emotional consequences for the woman. His message was that in trying to do good, doctors needed to consider that they might be doing more harm than any good that was achieved. Further, even if the doctor did no harm himself, he might inspire false confidence in others, or he might be the initiator of one small harm of infection which spreads to become an epidemic of harm. Harm was always a

possibility of practice. Jellet describes the frustration of watching his colleagues do harm in abundance, and being powerless to tell them so. How has the medical profession gained such protection for themselves? Do midwives in their current independent status (since 1990) share the same freedom of practice, free from formal censure until an official complaint is made against them? Who should have the power of deciding if there has been harmful practice? How do practitioners come to recognise the harm of what they consider normal practice if no-one tells them? Yet who should have the right to tell them? Who knows the truth of safety?

Being safe in anticipation

Paget quotes the Head of the British Ministry of Health: "No sound progress can be made in the reduction of maternal mortality apart from antenatal supervision" (AJHR,1925, p.34). What was so significant about this development? Was it that for the first time practitioners had the opportunity to examine women before birth, and to predict the possible problems? Was it that they could educate and instruct women in the hope of helping them avoid possible problems? The question remains, when a problem was diagnosed, were they able to make any difference? The underlying question is, whose interests were being served by women handing over authority and responsibility for their pregnant body to the hospital clinic? Was it women being safe for themselves; was it the practitioners being safe for themselves; was it the Health Department striving for statistics that demonstrate safe standards of care? Was it perhaps the professionals wanting an excuse to have a population of women on which to learn skills? Mein Smith (1986) offers the explanation of eugenics, that there was a drive for antenatal care to ensure that all children born were capable of healthy living for the wellbeing and prosperity of the Dominion (p.24). Antenatal care from this perspective was about building healthy nations from the worthy parenthood of the middle class (ie. the wives of working men). Yet within the initiation of antenatal care there comes a new perspective on practice. It is one of thinking ahead to consider the possibilities of problems, it is about thinking of strategies that might prevent those problems from developing, it is about working out what might cause the problem in the first place. Antenatal care was the beginning of a much more thoughtful approach to practice.

Where are the Maori women?

As almost an interruption to this story, I raise the question, ‘where are the Maori women?’ The whole question of maternity care for Maori women was recorded in the official documents under a separate heading from the general report. A 1935 report (AJHR) refers to the much higher Maori maternal death rate (7.65 per 1,000 women in 1932) in comparison with the European population (3.02 per 1,000 women in 1932). A further comment remarks on the great difficulty experienced in trying to persuade Maori into accepting skilled treatment. A 1936 report (AJHR) refers to the midwife in native settlements who “nowdays is an old lady who considers herself to be endowed with magical properties, and who believes that this magic will be lost if the information is imparted to anyone else, particularly to a European” (p.61). Was the government less concerned about the safety of Maori women in childbirth, and thus made less effort to gain control, or were Maori more sceptical about the so-called safety that was on offer, and chose to continue in their known ways? Continuing though, in their known ways was becoming more and more difficult. In 1907, the government had introduced the Tohunga Suppression Act which “constituted legislative enforcement of the racial subordination of Maori childbirth practices and knowledge from the first decade of the twentieth century” (Papps & Olssen, 1997, p.104). The Tohunga had priest-like, expert status over a specific domain, one domain being health. Those powers were now deemed illegal. By 1962, 95% of Maori women were birthing in hospitals (p.104). The question that lies before us in this era of the recognition of ‘cultural safety’ is ‘how safe were Maori women in institutions of the Pakeha¹, and how safe are they today?’

Having a new key to safe practice, but not using it

Technology continued to offer possibilities of increased safety as the twentieth century moved on. The sphygmomanometer, a machine to record blood pressure, was introduced to St Helens’ antenatal care in 1925, with the knowledge that raised blood pressure was the key symptom of pre-eclamptic toxæmia, the forerunner of eclampsia (Mein Smith, 1986, p.92). The diagnosis and hospitalisation of pre-eclamptic women from the St Helens’ clinics led to a reduction of over 50% in the eclampsia rate (AJHR,

¹ Pakeha is a term used for a person, or people, of non-Maori descent

1932). Technology in this instance was the key to diagnosis, and therefore the key to effective treatment. In a 1935 article reviewing the standard of efficient antenatal care by Paget and Ewart (AJHR, 1935), the following statement is made:

The outstanding feature of the investigation is that out of thirty-seven cases in which there was sufficient time and opportunity to detect the toxæmic condition, there was a total failure to make observations on the patient's blood pressure for this purpose in seventeen cases...Twelve of the thirty severe cases ended fatally, and the record shows that four of these had no antenatal care whatsoever...The figures of St Helens Hospitals show that the incidence of eclampsia can be and is being reduced by full antenatal supervision (p.70).

Ten years after the common use of the sphygmomanometer, it was still not considered necessary by some independent doctors in the provision of safe antenatal care. In fact antenatal care itself was probably not considered necessary. Doctors were free to make their own decisions about safe practice. The creation of the Obstetrical Society in 1927 and the full term professorship in Obstetrics in 1930 at Dunedin Medical School (Mein Smith, 1986, p.41) had not yet significantly influenced the safety of medical care.

Safety for whom?

The Department of Health of the 1920s -1930s was politically driven to lowering the maternal and neonatal mortality rates. The solutions to reducing mortality rates, that were high by international comparison (Mein Smith, 1986), were put forward by Department of Health representatives, people such as Paget, Jellet, and Truby King. These men shared a belief that birth was a normal life event, and that wherever possible such normality should be preserved. They also recognised that simple scientifically based strategies overcome the most predominant causes of death. With all the power of a bureaucratic organisation behind them they decreed the rules and standards of care (Mein Smith, 1986; Donley, 1986). Doctors were affronted that anyone should be able to tell them what to do and came together to form the Obstetrical Society to counter the Departments "reign of terror" (Mein Smith, 1986, p.41). As they stood by and saw the success of the free public antenatal clinics, run mainly by midwives, they perceived the need to "restore the credit for reducing maternal and perinatal mortality to the medical

profession” (p.422). Their belated efforts were not in the interests of safety for women, but were made to preserve their own status and right of control.

Decreasing the safe practitioners

A report by Jellet in 1930 (AJHR) highlights the paradoxical nature of decreasing the safe practitioner. On the one hand, he makes statements such as “It is difficult to understand the mentality of the practitioner who adheres to methods which have been criticised and condemned in every obstetrical school in the world” (p.47). He points to the comparison of public hospital forceps figures (hospitals with midwifery training schools) with a 2.2 percentage forceps rate, and private hospitals with a 15.81 percentage forceps rate (p.48). He states “I think that obstetrical prognosis will be largely improved when the care of normal women is left to midwives during labour, because the risk of infection brought by a practitioner whose practice is “mixed” is greater than that brought by the woman who only practices midwifery. Yet, at the beginning of this report he makes a very clear statement that:

the entire responsibility for the care of the patient during pregnancy and labour should rest on the medical practitioner ... he should be free to delegate such part of antenatal care and of the management of normal labour to the midwife as he considers well (p.46).

One wonders why ‘responsibility’ is so confidently laid on the medical practitioners, the very group of practitioners who had been resistant to adopting scientific advice on safe practice. One wonders why a midwife was considered safe to be given the entire responsibility for care if the doctor chose to do so. One wonders at the peer pressure on Jellet to so strongly back his own colleagues, who previously had been critical and had ignored his pleas to adopt his policies. There seems to be an unquestionable assumption here that the responsibility for ‘safe practice’ must rest with the medical profession, who can then choose to delegate, yet still must take the entire responsibility. Is there an attitude of supremacy; the all powerful, all knowing, medical practitioner being the most capable person to take responsibility for every aspect of safe care? Does this attitude still dominate the maternity services?

The responsibility of the woman and her family

In the midst of a series of reports from Jellet (1930, AJHR) there appears a more philosophical comment on the nature of safety in maternity care:

I have always considered it to be my duty to draw your attention to any matter of nursing or medical education or practice which seems to increase the dangers of women in childbirth, and perhaps I have failed to emphasize equally the fact that there are other factors, for which medical practitioners and nurses have no responsibility. Such an omission is unfortunate because of the tendency of the lay press and the public to throw on the medical and nursing professions blame for happenings for which the latter are not responsible and which they are powerless to prevent. A single practitioner can give a patient advice which may save her life or health: fifty practitioners cannot make her take it if her mental equipment is insufficient to enable her to appreciate its importance. Again, a medical practitioner single-handed can, if left unhampered, bring his patient successfully through a very difficult labour. If, on the other hand, his plans are obstructed and his mind confused by the injudicious interference of relatives and friends he can easily convert a normal case into a calamity. It is therefore very necessary that the public should remember that to the unavoidable consequences of disease and deformity, and of sometimes avoidable consequences due to insufficient medical or nursing education, there must be added the wholly avoidable misfortunes resulting from misguided and clamorous relations, neglected advice, and unsuitable surroundings (p.41).

Here we have the uncovering of the question of 'who is responsible for safe care?'. It seems that Jellet's answer is that the doctor was responsible, but only so long as the patient obeyed his instructions, the relatives did not harass him, and that the patient chose to give birth in suitable surroundings. Was the patient being blamed when the outcomes were not as the doctor would have wished? Was there a denial of the woman's/family's right to have any opinions about the care she should receive? Was there a sense of the omnipotence of the well educated doctor? Was there a belief that any birth could be made safe if the doctor was allowed to do things his way?

The paradox of being, or not being, responsible

The paradoxical nature of being safe is clearly apparent in a text book written specifically for New Zealand midwives by Dr T.F. Corkill (3rd edition, 1948) in his instructions to midwives. There are two sets of guidelines on 'being safe' during labour,

depending whether it was day or night. If it was daytime, the nurse was advised to notify the doctor at once, so he could “arrange to call in from time to time to note the progress of the case” (p.94). If, however, the doctor was in bed asleep and if everything was satisfactory “it is not necessary to notify the doctor until the morning unless he has to be summoned to the delivery or unless special treatment is to be given” (p.94). We see the belief that to ‘be safe’ the doctor must attend the labour himself, from time to time, presumably because the midwife was not safe enough to be left to her own decisions. On the other hand when the doctor needed his sleep, it was taken for granted that the midwife would be able to make safe decisions, and would call him if his presence was required. Was the practice of midwives more safe in the night than in the day? Was safety less at risk in the night than in the day? Were the visits by the doctor during the day about something other than safety? Were they about retaining power, control and status? Were the rules laid down by Corkhill therefore more about maintaining the vested interests of the doctor than about standards of safety?

Hospital -the safe place of birth

There was significant development of the public system of maternity hospitals in New Zealand from 1930 onwards (Papps & Olssen, 1997, p.104). Corkill (1948) reminds us of the advances brought to the safety of birth by the discovery of sulphonamides and, later, penicillin; and of the discovery of the relationship of the Rh factor to the haemolytic disease of the newborn. Ergometrine was now available to control post partum bleeding (Gordon, 1957, p.166). The number of caesarean sections was steadily increasing year by year. In the early 1930s, the average number of caesarean sections per year in general wards of public hospitals was ten. By 1950, it was 512 per year, and by 1959, 700 caesarean sections were performed in one year (Donley, 1986, p.56-57). A Family Planning Leaflet in 1941 offered women “Painless Childbirth -Safe and Possible” (Dobbie, 1990, p.14). ‘Painless Childbirth’ was eagerly sought by women who now handed over their labour to ‘twilight sleep’, and later awoke to find their baby had been born. New discoveries brought new skills and resources, which were held to be safe within the hospital environment. The hospital became the place where women

perceived that the unsafe could be made safe, where they could be spared the agony of labour, and where lives could be saved.

Coming to the perceived safety of the hospital, however, brought dangers of its own. Doris Gordon, a doctor who took upon herself the challenge of improving the maternity services of this country for the benefit of women, tells of her experiences while inspecting maternity hospitals. She describes the huge shortage of hospital beds at the time, with one woman being raced round the city by anxious taxi drivers trying to find an empty bed. In Christchurch Gordon was taken to visit babies who at four hourly intervals were placed together in a drop side cot, taken in an elevator to the third floor, pushed through the Ear, Nose, and Throat ward to the Gynaecology ward, where on a glass verandah, they were reunited with their mothers (Gordon, 1957, p.125). The mothers had arrived at the hospital as ‘gate-crashers’, and been delivered in a room “used daily for accidents or for treatment of discharging cases” (p.125). These women, who had been socialised into believing in the safety of hospital birth, had unwittingly put themselves and their babies at huge risk of infection simply by being in such an environment.

Doris Gordon’s vision was that there should be a building programme of small bungalow type maternity annexes to guard against such unsafe environments as described above. Instead, she found her recommendations swept into “building extravaganzas” (p.150) at great reward to architects and builders. The question is raised ‘in whose interests were the moves to invest in ‘safe’ hospitals?’ Were the needs of the woman and her family considered first, or the needs of the medical profession in its establishment of the developing field of Obstetrics (p.145), or the needs of the building industry?

What matters most?

Gordon had firsthand insight into the power of vested interest. For example, in acting out her Department of Health responsibilities she had cause to submit a formal complaint about doctors who had “*taught* and then *allowed* the sisters to give a full-

scale anaesthetic and then to wield the all-merciful forceps” (p.147). While the Nursing Division immediately censured the nurses involved, to her great surprise she found her report to the Medical Association had been recalled by someone “high up in the Health Hierarchy” (p.148). Gordon commented “I could only suppose that this was because the revelations of my report would not enhance the bureaucratic dream of making all doctors salaried servants of the state” (p.148). The fact that these doctors had been responsible for unsafe practice was not considered important enough to disturb political agendas. There were apparently matters of more consequence - of more consequence to whom, we might ask? The nurses became the scapegoats. The doctors were left, uncensored, to continue to practice in whatever manner they saw fit.

Routines and rituals

In 1926, following the Kelvin Hospital Inquiry, the Department of Health published a small booklet titled *The General Principles of Maternity Nursing, Including the management and aseptic technique of labour and the puerperium*. It is commonly referred to as *H.Mt-20*. It ruled the practice of midwives and maternity nurses until 1970 (Papps & Olssen, 1997, p.110-111). I examined the fifth edition published in 1949. It declares on the front page that it is “A standard to be adopted” and states it is “issued under the authority of the Hon. The Minister of Health”. Its nature from beginning to end is one of prescription, direction, and expected obedience. Its proof of worth is presented in the table on the second page which demonstrates an on-going decline in maternal death rate: 0.41 per 1000 in 1942, and 0.07 per 1000 in 1947. This small booklet, in its fifth edition, seems to take full credit for the declining death rate. The first two topics of discussion are ‘antiseptics’ and ‘hand technique’ and then a new introduction ‘psychological aspects’. The new introduction drew attention to recent publications by Grantly Dick-Read on “Natural Childbirth” and his statements about fear. The comment is made “that fear is a big factor in delaying and complicating a labour that would otherwise be normal will be supported by all experienced obstetricians, whether doctors or nurses.” (p.4). The use of the term ‘obstetrician’ to include both doctors and nurses, just as Gordon (1956) in her writing shares the term ‘midwifery’ reflects an equality of practice, and a wisdom of practice, that has little to

do with professional territory. It suggests that even though there had been no previous writing on the impact of fear, experienced people already understood how influential it was. 'Being safe' therefore was about much more than asepsis for some practitioners, even though such knowledge had been invisible previously in professional documents. Nevertheless, this new acknowledgment of 'the woman' who was to be the recipient of rituals and routines of *H.Mt-20* is found only in relation to how the midwife should relate 'to her'. The midwife was required to have a "sympathetic and kindly attitude, to set her as far as possible at ease and to give her confidence" (p.13). There was a sense that the purpose was to promote the woman's compliance with 'what must be done to her' rather than to engage her in any sense of getting to know her, or finding out her needs. *H.Mt-20* already knew her needs, right down to everything she should eat on the ten days following birth. 'Being safe' was about obedience to the tenets of *H.Mt-20* from both the woman and the midwife.

Parents speak out

By 1951, parents were voicing their concerns about New Zealand's system of maternity and infant care. Some parents joined together to become 'Parents Centre'. Helen Brew gives an account of a typical mother's experience of those times:

In our experience, she usually attends a busy doctor's surgery at regular intervals during her pregnancy. Due to the sense of rush which pervades the surgery and waiting room, she is usually too timid to ask for full explanations and reassurances to relieve her anxiety and ignorance about many (possibly minor) matters. In hospital, a place probably associated in the mind with illness and distress, she is left, without her husband, in the care of strangers seemingly perpetually rushed in their work. Through shortage of nursing staff, she is likely to be left alone in a small room with only intermittent visits from a nurse, while hearing strange and fear-inducing noises from the non-soundproofed labour ward or theatre. As no one has taught her the art of relaxation and its relationship to the stages of labour, she is usually unable to help herself. At last her suffering is completely relieved, and she is put to sleep, to wake up to be told she has a baby. During the next fortnight she sees her baby only at prescribed feeding times during the day, and at the end of the time takes home a little stranger. We feel that this pattern of care serves the best interests of neither the mother, her infant, her family, nor the nursing staff (Brew, 1978, p.7).

Parents were not feeling safe in their journey through pregnancy and birth. At their most vulnerable time they were alone, ignorant and frightened. They were offered no experience of the birth itself and no relationship with their baby. It all belonged to the hospital.

This extract from a New Zealand novel telling of the experience of a Maori woman going in to hospital for the birth of her baby in that same era speaks loudly:

I was unprepared for having to have a standing bath supervised by someone I didn't know, who was no older than myself, and then to be stretched out on a narrow bench to have her shave me, the razor first of all sweeping round and over my big stomach as though I was being peeled and sliced, then scratching and scraping between my legs until all the hair was gone and I was an egg, ready to crack. I was glad of the pains as they became stronger, that distracted me from all that was happening.

I was unprepared, when taken to the theatre in the early hours of the morning, to have to lie on my back while strangers pushed my knees up under my chin and a mask was held over my mouth and nose. I pushed that mask away, I pushed my baby down, heard myself scream, unprepared for the sound of it, felt myself breaking in two. The little Gloria came, my own wet baby, into the hands of strangers, but I don't mean to say they were unkind. At last she was given to me, but there was no one there to see her except for kind strangers (Grace, 1992, p.233).

Women did not feel safe. They were now two generations away from the earlier era of birthing at home with lay assistance. Advances in medicine such as antibiotics, caesarean sections, ecbolic drugs for controlling postpartum haemorrhage, meant the fear of dying during childbirth was becoming less of a threat. It was, however, replaced by a new fear: the fear of what was to be done to them in the hospital.

A Maori poet has published a poem reflecting on the death of her mother following her own birth. This is its beginning:

Let me put it bluntly.
The fact is:
Sixty-three years ago today
Or fifteen short days after
My first gasping cry,
You died.

So I was told as a child.

This is a lie
 I refuse to perpetuate.
 The truth is:
 Fifteen interminable days
 Of dirty surgery
 Medical negligence
 And unattended pain,
 Killed you.

I dare not speculate
 On how you fled from that place
 Or what the journey was like
 You made alone and so ill,
 Desperately seeking
 (too late, too late)
 Someone, anyone
 To save your nineteen years

(J.C. Sturm, 1996, p.74)

The poem tells of the facade of safe hospital care. It was the hospital that took away the poet's mother's safety by doing things to her, and causing harm to her through their lack of care and negligence. When she escaped from them, when she tried to find safety for herself, it was too late. The harm had been done. There was no-one able to tell her story then. Who would have believed that the hospital was to blame? The story was passed down to her daughter to tell sixty-three years later.

Full circles

The paradoxical nature of safety is that what was assumed safe moves to being considered 'unsafe', until one day the new way is found to be unsafe, and then the original way is returned to with all the fanfare of a new innovation of practice. Take the question of 'what should happen to the baby in the days following birth?'. With the establishment of maternity hospitals came the establishment of nurseries. The baby and mother were separated at birth, and met only for the prescribed times of feeding. *H.Mt - 20* describes the susceptibility of infants and the need to practice 'nursery technique' (p.44). It describes in great detail the trolley technique whereby four babies may be transported on the same trolley to their mothers, recognising that there was often a

considerable distance between the nursery and the mothers (p.46). With the best of intentions, the hospital took control and ownership of the babies. In the 1950s, the Hospital Bug, known as the H-bug, made its appearance in New Zealand hospitals causing fatalities among infants. At the Federation of Parents Centre Conference in 1957, Professor Harvey Carey pointed the finger at the risk of cross-infection between babies sharing the same nursery, and being cared for by the same nurse. His recommendation was for the adoption of the “rooming in technique” where the baby stays with the mother, which also facilitates their relationship with each other and allows demand feeding to be practised (Carey, 1978). Ironically, this was how the relationship between the mother and her baby used to be in the pre-hospital era. ‘Rooming in’ had been a successful practice for countless generations, yet with the hospitalisation of birth, mother/baby togetherness had been taken over by ritual and routine. So began a long slow battle for women to win their babies back. Hospital nurseries persisted into the 1980s with their rituals and routines still enshrined in the myths of safety. Perhaps too there was a reluctance to give away the ownership of babies, and the control over patients.

The political climate of change

Natural birth is another notion that has come full circle. In the nineteenth century, the only labour and birth possible was by natural means. Dr Jim Henderson returned to New Zealand from India in the 1940s and found to his horror “normal healthy women heavily sedated with nembutal for their labours, unconscious or wildly excitable, unable to deliver themselves, with labour frequently ending in forceps delivery and haemorrhaging. Women looked back on labour as a nightmare. Caesarean section was commonly advocated” (Dobbie, 1978, p.26).

Henderson came across Grantly Dick-Read’s *Childbirth without fear* and started natural childbirth classes in his own home. Dobbie states “he was unprepared for the hostility evinced by medical colleagues, by nursing staff of the local hospitals and by those in the community who regarded anything to do with the name of Grantly Dick-Read as dangerously radical and suspect” (p.26). Here was the beginning of a strong consumer

lobby in support of natural birth. This was the new tension of the meaning of 'being safe'. On the one hand the notion of safety was entwined in the ever-growing developments of technology, which promised pain free labour, safe monitoring, and birth by surgical induction and/or caesarean section at any time it should be deemed necessary. On the other hand, loud criticism was being voiced on the harm being caused by technology itself. Grantly Dick-Read comments: "Probably all of us pause to think sometimes of how much harm we do in our efforts to do good; how much trouble we cause when conscientiously endeavouring to prevent it" (1958, p.3). The meaning of 'being safe' was now in dispute between consumer and professional groups. There emerged women, supported by their partners, who were no longer convinced that their salvation lay in technology, nor in practitioners who chose to interfere in a labour before there was evidence of a problem. Their voices provoked action through the lobby of *Parents Centre* (Dobbie, 1990), in the formation of the *Home Birth Association* in the 1970s and a consumer organisation called *Save the Midwife* in the early 1980s (Donley, 1992). A 1979 Board of Health report states: "We must be prepared to replace rigidity with flexibility, if we are to keep our patients happy. Some women who are demanding home deliveries may be doing so as a protest against regimented institutional care" (in Donley, 1992, p.10). A prevailing attitude of ownership still operated at this time, an attitude that knew 'what was safe', but there was now some recognition that women had the choice not to come to hospital at all. Hospitals had to begin to take some notice of what women were saying. 'Safety' was becoming a negotiable commodity.

The unmasking of power

In 1987 the *Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital* (known as the *Cartwright Inquiry*) began. It went beyond the gynaecological issue to scrutinise the broader issues of patient rights and medical power. A quote from the Ministry of Women's Affairs final submission to the inquiry in 1988 states: "Ultimately the issues are about who controls medicine and how; about who benefits from it and who are its victims. Thus, as so many witnesses have so clearly stated, the central issue, above all others, is power" (Coney, 1988, p.6). The Cartwright Inquiry was reported widely in the media. The questions about medical power, once

they had been asked, could not be unasked. The consumer took on a new confidence in their own opinion, belief, and right to be informed and involved. The era of medical omnipotence was over. The meaning of safety was reclaimed by consumers who at times held different views from the policies of standard institutional care (Donley, 1992).

Childbirth and choice

In 1990 midwives in New Zealand won back their right to practice autonomously. Helen Clark, the then Minister of Health, made this statement in the information booklet that subsequently went out to all health providers:

The implementation of the Nurses Amendment Act 1990 should increase the choices available to women and their families in childbirth services. The Act restores autonomy to midwives who were previously limited by legislation which allowed medical practitioners only to take full responsibility for the care of women.

Statistics reflect the benefit of a commitment to natural childbirth, of continuity of care of the client and the rejection of unnecessary intervention. The majority of women have been socialised to perceive birth as an illness. The challenge of this legislation is to change that perception (p.1).

The safety of women has been officially opened up to allow for many more possibilities for 'being safe'. The responsibility has moved away from the medical profession, and has been handed back to the woman and her family. It seems they are able to choose the type of care that feels safe for them. They are encouraged to believe again that it is possible for birth to be a normal process, and able to be accomplished by the woman herself without unnecessary intervention. At the same time, it is recognised that both practitioners and consumers have travelled through many decades of learning and establishing the meaning of 'being safe' - now is the time for un-learning some of those unfounded, ingrained attitudes, beliefs and values. It is a new era of new meanings.

The changeless, changing meaning of 'being safe'

The snapshots of safety offered in this chapter are about much more than the decisions and practices of childbirth. They are snapshots of a changing society. They reflect the

trends of industrialisation, professionalisation, and the increased power of a bureaucracy. They are underpinned by the advances of science and technology, giving practitioners tools to save lives. In more recent times the pictures speak of feminism, consumerism and the post-modern acceptance of multiple truths.

Within these snapshots is the place in time when it was assumed doctors knew best, and midwives and women complied with the rituals and routines expected of them. There are the reminders of how eager practitioners have been to seize the new technology and the new knowledge, and how blind they have been to the harmful consequences. In any snapshot, we see what we are looking to see, and may not notice, for example, the sadness in the eyes of the smiling face. The women of today look back for inspiration to their forebears who gave birth naturally, and were not interfered with by ever-hovering technology. Do today's women also see the fear those women forebears took with them to childbirth, the fear that they or their child might die? The practitioners of today look back in horror to the excessive gowns and masks and aseptic procedures from the 1920s-1970s that seemed to be a barrier, keeping the woman apart and distant. Do today's practitioners also see the barrier that stopped the spread of infection, and saved the woman's life in an era pre-antibiotics? How quickly it seems we take for granted our everyday ability to save lives. Perhaps, we have forgotten that that is indeed what we are doing when we chart the antibiotic, or arrange for the caesarean section. Perhaps, we have forgotten the long hard road that has led us to the maternity services of today. It seems the challenge before us is to value the good that we can do, while at the same time to always question the harm that might be happening in the name of safety. It is the wisdom of knowing good from harm, and possible good from possible harm. From T.S. Eliot comes these thoughts:

*the future is a faded song, ...
 Pressed between yellow leaves of a book that has never been opened.*

...

*You shall not think 'the past is finished'
 Or 'the future is before us'*

...

*While time is withdrawn, consider the future
 And the past with an equal mind.*

(from The Dry Salvages, Four Quartets)

The past is not a chronological sequence of events that lies forgotten behind us. It is not finished. It lies waiting for us, pressed between the pages of what is still to come. We cannot consider how we will be safe tomorrow without remembering how we tried to be safe yesterday, for yesterday's understanding is the way forward to tomorrow. This chapter has explored the way back to the meaning of 'being safe', finding both meanings that seem changeless over time, and meanings that are ever-changing. Nothing stays the same, and yet, fundamentally, childbirth is exactly the same as it was in the very beginning.

Once upon a time
childbirth was safe
or it was not safe.
It was a possible encounter with death.
It was fate, it was destiny
it was part of living.

Then death was named the enemy
and the battle began
with all the weapons of warfare
the discipline
the casualties
the new advances
and always
the crusade to win

The women
joined the soldiers on the field of battle
thankful to watch death retreat
but wondering why
the birth of their child
needed to be amidst
the nightmare
and the terror
of battle

One day a woman whispered to another
“it is not how birth should be”
who said to another
“it is not how birth should be”
who shouted to all the families she knew
“this is not how birth will be”

Is birth a battle with death?
or is it a celebration of new life?
Is safety the thing that matters most?
or does it only matter if it comes to matter?
Do the soldiers know
the time for peace
and the time for war?

CHAPTER THREE: EXPLORING THE LITERATURE

The assumption of this study is that in the literature relating to childbirth the meaning of 'being safe' is most often taken for granted. Texts speak of safety in a manner that assumes the writer and the reader share the same meaning. At times the writer may choose to use their particular belief about 'what is safe' to decry the practice of another, still without explicating the underlying meaning of 'being safe'. Most commonly a text will offer the reader the meaning of 'being safe' from between the lines.

The conventional style of literature review pieces together and critiques the findings of all other relevant scholarly writing (Drummond, Fernandez & Mannong, 1995). Such an approach does not fit with this study, for every text about childbirth is likely to be rich in assumptions, attitudes and beliefs that capture the phenomenon of what it means 'to be safe', yet few will pause to consider what they mean by 'being safe'. I can only hope to bring you glimpses from the literature that will offer you a sense of the textures and patterns that exist in the vastness of the whole. The phenomenological approach to exploration of the literature is described by van Manen (1990). He writes of searching for the metaphors that dominate the literature, and then asking what these metaphors say about the nature of the phenomenon under study. He sees that it is the metaphor that will lead us toward the place where "language speaks through silence" (1990, p.49). The challenge therefore is to present an understanding of what lies behind text, of what is assumed, of what is deemed to be the road to safe practice.

The meaning of being safe in childbirth, from where it speaks the loudest

Who talks specifically about safety in childbirth, with what meaning, and for what purpose? Explorations reveal that one voice calls loudly above all others. It is the voice pleading for attention from the parts of the world where women and babies still die in childbirth at alarming rates. The World Health Organisation (WHO) tells us one woman will die because of childbirth, every minute of every day, and 99% of these will be in developing countries, where 88% of the world's births happen (Sungkhobol, 1994). In 1987 WHO announced a safe motherhood initiative with a target of reducing maternal

mortality by 50% in one decade. They identified ways they believed birth could be made more safe. These related to improvements in primary health care and nutrition, available family planning, good prenatal care with referral of high risk women, the assistance of a trained person for all women in childbirth, and access to obstetric care especially for emergency situations (Kwast, 1991). A round-table discussion article followed in the same journal adding these opinions: from Rwanda - that more midwives should be trained, and better use made of them (Nasah); from the Netherlands - that obstetricians and technology should concentrate on cases involving some danger (Cuppen); from England - that midwives should know and respect the community resources and the traditional birth attendants, but be available to deal with any emergencies that arise (Bentley); from Nigeria - that doctors and midwives need to work closely together, each understanding their respective roles (Lawson); from Sierra Leone - that difficult transportation and poor communication be recognised as major hindrances to safety (Betts); and from Ghana - that massive financial commitment needs to be behind directives for effective change (Kusi-Yeboah); from a representative of the International Confederation of Midwives - that midwives need appropriate preparation and field support to enable them to do the job before them (Goubran); from a representative of the International Council of Nurses - that laws restricting the practice of midwives should be changed (Holleran). It quickly becomes clear that 'being safe' as a practitioner of childbirth is about much more than skills. It is a societal issue, dependent on everything from food and roads to laws and funding.

Thompson (1996), also from the WHO, tells us that ten years after the launch of the Safe Motherhood Initiative, the problem is not getting any smaller. She describes the reasons for this as due to the severe global economic crises of this century which have left whole populations without health services, and which have occurred alongside situations of war and civil unrest. She quotes the WHO, suggesting that maternal mortality statistics of a country offer "an acid test of the status of women" (p.159). In other words, if maternal mortality rates are high in a particular country, it is most likely that one would also find it to be a country where women had low status, minimal access to education, no voice in local, community or national policy making, and lived out

their daily lives in a role of subservience to men. Thompson goes on to offer a meaning of 'being safe' that is very broad:

Creating the circumstances which would make maternal health achievable depends also on how women are treated in any given society, how much scope they have for decision making, what level of social and economic independence they have and how much formal education they have ... If those of us working for safer motherhood lose sight of the broad picture we may end up putting plaster on wounds rather than preventing the damage from arising in the first place (p.160).

It presents the challenge to uncover layer by layer the factors underpinning the death of a woman in childbirth. Was it because she was bleeding? Was it because there was no trained person to stop the bleeding? Was it because her diet was so poor her body could not sustain that blood loss? Was it because there was no means of transport to get her to safe care? Was it because the men in her family did not think the life of this woman warranted the cost involved in obtaining care? Was it because this woman, with no education, didn't have the knowledge or the confidence to ask for, or to fight for safe maternity care? Was it because the war had stripped her country of the health service that once existed?

The developing countries show us again the complexity of 'being safe'. They remind us of how much we in New Zealand take for granted when we talk of safe maternity services. We forget the political stability, the accessibility of nutritious food, the ambulance and the helicopter, and the power of women as participants in political decision making that we have in New Zealand.

THE MEANING OF BEING SAFE FROM THE INDUSTRIALISED WORLD

To be 'at risk'

Maternal death seems far removed from everyday practice in a country such as New Zealand. A recent WHO estimate of the risk of a woman dying in childbirth in the industrialised world is about 1 in 10,000, and of babies near term gestation, about 10 per 1000 (Oakley & Houd, 1990, p.115). Does it follow therefore that in these countries

birth is assumed to be safe? Enkin (1994) suggests that most of us, women and practitioners, will never see a woman die through childbirth causes, and therefore both the real risk, and the fear of maternal death “have largely disappeared from our collective consciousness” (p.132). He reminds us that the credit for this lies with antibiotics, blood transfusions, and safer anaesthetics rather than with advances in obstetrical care itself. Nevertheless, the word “risk” is alive and well in obstetrics literature (James & Stirrat, 1988). Some have suggested that it was in the vested interests of professions such as doctors to create the notion of risk. De Vries talks of the ‘how’ of creating risk: “that is by *emphasising risk*, highlighting uncertainty, by redefining life events as ‘risky’ ” (1996, p.171). Arney (1982, p.51) supports this with his opinion that doctors had to “develop ways to ‘foresee’ pathology and act prophylactically because they could not depend always on pathology being obviously present”. In other words, monitoring for risk, identifying risk and treating risk becomes a business in itself, quite apart from any real situation of risk. It takes away from women the belief that pregnancy and birth are normal life events, and reclassifies the situation as being either ‘high risk’ or ‘low risk’, with the emphasis always on **risk** (Katz Rothman, 1982 / 1991, p.132). Pel and Heres (1995) uphold the Netherlands model of care based on what they describe as a unique risk-based approach, with a clear distinction of primary care for low risk women, and secondary care for medium and high risk women. They suggest that the application of secondary care to all patients is one of the causes of the high caesarean section rate in America and Canada (p.209). In other words, the Netherlands are trying to reduce the notion of risk where there is little risk, for it seems to them that perception itself can lead to more intervention, such as fetal monitoring in labour, which leads to the possibility of caesarean section for perceived fetal distress, which is later found not to be so. If the monitoring had never happened, the woman would not have had a caesarean section, and the baby would still have been fine. Having had a caesarean section now puts this woman into a different risk category for her next birth. Risk creates more risk.

Whose risk?

The language of risk has been explored by Kaufert and O'Neil (1993). They identify three languages: the language of the epidemiologist for whom risk exists as a statistical construct, the language of the clinicians who use risk to lay claim both to more intervention (eg. obstetricians) and less intervention (eg. midwives), and language of the lay person who sees risk as an occasional threat of danger which is accepted as part of the natural process. These authors see the conversations of risk being ultimately about politics and power, about who defines risk, and who insists on their views prevailing over others (p.51). They showed the influence of fear, particularly as it affected the clinician who had personal negative experience of, for example "a really horrendous postpartum haemorrhage" (p.47). They believe such an experience breeds fear in the clinician: the fear of it happening again, and the fear of helplessness, the fear of not being competent to cope. Risk then is also risk to the clinician who must carry the burden of what happens, and who then works from a reputation that grows out of the high-profile re-telling of the dramatic situation. If they save the patient, they are a hero. If the patient dies, they will always be remembered for 'not preventing the death', which in turn may be interpreted as 'being unsafe'. It is little wonder that what emerges is an approach where birth is regarded "as a life-threatening situation, requiring surveillance, control, and intervention at any sign of deviation from the 'normal' " (Enkin, 1994, p.133). Yet even those who support the risk management approach are aware of its limitations. James and Stirrat (1988, p.4) remind us that although the risk is defined in mathematical terms, it is always interpreted by subjective judgement, varying from practitioner to practitioner, and varying again in the judgement of the consumer. They admit that some risks are in fact the result of misjudged intervention, and point to the responsibility of asking "although we can do this, ought we to do it?" (p.4). They conclude with the recognition of the dilemma of deciding what constitutes an 'acceptable risk'.

Who determines the meaning of risk?

Tew (1990) talks of the statistics of risk being used to create medical propaganda. When her own statistical analysis contradicted what was deemed to be safe care by

obstetricians, she met with what she described as a formidable resistance to her open, honest criticisms of policies that had been long established. New Zealand has its own examples of resistance. In 1984, Professor Rosenblatt, from Washington, was awarded a grant, partly funded by the Medical Research Council of New Zealand, to conduct a Health Services Analysis of the regionalization of obstetric and perinatal care in New Zealand. It was at a time when the small rural maternity units were being closed, or were under threat of closure. His report concluded that “the majority of pregnancies are relatively uncomplicated, and in an ideal system could be best handled in decentralised, home-like settings close to where the patients live” (p.80). He cautioned that “at some point large obstetric facilities become unwieldy and uneconomic, alienating patients and staff alike” (p.82). He believed that the extensive data he had analysed demonstrated that further centralisation of services “would probably not improve perinatal statistics” (p.83).

His report emerged in an era described by Donley (1992) as one where women were being squeezed into hospitals with increasing levels of technology and medical expertise and subjected to increasing medicalisation of childbirth, as the Postgraduate School of Obstetrics and Gynaecology “embarked on its bid to gain monopoly control of childbirth” (p.3). The response by the Department of Health to Rosenblatt’s report was to backtrack on their agreement to publish his report. Instead, a draft report was produced with clear instructions on the front cover to “Please do not cite or circulate” and with a disclaimer from the Department of Health on the first page stating their belief that there were “significant errors in the statistical information in this draft report”. They accepted no responsibility for it. It is interesting to note that *The Lancet*, a reputable international medical journal, published a paper by Rosenblatt and colleagues based on his report which stated that “Level 1 maternity hospitals - mostly small rural units staffed by general practitioners and midwives - had lower birth-weight-specific perinatal mortality rates in all but the lowest birth-weight categories than the better equipped hospitals to which they refer” (1985, p.429). It seems that there exists a strong societal belief about the meaning of ‘being safe’. In this instance, it was the Obstetricians and the Government who held the power to uphold their own meaning of

'being safe'. Was it because they genuinely believed small rural maternity units to be unsafe? Was it because they thought the money to maintain these community hospitals could be better invested in large regional hospitals? Was there a professional vested interest to develop large regional hospitals where centres of teaching, and research could be developed? We see the meaning of 'being safe' buffered by political interest. Statistical analyses which ascertain the likelihood of risk are open to as many meanings as people wish to bring to them. The Homebirth Association obtained a copy of the Rosenblatt report and ensured its contents were disseminated widely (Donley, 1992). The report validated their own understanding of the meaning of 'being safe'. Just as it had been in the best interests of the Department of Health to undermine and hush such views on the meaning of safety, so it was in the best interests of those who sought to re-establish homebirths to have this view on safety made freely available. A meaning of safe can be both powerful and vulnerable, both acceptable and intolerable, both true and untrue.

The grounding of meaning

To find the meaning of 'being safe' one must find the beliefs from which people interpret the process of childbirth. Gaskin (1977/1990) brings to the international community of midwives and women her notion of Spiritual Midwifery. From the Zen tradition, she describes every birth as "spiritual because it is concerned with the sacrament of birth" (p.14). She talks of following the laws of spiritual energy and of coming to understand how the energy of childbirth flows. She says the midwife's job "is to do her best to bring both the mother and child through their passage alive and well and to see that the sacrament of birth is kept holy" (p.276). While she declares the midwife must be "an avid student of physiology and medicine" (p.279) there is a clear sense that 'being safe' is about much more. Gaskin is a self-taught midwife, who in turn has taught the other women who have become midwives in their community known as The Farm. As women in this community made the choice to birth at The Farm without professional assistance, they came "to look at birth as a sort of initiation or rite of passage - something for which you could gather up your courage with the help of friends" (p.23). Pamela, who took on a role as midwife reflects "I always say a prayer as

I'm going to a birthing or sometime during the birthing. Sometimes I ask for God's help and sometimes I tell God exactly what I need and ask that He helps with that specific thing. He has never let me down." (p.34). Here we have a community of women and midwives who live out their belief that birth is a normal, sacred life event. While they do call in obstetric help when required, the assumption is that in most instances they will not require it. Being safe is about being in tune with the spirituality of birth, of offering love to each other, of acting from the knowledge of medicine but being free to be led by the spiritual energy flows. Being safe is grounded in their deeply held philosophy of life.

Uncovering the meaning of being safe

Not all women or practitioners have a philosophy they can so clearly articulate, yet all have their own beliefs. Katz Rothman (1982 / 1991) begins her sociological analysis of woman and power in the birthplace with reflections of her own first birth, and her personal quest for 'being safe'. She recognised her assumption that hospitals were the safest place for giving birth but at the same time had a knowing that they also took away personal autonomy and the loving, warm atmosphere of family and home (p.11). As she began researching her choices she learned "that hospitals have never been demonstrated to be the safest place for a woman to give birth" (p.11-12). In 1973, in New York, nobody had births at home, yet Katz Rothman made that choice. She makes the observation that it was seen as acceptable risk-taking behaviour to go into hospital late in the labour, or to come home from hospital straight after birth, yet it was not considered safe to birth at home. She comments "Now, things *do* sometimes go wrong early in labor, babies *do* sometimes die when they're two days old, women *do* sometimes haemorrhage twelve hours later - but those were acceptable risks, risks the doctors were willing to take. So it was never a question of risk or no risk, but of *which* risks" (p.17). Following her satisfying homebirth, that was better than even she had imagined, she began to reflect on how her birth experience had been different. She theorised that there are two different models of care. One she called the medical model, derived from "the technological orientation of modern, industrialised society" (p.24), in which the body is seen as a machine, which when pregnant or giving birth needs

treatment, medical management. The non-medical model she called the midwifery model, derived out of respect to midwives of earlier generations, and those of present time, who “have much to teach us about birth, babies, our bodies, and our lives” (p.25).

Naming ways of being safe

Katz Rothman joined a discourse of childbirth that was appearing elsewhere by those who also sought to critique the approach of the medical model (Oakley, 1980,1984; Oakley and Houd, 1990; Wagner, 1994). In her naming she placed the medical model against the midwifery model, and the midwifery model against the medical model. She dichotomised the meaning of being safe. Oakley and Houd (1990) paint a picture of this dichotomy. They describe the midwife who works by the medical model as “trapped by the idea of risk that is so close to the heart of the obstetrician; everywhere she looks, she is instructed to remember the possibility of death” (p.162). The midwife free to work by the midwifery model, on the other hand, takes the premise that “childbirth is about the possibility of life; it is about renewal, hope, growth, change, optimism, a vision of the future. The midwife is a defender and a protagonist of this vision” (p.162). Wagner (1994) suggests that the conflict between the fundamental beliefs of these two models goes back to ancient Greek philosophy, and is ingrained in current Western thought. The medical model is grounded in objectivity, logic, masculinity and emphasis on quantity, while the midwifery model, or, as he calls it, the ‘social’ model, draws its being from subjectivity, intuition, femininity and emphasis on quality (p.27). The medical model sees ‘health as a problem’, to which must be applied the power of science to create the necessary interventions (p.28). The midwifery/social model sees ‘health as a solution’. It sees its best strategy as relying on people to heal themselves. Medical care is acceptable in this model, but only if it employs the least intervention necessary. Care is about body, mind, spirit, the environment, and the structures of society which impinge on health (p.29).

The tensions of being safe

The tension of the meaning of being safe is apparent. On the one hand, it means the expert, with a scientific knowledge base, dictating safe care to a passive recipient. On

the other hand, it means the recipient being active in deciding for themselves whether or not, from their own perspective of what is normal, intervention is needed at all. Being safe therefore depends on one's personal perspective. The irony is that those who reject the medical model, still may need to access its expertise. Safe keeping, and safe making, may be found in both philosophical approaches, but at times of life and death, they are more likely to be found in the medical model approach. Those who bombard the medical model with scathing critique, still need to keep it within their reach. Sawicki (1991, p.70) criticises feminists who "demonise technologies and the men who design and implement them" suggesting that their "anti-technology stance sometimes lapses into utopian romantic appeals to a pre-modern era and is therefore not helpful to the majority of women facing decisions about childbirth". The relationship between the medical and midwifery models is one of tension, yet it is a tension that cannot afford to stretch itself to the point of separation for safe maternity care requires the beliefs, values and expertise of both models.

What matters most?

A recent Australian research project sought the views of midwives and obstetricians about what they considered to be important aspects of routine antenatal care (Haertsch, Campbell and Sanson-Fisher, 1996). When the midwives as a group were compared to the obstetricians as a group, it was found that while some things mattered equally to both of them, there were some contrasting views. For example, the midwives considered it much more important to give advice about a healthy diet, and about the use of drugs during pregnancy than the obstetricians. The obstetricians favoured a vaginal examination to check for uterine size at 12 weeks, and an ultrasound scan between 16-20 weeks, both of which had low scores from the midwives. In a list of components rated as 'very important' by 90% or more, the midwives included statements such as 'opportunity for women to express fears and concerns', and 'women should hold their own antenatal care record'. The obstetricians did not rate these so highly. In response to 'waiting times being no more than 15 minutes', 52% of midwives considered this 'very important', while only 13% of obstetricians did.

In an American study (Leppert, Partner and Thompson, 1996), women from disadvantaged neighbourhoods were asked what the things were that prevented them from seeking health care when they needed it. Their responses included the disinterest of the doctor, long waiting time to see the doctor, lack of respect from doctors, and denial of the privilege of seeing the same doctor at every appointment. They wished the doctor would talk to them for a longer period of time, and would take their problems more seriously. Is the meaning of 'being safe' to be found in 'what matters most'? If it is, how is it that the things that appear to matter to women, like waiting times, are fairly low on the list of the practitioners? Is it safer to have a service where the women feel respected, and genuinely cared for, and therefore make every effort to attend, or to have a service that is more focused on the safety needs of the practitioner (knowing the blood pressure, knowing the previous complications, knowing the blood tests, recording the details)? Who should determine 'what matters most?' Whose interests are served by 'being safe' and in what way? When a woman chooses not to attend her antenatal appointment, where does responsibility for the possible lack of safety lie?

Is being competent being safe?

An editorial in the British Journal of Midwifery addresses the question 'How do we know that midwives are competent to practice?' (Fraser, 1997, p.126). It seems that the real question the editor asks is 'how do we know the meaning of competence, and once we know it, how do we assess it?' Nagelsmith (1995) suggests the way to defining competence is to consider the antecedents to competence. She sees a need for identifying empirical data that illustrate competence, and for analysing the factors that lead to incompetence and ineffective functioning (p.247). Does it follow that if the person is incompetent, they are not 'being safe'? Worth-Butler, Murphy and Fraser (1994) question whether 'ensuring a safe practitioner' is "a necessary and sufficient basis for determining what it means to be a competent midwife" (p.226). In their review of literature they uncover several schools of thought on the meaning of competence. They conclude the article with their own view that "the most hopeful models of competence conceptualise competent professionals as people who have learned an adequate overarching set of skills and knowledge to do their job

satisfactorily. A capable professional then is someone who is able to draw on that repertoire of skills and knowledge in different ways in different contexts to perform in a way that is recognised as competent” (p.230). Do they consider that this is more than what is involved in ‘being safe’?

The Nursing Council of New Zealand has its own definition of safety in the glossary of the Code of Conduct of Nurses and Midwives (1995):

Safety refers to nursing or midwifery action to protect the client from danger and/or reduce risk to patient/client/community from hazards to health and wellbeing. It includes regard for the physical, mental, social, spiritual and cultural components of the patient/client and the environment.

Unsafe nursing or midwifery practice is any action or omission which endangers the wellbeing, demeans the person or disempowers the cultural identity of the patient/client (p.11).

This is an almost overwhelming definition. The midwife is charged with keeping the woman safe from anything that could go wrong, that could offend, that could take away her sense of control, that could leave her feeling less than satisfied about her body, her emotions, the response to her family, or to her spiritual and cultural beliefs and practices. The midwife is responsible both for what she does do, and what she neglects to do. This is about much more than being competent. This is perhaps more akin to saintliness.

Proving safe

The performance of a practitioner may be seen to be competent, but does that necessarily mean it is safe? In his address to the Pacific Coast Obstetric and Gynaecology Society, the President of the Society said “Societal, economic, and political demands are increasingly challenging our reliance on the truths that have been our pilots” (Forrest Boyd, 1996, p.1675). More and more it seems questions are being asked about ‘what is true’? Evidence-based care is becoming the paradigm of practice in today’s Western health care (Murphy, 1997, p.1). There is a challenge to assumptions of care, to knowing based on experience and to conventional clinical wisdom. There is a

call to midwives to “commit to the search for and collection of those data needed to provide scientifically sound evidence for what they do” while at the same time a recognition that evidence is “only part of what goes into making good clinical decisions” (p.3). Page (1996c) signals that this new paradigm brings with it new habits of thought and practice. For example, the available evidence needs to be shared with the client, shifting the authority away from the practitioner to the client in a way that may be difficult for practitioners to get used to. The new paradigm will ask them to share with women the uncertainties about the evidence that is available. It will require the skill of intelligent appraisal of evidence, while at the same time the ability to keep the individual’s concerns, values and clinical needs uppermost. Page assures us it is far from being recipe based care (p.192). Renfrew (1997, p.131) reminds us there are over two million articles published each year in the biomedical literature, placing the challenge of finding, and then critiquing, the evidence into perspective.

Practising from proof?

The obstetricians might well argue that their medical model is firmly established on the notion of scientific evidence as the truth of practice. Yet there are those who would question whether evidence has been the influence on practice one would expect it to be. In 1982, Arney reviewed the history of the use of episiotomy and found it had arisen largely from a belief that doing an episiotomy protected the baby from possible brain damage and served a woman’s sexual interests (p.70-71). Arney tells of a 1935 study done by Nugent. It was not a randomised controlled trial, but its conclusions were that there was “a substantial increase in morbidity attributable to episiotomy” (p.72). Little attention was given to these findings. Studies that were done tended to focus on different kinds of episiotomies, with the assumption that episiotomies were better for women (p.73). In 1996, Lede, Belizan and Carroli asked the question “Is routine use of episiotomy justified?” (p.1399). Their conclusion is that “there is no reliable evidence that the routine use of episiotomy has any beneficial effect; on the contrary there is clear evidence that it may cause harm” (p.1399). The question is ‘will this evidence change practice, or will practitioners still make their own judgements, based on their personal assumptions?’ Is ‘being safe’ about working from personal judgement based on

expertise? Is it also about examining one's own prejudices and assumptions in the new light brought by research evidence, with the willingness to change? When there is tension and difference between 'personal judgement of the expert practitioner' and 'research evidence', which advice is most likely to bring 'safe practice'?

What needs to be proved?

It is not only practitioners who need to make judgements about what is safe practice. Pradeepkumar, Tan and Ivy (1996) tell of a child diagnosed as having fetal alcohol syndrome. On investigation it was discovered that the only source of alcohol the mother had been exposed to was from a Herbal Health Tonic, which was found to contain 14% alcohol. With the best of intentions, this woman had taken it daily for the first two months of her pregnancy. This case broadens the awareness of the scope of evidence that needs to be uncovered, and the challenge of ensuring women have access to such information.

The meaning of 'being safe' surely has a relationship to the evidence about what has been scientifically demonstrated to be safe. Murphy (1997, p.2) challenges midwives to consider the evidence that supports the common advice they give women to take ginger tea for nausea and vomiting during pregnancy as possibly detrimental advice, citing a laboratory study that showed ginger to have the potential to affect the development of the fetal brain. Hotchin (1996) raises awareness of the assumptions New Zealand midwives in her study made about complementary therapies 'being safe'. On the other hand, other practitioners engage in research to determine the safety of what is commonly believed to be safe care. For example, Berghella, Rogers and Lescale (1996) conducted a randomised controlled trial specifically to assess the 'safety and effectiveness' of stripping membranes at term to reduce the incidence of prolonged pregnancies (p.927). It seems that we practice from a continuum with taken-for-granted practice at one end, and evidence based practice at the other. Is that a continuum of unknown safety to guaranteed safety? Or is the world of practice more complex than that?

The role of proof in keeping the practitioner safe

When the outcomes of the childbirth experience are deemed by parents to be unsatisfactory due to unsafe care, more and more of these parents are suing their doctor and/or midwife for malpractice (Ranjan, 1993; Symonds, 1993; Flint, 1997). A common focus of such a case is often the record of the fetal heart rate during labour. The evidence, however, that routine continuous electronic fetal monitoring produces safer outcomes is not convincing. Lumley (1983, p.150-151) states that from five randomised controlled trials conducted between 1976 and 1981, the use of continuous electronic fetal monitoring was not associated with a lower perinatal mortality, but did increase the caesarean section rate dramatically. In other words, it seems that the babies born during these trials were no more safe because they had been monitored in labour, while more of the women underwent caesarean section than if the monitoring had not been done. Wagner (1994) cites eight randomised controlled trials, still offering no evidence that fewer babies die if electronic fetal monitoring is used on all women during labour, yet suggesting that the practice of fetal monitoring continues as if those trials did not exist. No one has paid attention to the evidence that fetal monitoring not only achieves no gain, but brings increased harm to the women who suffer unnecessary caesarean section. Wagner estimated that 75% of American women were monitored continuously through labour, and were therefore at greater risk of intervention for falsely diagnosed fetal distress. Neilson (1994, p.103) suggests that one of the reasons why this practice has continued with such tenacity is because the records of the fetal heart “are carefully scrutinized and sometimes pivotal in expensive legal actions”. Wagner (1994, p.164) agrees that it is “difficult to defend the non-use of this machine to juries who are facing grieving parents and brain damaged children. Juries are easily convinced that the use of a monitor prevents death or disability”. Yet the effectiveness of monitoring lies in the judgement of the interpreter, and that in itself has been found to be widely varying even among expert groups, and even when the same person reviews the same trace after an interval of one month (Symonds, 1993, p.9).

What then is the proof of safe care? Is it that every possible measure has been taken, even if that measure may have made no difference, or even resulted in harm? Is proof

only ever to be found when the judgement pre-birth is validated by the outcome post-birth? Does that mean that even if expert practitioners all agreed the trace suggested the fetus was in good condition, if at birth the baby was found to be compromised, would they all be deemed to have been wrong? Would a person make an interpretation that they did not assume to be true? Who then ultimately decides truth? Is it fair that those who sit in judgement have the benefit of knowing the condition the baby was born in, which may bias their interpretation of a fetal heart trace? Is it safer for the practitioner to have proof, in a society that has come to expect them to have proof? Is the need for legal proof driving practice? Is fetal monitoring, as an example, more about keeping the practitioner safe than keeping the baby and woman safe?

The meaning of 'being safe' for the woman

Whatever strategies the practitioner may employ for their own ends, the woman has her own experience which may or may not feel safe. Berg, Lundgren, Hermansson and Wahlberg (1996) uncovered three themes of what mattered to women in their encounters with the midwives who had offered them care. These themes were 'to be seen as an individual', 'to have a trusting relationship', and 'to be supported and guided on one's own terms'. When this did not happen, the women talked about the midwife being "absently present"(p.14). Above all, the women described the need for her sense of 'presence'. Halldorsdottir and Karlsdottir (1996) uncovered similar findings in their research: the need for a sense of control, the need for caring and understanding, and the need for a sense of security. The ways in which women described 'feeling safe' were: being able to trust that the midwife would know if something was wrong, and know what to do, and to have explanations about what was happening. One woman described her sense of security in the words "she never deserted me" (p.54).

Is it because they were talking only of midwives that they focused so strongly on the interactional factors - the way they were treated, the way they felt about that treatment? Would they have had the same expectations about obstetricians? Would they perhaps expect a different sort of safe keeping from an obstetrician? A review of a study that revealed a risk-approach by obstetricians, and a 'normal event' approach by midwives,

suggested that differing viewpoints held by midwives and obstetricians “should serve to enhance care given to pregnant women, not detract from it” (Sommerville,1993). It may be that women expect obstetricians to be concerned about ‘risk’ and midwives to be concerned about ‘experience’. Are behaviours of ‘being safe’ socially constructed by all the players involved? Does the woman herself determine the role that her practitioner will play? Are expectations of women and practitioners made explicit, or simply assumed?

A comprehensive defining of safety

The 1993 Report of the Expert Maternity group outlines their review of the maternity services in England and Wales. Within the report the authors took on the responsibility of defining what they meant by safety. They became aware of the need to make a clear statement about their shared meaning of safety because they realised it was a complex area. They saw it as an underlying principle, stating: “No-one cares more about achieving a safe happy outcome to a pregnancy than the pregnant woman and her partner ... Professionals working in this area share this aim” (p.9). They quickly qualify this, however, by their observation that “the issue of safety may become an excuse for unnecessary interventions and technological surveillance” (p.9). Situations were mentioned where there was conflict about safety between the woman and professionals. Sometimes it was the professionals believing that the woman cared more about her own wellbeing than the health of her unborn child, and other times it was unsympathetic doctors and midwives who “used safety as a reason to try to impose arrangements or interventions which the mothers found unhelpful and disturbing” (p.10). They saw safety not as an absolute concept, but part of a greater picture related to the individuality of each situation. They talked of the need to enable each woman to understand the risks and benefits of care by giving clear, unbiased information. They concluded that safety, encompassing emotional and physical wellbeing, “must remain the foundation of good maternity care” (p.10). This group, in a government policy document, has removed the medical control of the definition of what is safe, and have opened it up to include the meaning for each particular woman. The meaning has been stripped of its hard, smooth surface to become open, contestable, flexible, with different possibilities of meaning for

different situations. Nevertheless, there is still the belief that at every encounter, the question 'is this safe?' still needs to be addressed. The difference is that the answer is now a responsibility shared between professionals and consumers.

A definition of meaning: from a fundamental perspective

There are those who would argue that there are some meanings of safe that are not contestable. They see aspects of childbirth that are sacrosanct, and must be respected at all cost. Stewart (1981) describes "*The Five Standards for Safe Childbearing*: (1) Good Nutrition; (2) Skilful Midwifery; (3) Natural Childbirth; (4) Birth at Home; and (5) Breastfeeding." (p.61). His opinion is that even when the childbirth process becomes complicated and these standards are no longer achievable, they should still be guiding standards, they should still be recognised as the standards of what is safe. It is easy to discount this book as emotive, and irrelevant to today's practice where more than 95% of women give birth in hospital, yet, I believe there are challenges in the book that need to be responded to. Stewart declares:

Because of the rampant overuse of technology upon healthy mothers, truly normal birth has all but ceased to exist in American Hospitals. It doesn't matter if an obstetrician has officiated at 10,000 hospital deliveries, unless he has witnessed a good home birth, and only stood by and watched, he has never seen a normal birth. He has no experience in true normality (p.25).

Do we give lip service to 'promoting the normal process' without truly appreciating the normal? What is the real difference between a home birth and a hospital birth? Can those differences be minimised? How often do doctors who will go on to become obstetricians get the opportunity to witness labour and birth in its untampered natural being? Why is it that despite a commitment to breast feeding, there is still professional doubt in a woman's ability to achieve this, evidenced by complementary feeds still being ordered and given in many postnatal wards, and by women themselves declaring they do not have enough milk? What attention is ever seriously paid to the woman's nutrition? Money is likely to be poured into a series of scans to monitor poor fetal growth, but would that same amount of money be invested into funding a nutritious diet? As science and technology have come to claim their power over understandings of

what are 'safe standards of maternity care' have we forgotten the things that matter most? Stewart tells us we have moved into a "bizarre 20th century experiment in childbirth (p.31)".

So how does the literature declare the meaning of being safe?

The literature pertaining to childbirth and the maternity services carries with it multiple voices and multiple meanings. No author puts fingers to computer keyboard without their own deeply held understandings of the meaning of 'being safe'. They are likely to be meanings shared by the people they associate with, people whose respect they wish to maintain. They are likely to be meanings that the writer perceives will keep them safe from attack, from ridicule, from any perception that their practice is 'unsafe'. The nature of this world however, is that there will be those readers who respond to the political opportunity to attack, scorn and voice concern about descriptions of 'being safe' that oppose and threaten their own.

Everyone wants to be safe. Everyone believes in their own understandings of what is safe. Everyone would say they have the best interests of the woman and her baby at heart. When we turn to the literature we come with our own understandings and beliefs, and there we meet other opinions, other interpretations of truth. It is our own responsibility to consider what the meaning of the other voice might be, to search the literature further to find other possible meanings, and to come to our own understandings of the meaning of 'being safe'. Perhaps its meaning lies in the interconnections of all possible meanings, in the converging conversations.

Women die in childbirth because the traditional birth attendant is not skilled.
No! They die because of war, famine, and oppression.

The mother and the fetus are both always at risk
and must be treated accordingly.
But don't you see that 'treating accordingly'
creates problems of its own?

'Being safe' is about the woman feeling safe, in her inner core
But what if while she is safe in the comfort of feelings
her unborn child is struggling for life?

The practitioner knows best, how to assess, how to plan and how to act.
But how well can they know every woman
and what matters, and will work, for her?

There is proof, there is evidence,
meta analysis of gold star randomised controlled trials
to show us the way to safe care.
But how do you know for sure
that the evidence is relevant to this woman
in this place and time, in this situation?

But, as practitioners, we must follow the rules to keep ourselves safe
Then who will keep the woman and her baby safe?

There are many loud voices,
challenging each other, opposing each other, undermining each other
declaring they alone are safe.
How then are we to decide what is truth?
How are we to know the meaning of 'being safe'?

CHAPTER FOUR: PHILOSOPHICAL APPROACH

Lawler (1998) suggests that in interpretive phenomenology there is a tendency for philosophy to overpower methodology. I argue that philosophy is so integral to both methodology and method that its 'power' is at the very heart of such a research study. Gadamer (1960/1975) clarifies the difference between method and philosophy as "what we do or what we ought to do [as against]...what happens to us over and above our wanting and doing" (p.xvi). What happens to us are our embodied understandings of 'being human' and 'doing research' which guide our thinking and our actions. Hermeneutics, or interpretive phenomenology, takes the stance of first making explicit what is guiding our thinking and doing, our wondering and questioning, our analysing and writing, for such influences will already be there in our method. When the researcher makes explicit the 'being' of the method, that is the underpinning philosophy, there is more possibility of a pervasive integrity and coherence. Just as the methodology seeks to uncover the everyday, taken for granted assumptions related to the phenomenon of interest, so the researcher must uncover the philosophical assumptions that permeate and direct methodology, method and outcomes. Philosophy, methodology and method are not three distinct and separate facets of the research process. They inform and are informed by each other in such a way that they become indistinguishably merged together. One can say 'this is philosophy' and 'this is method', but one cannot say how they are separate from each other.

What are the foundations of the philosophical underpinnings of this study?

The notions of Heidegger and Gadamer are the dwelling place of this study. Heidegger situates his understandings as "nothing but the questioning of Plato and Aristotle brought back to life: *the repetition, the retaking of the beginning of our scientific philosophy*" (1925/1985, p.136). It is a going back to the fundamental question of the ancient Greeks, asking again 'what is the meaning of being?' Gadamer tells us "no one before Heidegger thought back so far" (1985, p.53). Grondin (1995, p.9) suggests that "Heidegger represents the crucial juncture in the philosophical transition from metaphysics to hermeneutics". Metaphysics

represented a belief that the aim of philosophy was to “provide a universal, causal and logical account of Being” (p.10). Heidegger used the example of the statement “the hammer is heavy” to demonstrate the difference between metaphysics and hermeneutics. In metaphysical terms it is simply saying that the independent object, the hammer, has a property of heaviness. In other words, it would be perceived as heavy for all people at all times and in all ways. It is a truth in its own right. Hermeneutics, however, listens not simply to the statement, but to the neglected meaning of the sayer of the statement. It suggests “one has to develop an ear for *Dasein*. The statement ‘the hammer is heavy’ could then mean something like: ‘I can’t take anymore’, ‘please help me out’, ‘please take over’, ‘lets have a break’” (p.12). Heidegger opened the way for hearing the possibilities of meaning lying within and behind the words. Gadamer followed on from him, claiming that we can only understand if we take into consideration “the unsaid side of our statements, what hopes to be heard in our utterances even if it cannot be said” (p.13). It was a move from language being understood in simply its logical, dictionary sense of meaning, to a sense of dialogical understanding.

How has my own horizon of understanding been influenced?

Lawler (1998) states that we have many possible positions as researchers which have “social, personal and contextually defined facets” (p.110). Let me, therefore, describe the position that I have come from related to the philosophical underpinnings of this thesis. In 1988 I attended a workshop in New Zealand led by Patricia Benner. She opened up for me the idea that we could find new meaning about our practice by telling, and listening to, the stories of practice, and in a powerful way shared with us the stories and understandings from her own research (Benner, 1994). In 1986 I had written a paper exploring the meanings within poetry that I believed brought a rich gift of understanding to inform practice (Smythe, 1987). I was open to valuing the meaning within narrative. When it came time to choose my own research methodology, my teacher was herself a phenomenologist. When I read her thesis (Madjar, 1991) it “was like a shining light that said ‘this is something worth doing’” (Smythe, Spence, and Gasquoine, 1995, p.182). It led me to explore the writings of early nurse phenomenologists (Omery, 1983; Knaack,

1984; Oiler, 1986). I came to understand that there were different opinions about what phenomenology is, and different truths about how it should be done. It was for me to find my own way forward, which ultimately meant finding my way back to Heidegger and Gadamer. Van Manen has had an important influence on my work, both through his writing and his workshop. I have turned to his own students in the writings in *Textorium* (van Manen, 1995) and Bergum (1989) to develop my feel for phenomenology. I have been provoked by the writing of Crotty (1996) who voices a harsh critique of that which is claimed to be 'phenomenology' by nurse scholars. His call is to seek out the 'phenomenon' rather than staying trapped within the subjective experiences. I have been freed by a conversation with Pearson (1996) who suggested it is appropriate to find and develop one's own methodology, acknowledging the philosophies that have informed it. I have been greatly inspired by the workshops of Nancy and John Diekelmann (1996, 1997) giving me a time of dwelling with the thoughts of Heidegger, and showing me how those thoughts could help me understand my own data in a new light. I have come to distinguish Heidegger's philosophy from the originating notions of Husserl. Cohen describes the important constant of 'radicalism' throughout Husserl's work, of "going to the 'roots' or 'beginnings' of all knowledge - to its ultimate foundations" (Cohen, 1987, p.32). I accept that Husserl's famous appeal "To the things" (p.32) rather than to theoretical abstractions, lies at the heart of phenomenology. I see the divergence of Heidegger in regards to the notion of 'bracketing' where Husserl decrees one must suspend all that one already knows and believes about the focus of the study. I stand with Heidegger in my experience that it is impossible to be a detached observer of the world, for one is always a part of that same world. The key philosophical works that I have strived to come to understand are Heidegger's *Being and Time* (1927/1962), and Gadamer's *Truth and Method* (1960/1982).

THE UNDERSTANDINGS I HAVE COME TO

What is a phenomenon?

A phenomenon is "that which shows itself in itself" (Heidegger, 1927/1962, p.51). Heidegger cautions however that "it is possible for an entity to show itself as something which in itself it is not" [semblance] (p.51), and further, it is possible for

something to indicate something which does not show itself [appearance] (p.52). He goes on to ask the question "what is it that phenomenology is to 'let us see'?" (p.59) and tells us it is to see that which normally we do not see, because it lies hidden, that which stands in front of our eyes and we cannot see. It is to understand at the same time that what we do see may not represent what we think it represents, or may only partly represent it. He goes on to explain that it is the combination of 'the hidden', the 'covered up', and the 'in disguise' that is the 'Being' of entities. "Phenomenology is the science of the Being of entities - ontology" (p.61). Heidegger cautions us "that it is one thing to give a report in which we tell about 'entities', but another to grasp 'entities' in their 'Being' " (p.63), that is, to let entities such as 'being safe' show themselves as themselves.

What does this mean for my study? It means that I make the assumption that the meaning of safety in the maternity services is likely to be mostly hidden. It cautions me that what is said 'to be safe' may not 'be safe' at all. It awakens me to look for the meaning of safe in itself, in the experiences of the people, rather than to seek it as one would seek knowledge through controlling, testing, asking and answering questions towards the aim of developing knowledge.

What is the meaning of 'being'?

The foundation of Heidegger's thinking rests on the question "what is the meaning of 'being'?" In *The History of the Concept of Time*, Heidegger tells us: "We ('Anyone') do not know what 'being' means, and yet the expression is in some sense understandable to each of us" (1925/1985, p.143). In his *Introduction to Metaphysics* (1935/1987) he asserts that to disclose the meaning of 'being' we must unlock "what forgetfulness of being closes and hides" (p.21). Being is a phenomenon, and in the nature of phenomena it conceals itself and disguises itself. He tells us that we encounter 'the essent' [the things that are] everywhere; "it sustains and drives us, enchants and fills us, elevates and disappoints us; but with all this, where is, and wherein consists the being of the essent?" (p.31). It is the paradox of knowing something is there because we feel it, experience it, live with it, yet at the same time we struggle to show 'what is'. Heidegger says "when we wish to apprehend being, it

is always as though we were reaching into the void” (p.35). His quest is to recapture both the emptiness and the fullness of the word “being” (p.51). Being simply ‘is’. It is the here and now. It cannot be taken away, or added to. It is complete in itself. It is uniquely itself, and only itself. Stenier tells us that “To inquire into Being is not to ask: What is *this* or *that*? It is to ask: What is ‘is’?” (1989, p.153). Heidegger explains the nature of the ‘is’ of being as found in the following set of notions. Being is already there ‘over against’ becoming. Being is already there ‘over against’ the mere appearance of something. Being is already there ‘over against’ thought. Being is already there ‘over against’ what we think we ‘ought’ to do or to be (1935/1957, p.202). Being ‘is’, and always takes precedence over against everything else. All this, Heidegger suggests is about our humanity. In seeking to understand ‘being’ we seek to open up what it means to be human (p.204). This understanding of ‘being’ begins the journey of data analysis in Chapter Six.

What is the meaning of ‘being there’?

“Complexly intertwined” (1935/1957, p.204) is the notion of our ‘being there’. Heidegger discusses the concept of ‘Being-in-the-world’ (*Dasein*). Steiner (1989) interprets the meaning of *Dasein* as “to be there ...and ‘there’ is the world: the concrete, literal, actual daily world ... It is here and now and everywhere around us. We are in it. Totally. (How could we be anywhere else?)” (p.83). Gelven (1970) suggests that what Heidegger meant by the term *Dasein* is “that entity which is capable of inquiring into its own Being, and indeed, such an inquiry into its Being is what makes *Dasein* what it is. ... The whole point about *Dasein* is that it itself can wonder about itself as existing.” (p.23). King (1964) offers her understanding of Heidegger’s use of the term *Dasein* to indicate that “man can never be merely a case or a sample of the species *man*, because what makes it possible for him to exist is not his species, but his understanding of himself in his being...The fundamental characteristics of man’s being are not properties and qualities, but ways in which it is possible for him to be” (p.66). Our being-there, or Being-in-the-world, is more than our being, yet it is our being, for we are always in the world. It places us in context, with people, with things, with atmospheres, with political tensions, with sights and smells, with everything that is within our awareness. Heidegger

(1927/1962) reminds us that “we already live in an understanding of Being and that the meaning of Being is still veiled in darkness” (p.23). We already understand the world that encompasses us in any situation, yet the meaning of Being in the everydayness of here-and-now is still veiled in darkness. We understand, yet do not understand all that there is still to be understood. This is the challenge of an interpretive phenomenological approach. It is not enough to stay focused on the research question, for the answers to that question are inextricably intertwined with so many other influences. It means that when the participant begins to tell a story, it is important to let the story unfold with all the details deemed relevant by the person telling it. It means that in the process of data analysis the meaning must be looked for in the interconnections, the influences, the moods, the cacophony of voices. It means that the darkness, the ‘being’ that is not yet talked about or understood, must be remembered to draw one back from any sense of certainty.

Where is meaning found?

All this, Heidegger tells us, is to be considered "within the horizon of average everydayness - the kind of Being which is closest to *Dasein*" (p.94). Gelven (1970) explains ‘everydayness’ as a descriptive term that means “that uncritical mode of daily life which is lived even by the most profound of men” (p.30) recognising it as one of the most frequent modes of our existence. To me this means that to understand the meaning of being safe, I seek out the understandings from ‘everyday’ practice and experience. Heidegger explicates his meaning of ‘everydayness’ further in telling us it is the “‘how’ in accordance with which *Dasein* ‘lives unto the day’” (p.422), and “to this ‘how’ belongs further the comfortableness of the accustomed” (p.422). We know everydayness because it is part of everyday, it is our way of being. “In everydayness everything is all one and the same, but whatever the day may bring is taken as diversification” (p.422). The bringing of the day, is the bringing of time to everydayness. Yesterday, today and tomorrow all lie within everydayness. Time, or temporality, is what Heidegger means by the term ‘everydayness’. It is not the sum of the days, or the calendar of days, it is the ‘how’ of the days by which our Being-in-the-world is dominated.

Benner talks of seeking “narrative accounts of everyday skilful comportment [to] allow participants to describe their everyday concerns and practical knowledge, thereby giving access to practical worlds” (1994, p.112). By this means, she suggests that “interpretive phenomenology holds promise for making practical [everyday] knowledge visible, making the knack, tact, craft, and clinical knowledge inherent in expert human practices more accessible” (p.124). Interpretive phenomenological research enables everyday experiences to be uncovered to expose the meaning that lies within them. It goes far beyond what appears at first glance. It brings to light what we take for granted because we are so familiar with its presence. Many of the stories, and the conversations of this study are about the sort of experiences that are part of the everyday. I did not deliberately seek the stories that stood out as being extraordinary, rather I sought to hear the stories that any woman or any practitioner might relate to as being similar to their own experiences.

What is the meaning of ‘being-with-one-another’?

Heidegger (1927/1962) goes on to address the reality of 'Being-with-one-another' and describes his perception of the 'dictatorship of they'. He describes the 'they' as something of a measuring stick by which we determine our own actions and thoughts. If 'they think so', then we agree. If 'they do it a certain way', we follow their example. If we were asked to tell you who 'they' were, we would find that difficult, for 'they' are no one person in particular, yet we still bow to the sense of 'authority' that we perceive 'they' exert. In other words the opinions of the day, the 'right way of doing things', and the desire to be both accepted and acceptable, all colour our own Being-in-the-world.

This is particularly relevant to the notion of being safe in the maternity services. It suggests that practitioners are likely to have a sense of what they believe 'they' think being safe means. Women also are likely to have perceptions of what 'they', the maternity services, expect of them, and in turn what service they can expect to receive. It is as though the phenomenon of 'being safe' has a meaning that is decided upon and made known by the anonymous but all powerful 'they'. In other words, there are likely to be shared understandings between individuals that arise from their

understanding of what 'they' say being safe is about. It is expected that what 'they' say about 'being safe' will be apparent both in the data from the participants, and in the literature related to the maternity services. It may not ever be said directly, but its implications will be there.

How do we understand?

Understanding can be described further. It may be projected (being-towards-possibilities) into 'interpretation'. "In interpretation understanding does not become something different. It becomes itself" (1927/1962, p.188). Heidegger points out that in every case this interpretation is "grounded in something we have in advance" (p.191). What we have in advance is what has come to us at an earlier time. Time is described as the standpoint of human Being-in-the-world. It is "the horizon for all understanding of being and for any way of interpreting it" (p.39). The past of our understanding of being does not trail along behind our understandings but rather is "something which already goes ahead of it" (p.41). Heidegger therefore, believes that in working out the question of Being we must first come to understand it in its "temporality and historicity" (p.42).

That means, to understand the experience for practitioners and for women within the maternity services, I need to first look back before I can look ahead into the present. I need to come to understand the traditions that have influenced notions of being safe. I need to uncover the attitudes and values, the commitment and the cost. I need to consider the participants in terms of their place in time. I need to go beyond the self-evident notions to uncover the layers upon layers that understanding rests upon. I have, though, put limits on my 'going back' and have stayed within the colonial history of childbirth in New Zealand (see Chapter Three).

What is truth?

Ambiguity is a very real part of being-in-the-world. So what can be taken as truth? Heidegger's definition of truth is in terms of 'being-true' which must be understood in terms of "being uncovering" (1927/1962, p.261). It implies a sense of process. As each layer is peeled back to uncover a new sense of understanding, a new layer is

revealed which in its turn needs to be peeled back, and so it goes on. The notion of the understanding 'being true' is in the uncovering, not in the objective, uncovered 'fact'. This uncovering guides the review of literature. It looks for 'possibilities of being the truth' rather than 'the truth'. It guides the interpretation of the data, recognising that meaning lies hidden between the layers of meaning, and that analysis simply achieves the possibility of coming closer to 'truth'.

Adding the philosophical thoughts of Gadamer

Evidence of the influence and teaching of Heidegger on Gadamer becomes clear in such statements as "understanding belongs to the being of that which is understood" (Gadamer, 1965/1982, p.xix). It is sometimes difficult to decide whether Gadamer is saying something new, or whether he is simply articulating the notions of Heidegger in a way that makes their meaning clearer. He places emphasis on the need "to be open to what is other" (p.17). In other words, you do not go in search of agreement for your own opinions and understandings, but rather value those that differ from your own, for it is in the understanding that lies between 'own and other' that new insights will emerge. The first step towards this goal is to become aware of the understandings you the interpreter already carry with you, to identify your own bias or prejudice. Having done that, "a person trying to understand a text is prepared for it to tell him something ...[they are] sensitive to the text's quality of newness" (p.238). Gadamer points to Heidegger's similar message of "deriving our fore-having, fore-sight and fore-conceptions from the things themselves" (p.239). In further clarifying this notion of 'historically effected consciousness', he reminds us that "the recognition that all understanding inevitably involves some prejudice gives the hermeneutical problem its real thrust" (p.239). My understanding then of 'doing hermeneutical interpretation' is that I need to try and uncover my own prejudices and biases about what 'being safe' means to me as a midwife, and what I think it might mean to my colleagues, and the women who seek care from the maternity services. Only if I am able to overcome my own prejudices will I be able to make my interpretation "in the spirit of the writer [or participant]" (p.159).

What is prejudice?

Gadamer goes on to clarify the meaning of the word 'prejudice': "prejudice means a judgment that is given before all the elements that determine a situation have been finally examined" (p.240). He distinguishes two kinds of prejudice: that "due to human authority and that due to over-hastiness"(p.241). In other words, I may think I know what 'being safe' means but may have been over-hasty in stopping at understandings that have not been properly examined, or I might think I know what it means because an authoritative source has assured me of a meaning. Gadamer cautions us that "It is not altogether easy to realise that what is written down can be untrue" (p.241). I have been educated as a midwife in a generation that took its truth from text books and people in authority. I need to be open to possibilities that what I have for a long time believed and acted upon as truth may not be so.

How do we 'interpret?'

The process of interpretation described by Gadamer is one of discipline. He talks of "being on guard against arbitrary fancies" (p.236). He decrees one must "keep one's gaze fixed on the thing throughout all distractions" (p.236) suggesting that distractions will come from the person themselves. When talking of letting such things as "imperceptible habits of thought" (p.236) take over, he describes guarding against them as "the first, last, and constant task" (p.236). In other words, the interpreter cannot empty their head of all that they understand and put it aside so it will not contaminate or influence their reading of the other text. It is an on-going challenge for our understanding stays within us and pervades our thinking in an imperceptible way. Our understanding is within our tradition. Gadamer says "we stand always within tradition ... it is always part of us" (p.250). Not only is it "a precondition into which we come, but we produce it ourselves, inasmuch as we understand, participate in the evolution of tradition and hence further determine it ourselves" (p.261). It is likely that the other will share common understandings from traditions that are shared. Gadamer describes the tension of the place between strangeness and familiarity, between what we understand and what is new. This, he says, is the true home of hermeneutics (p.263). I needed, therefore, to always be open to the possibility that I was making inaccurate or contaminated interpretations,

and to question myself about my own assumptions about the meaning of 'being safe' in childbirth. In Chapter Five I go on to describe the tension of the method.

How do interpretations differ?

Gadamer identifies the ability of the interpreter to do something other than uncover the understanding that the author understood for themselves. The interpreter does not necessarily attain a 'superior understanding' but may understand in a different way (p.264). Thus my interpretations of the experience of the participant may be different from their own. It does not mean that one is right and the other wrong. They are simply different. That helped me to understand that it was not necessary for each participant to be given the opportunity to agree with the interpretations of this study, for my interpretations were always from an understanding that was different from their own. My interpretation, therefore, does not take on a mantle of 'truth', it is simply my interpretation. The discovery of true meaning "is never finished; it is in fact an infinite process" (p.265).

What are our horizons?

Drawing from Heidegger's notion of horizons of "future, present, and having been" (1927/1962, p.416), Gadamer's philosophy explicates further the notion of 'horizons'. A horizon is "the range of vision that includes everything that can be seen from a particular vantage point" (p.269). The person who does not have a horizon is said to not see beyond that which is nearest to them. In contrast, the person who has a horizon knows and values both what is "near and far, great or small" (p.269). When we see the past not in terms of the history books, but in terms of our own being, then we have established our historical horizon. In keeping with the notions of temporality Gadamer informs us that our horizon is both something into which we move and which moves with us. It is always in motion. It is through our historical consciousness that the motion becomes aware of itself (p.271). Furthermore, there is this on-going tension between past and present. When the two unite in a fusion of horizons, this conscious act is termed "effective-historical consciousness" (p.274). This is the act of achieving understanding. In the writing of this thesis I have been deliberate in making my horizons related to childbirth and to

interpretive phenomenology explicit. I have situated myself in terms of who I am, what my professional roles have involved, and what the philosophical influences on my journey of writing this thesis have been. The purpose is to enable the reader to recognise the influences and assumptions that are within this work, just as they are in every piece of work.

How do we ask hermeneutical questions?

A central tenet that arises from Gadamer's stand on 'openness' is that the openness that is part of an experience "has the structure of a question"(p.325). He talks of questions needing to have "sense" (p.326) that is, to have direction and to have perspective. In this manner they will open up the being of an object. He reminds us that "in order to be able to ask, one must want to know, which involves knowing what one does not know" (p.326). Openness is not an easy achievement. In asking a question we may imply openness, but at the same time we bring with us our own presuppositions which limit the horizon of the question. A question is false when it pretends openness, but "inhibits it by holding on to false supposition" (p.327). A question is distorted when there is an intended openness but it has moved away from the right direction. Open questions will remain open to "both negative and positive judgments" (p.328). The challenge that Gadamer leaves with us is that "the deciding of the question is the way to knowledge" (p.328). At the same time, he reminds us "every sudden idea has the structure of a question" (p.329) suggesting that we do not raise a question for ourselves but that it " 'comes' to us, that it 'arises' or 'presents itself' " (p.329). Again we sense the process of engagement and involvement that is at the heart of Gadamerian hermeneutics. It is more an act of submitting oneself to openness, and awaiting the questions that will emerge. Heidegger also acclaims the importance of questions. He says: "it is this questioning that moves us into the open, provided that in questioning it transform itself (which all true questioning does), and cast a new space over everything and into everything" (1935/1987, p.29-30). Therein lies the quest 'to cast a new space of understanding', a space where understanding is able to take on new meaning, new insights, new concerns. Many questions emerge from this study. Many point to the possibilities of a new space of understanding, for the understanding itself has not yet emerged.

How do we interpret text?

Gadamer moves on to relate 'understandings' to the relationship between interpreter and text. He tells us "a person who seeks to understand must question what lies behind what is said. He must understand it as an answer to a question" (p.333). It is the work of the interpreter to retrace, and reconstruct the question from which the text arose. Such a journey takes us into the historical past of the author. Gadamer suggests "we understand only when we understand the question to which something is the answer" (p.337). Asking such questions "opens up possibilities of meaning and thus what is meaningful passes into one's own understanding" (p.338). Questions however must themselves be considered in relation to their "questionableness" (p.337), they too must remain open to the many possibilities that exist. It is through such interpretation that Gadamer is able to say that "all understanding is always more than the mere recreation of someone else's meaning" (p.338). When the interpreter has before him the text of another, they are not able to engage in a conversational process of question and answer. The challenge before them however is the same. They must question the text, and listen to its answers. Gadamer calls this kind of understanding "making the text speak" (p.340). By bringing their own effective historical consciousness to bear with the horizon presented by the author, there is "mediation between the text and its interpreter" (p.340). Gadamer refers to this as the "fusion of the horizons of understanding" (p.340).

How can this disciplined and seemingly complex consciousness be brought to the interpretation of the texts of the participants of research? Hermeneutics begins with an awareness that there is much more to interpretation than the re-telling of what has been said. It reinforces the quest for openness. It validates understanding that arises from the questions of the researcher as being possibilities of understanding. It enables a relationship that has moved beyond that of researcher and participant, to that of researcher and text. It enables any other text that offers meaning to the study to be approached in the same way.

Who does understanding belong to?

Gadamer explains that the nature of understanding of what a person says is “to agree about the object [or the phenomenon], not to get inside another person and relive his experience” (p.345). He stresses the place of understanding is on what the other person says, not on understanding the person. When you understand the opinions of the other person, you then bring them back to your own views (p.347). In other words, you are not listening to their opinion in a detached, objective manner in order to judge it as right or wrong, good or bad. You are rather grasping an understanding of what they mean which you then bring back to your own meaning to examine the tension between the differences. The understanding that emerges is therefore very much the understanding of the interpreter. It is not a representation of the opinion of the other person.

Gadamer’s philosophical approach has a strong message to bring to the interpretation of my study. It makes no pretence to be anything other than my interpretation, for it believes the uncovering of my possibilities of meaning is likely to provoke others to recognise their own possibilities of meaning. It takes away the need to take interpretations back to participants for validation, for it understands and accepts that they may not, and indeed need not, be the same interpretations of the people who told the stories. This does not mean that I consider my interpretations to be better than their own, simply that I am the person making this journey of interpretation.

How does language relate to meaning?

Underpinning hermeneutics is Gadamer’s notion that “every conversation presupposes a common language, or, it creates a common language” (p.341). Language is what allows an object to “come into words” (p.350). It belongs to the process of understanding (p.351). Meaning is held by us all within a “linguistic tradition” (p.352). The way in which something presents itself to us, through language, is “part of its own being” (p.432). Language gives the “freedom of ‘the speaking of oneself’ ... [and of] ‘allowing oneself to be spoken’ ” (p.498). It is a “generative and creative power” (p.498). In hermeneutical interpretation language is

much more than mere words. It is the very being of understanding. It has a power and a creativity of its own. It is bound up with our traditions and our present. We share language with one another in a manner that may or may not be effective. Language is what this thesis is. Without language there would be no research study, no shared understanding of 'being safe', no written words to present to you as text. At the same time we need to remember that language is always open to question. When a participant uses words to describe meaning, I may take from those words a meaning of my own, and you the reader may see yet another meaning. The words have a dynamic quality that takes them beyond the intent of the speaker or writer. Words can both give and take away meaning, and can never be treated as objective entities.

What is the role of 'words on paper'?

Gadamer specifically addresses the nature of the written word. He describes it as "a kind of alienated speech" (p.354) which needs to be translated back to speech and meaning by the reader. He describes the art of hermeneutic writing as "writing in such a way that the thoughts of the reader are stimulated and held in productive movement" (p.355). Thus the words on paper are not an end in themselves but rather a link between the understanding of the writer, passed on to the understanding of the reader. This confirms my style of writing that directly speaks to you the reader, and I expect that you will become involved in your own process of interpretation. It takes away any assumption that what is written are words set in concrete that are an end in themselves.

The words on paper that represent the data of the participants comes from a historical horizon where the words of speech are captured by means of a tape recorder, with the assumption that the only true meaning of those words lies in their exact representation through the process of transcription. Gadamer's concept of 'alienation' seems to be particularly relevant in describing the meaning that is disrupted by the irrelevant talking within conversations. I therefore accept the methodology of van Manen, which is based on the belief that "text succeeds when it lets us see that which shines through, that which tends to hide itself" (1990, p.130).

When I take the transcribed text, my responsibility is not to reproduce its pedantic word by word correctness, but rather to offer to you, the reader, the meaning that shines through. That understanding has guided my re-working of the words from the transcript to bring them together in a manner that most clearly shows their meaning.

How is thinking evoked?

The final notion that I bring from Gadamer is about 'evoking thought'. Thinking is the experience of letting the words, and the suggested interpretations, meet with the understandings from your own horizon, and in so doing, allowing you to be open to exploring the differences, and the emerging possibilities of meaning. The person who owned the copy of Gadamer's *Truth and Method* before me adds to the dynamic quality of text by penciling a heavy wavy line and a question mark beside the following statement:

Interpretive concepts are not, as such, thematic in understanding. Rather it is their nature to disappear behind what they bring, in interpretation, into speech. Paradoxically, an interpretation is right when it is capable of disappearing in this way. And yet it is true at the same time that it must be expressed as something that is intended to disappear (p.359).

What might the notion of 'an interpretation that is capable of disappearing' mean? How might one go about making an interpretation disappear? How would one see in the writing of another that an interpretation was there but not seen? My understanding is that the reading of my thesis will not be that of perusing neat and tidy lists of themes, each of which is defined, and under which are given examples to validate the meaning. You will not be able to turn to any one page and say 'here is the summary of all of the understanding'. It is my hope that you will come to the end of your reading with the feeling that your mind has been opened to a rich feast of fresh interpretations, yet if you were to go back to find each of these fresh interpretations of yours you might have the sense of them 'not being there to find'. In this Gadamerian notion, their very success is in their disappearance. It is a paradox. I am not even sure of the process by which it will happen, but I have a sense of its 'happening'.

What is the hermeneutic circle?

I talk of you coming to the end of the whole, having been offered part upon part upon part. Wherein is the meaning? Is it with the sense you take away with you at the end? Is it with a specific example of particular meaning? Do you understand that particular meaning in a new way once you have understood the whole? Can you see the whole more clearly by examining again that one example? Within this philosophical approach, the answer is that the meaning lies in both the parts and the whole, each informing the other, each finding new meaning from the other. It is described as the Hermeneutic Circle. This is a term chosen originally by Schleiermacher to represent the 'art of understanding', carried through into the work of Dilthey and Heidegger, and brought to the fore of philosophical hermeneutics by Gadamer (Annells, 1996, p.707). The hermeneutic circle, as in this study, has no beginning and no end. It takes on the spirit of movement and flux. Each understanding is taken back to all previous understandings, and moves forward to all new understandings. No one understanding stays static or fixed. All are open to growth and change.

The political challenge to meaning

The writings of Heidegger, which underpin Gadamer's work, and many others, have been called to question because Heidegger was deeply involved in the world of philosophy and teaching in Germany during the rise of the National Socialist (Nazi) party. It is, therefore, necessary to explore the validity of the calls to avoid his work.

Heidegger is described by Holmes as one who "enthusiastically embraced the process of nazification, militarizing student life, shunning former friends because of their racial or political affiliations, denouncing Jewish and Marxist colleagues, and actively making life difficult for Jewish students" (p.580). Bemstein quotes Rorty who called Heidegger "a rather nasty piece of work - a coward and a liar" (1991, p.81) yet who claims that there is no correlation between Heidegger's philosophy and his moral character. Rorty's suggestion was that we should read Heidegger's works "as he would have not wished them to be read: in a cool hour, with curiosity, and an open tolerant mind" (p.82). Others, such as Adorno believe Heidegger's

philosophy is “fascist right down to its innermost components” (Bernstein, p.81). Gadamer, however, defended Heidegger’s “philosophic originality and profundity” (p.134) and saw him simply as a man caught up in a dream of “a new human religion” that ended in “a ruined revolution” (Bernstein, p.134). Young (1997), after a thorough exploration of both Heidegger’s writings and his involvement with Nazism, comes to the acceptance that while there is no denying the depth or seriousness of Heidegger’s involvement, that as a body of philosophy it is “free from the taint of Nazism”. The sin that critics lay at Heidegger’s feet is that once the war was over in 1945, and the atrocities of the Nazis were revealed, Heidegger made no attempt to defend himself; he remained silent. Bernstein replies “It is ‘correct’ to say that Heidegger was virtually silent about Nazi atrocities, and his responsibility in supporting the ‘movement’ of National Socialism. But this is not the *truth*” (p.136). What then is the truth about Heidegger? Bernstein warns that there is a danger in his late essays that “we become so mesmerized by his strange idiom that we lose any critical distance in understanding what he is saying and doing” (p.96). Yet, he then tells us that Heidegger “seeks to disrupt and dis-turb our common patterns of understanding in order to call forth a thinking and questioning of what we ‘normally’ do not question” (p.99). Can you be both mesmerized, and actively involved in thinking new questions at the same time? Does the writing of Heidegger somehow cast a spell around you, that makes you a submissive receptacle for all his own personal beliefs and values? If it does, why then do his thoughts always evoke new thoughts? Why do his ideas make sense of being-in-a-non-fascist-world? Why do some describe his work to be “positively theistic in its import and of great value for religion?” (although it is acknowledged that some do not) (Reynold, 1977, p.2).

Nancy Diekelmann, a strong advocate of the philosophy of Heidegger within nursing suggests that the valuable legacy the debate on Heidegger leaves us with is the question “where is the fascism in our own work?” (Workshop, 1996). Fascism is described as outright opposition to the values of “liberty, equality, democracy and socialism” with the belief that “the supreme human values can only be realized in war” (Mann, 1983, p.128). The question then is not “was Heidegger a fascist?” to

which any answer rests on supposition of the meaning of his silence; it is rather “has Heidegger influenced me in any way that could lead me to fascist beliefs and behaviours?” My experience has been to the contrary. His writings have led me to be more open to the meaning of others, to consider more possibilities of truth, to respect the understandings of others that emerge from their own unique Being-in-the-world, to become aware of the influence of the unseen ‘they’ on my thinking, to take ‘concern’ as the guide of authentic being. I respect those such as Holmes who challenge the wisdom of drawing from the philosophy of a man whose values are questionable, but I suggest ‘to be questionable’ is the approach that should be taken to whatever we introduce to our own understandings. It means the questions live with me, they are part of my being. My own thoughts are always open to my own scrutiny.

Gadamer tells us that Heidegger never lacked for enemies and still does not. He goes on:

Even a person who knows nothing of Heidegger can hardly let his eye wander away indifferently when he looks at photographs of this lonely old man, seeing him peering into himself, listening to himself, reflecting beyond himself. And one who takes himself to be ‘against’ Heidegger, or for that matter ‘for’ Heidegger makes himself ridiculous, for this is not the way to get around a mode of thinking” (1985, p.46).

There is a picture in this same book of Gadamer and Heidegger at each end of a saw, sawing together the trunk of a tree. It places them in connection with each other, in the everyday world. They have achieved a rhythm together, they work at a common task, they lend strength to each other, they speak the message that it is only by hard work that what lies inside will be revealed. I take the modes of thinking they have offered to the world of scholarship and with them begin to saw into my own log of wood.

Being is already
 To ignore it
 is to forget what matters most
 To disregard it
 is to fool oneself into a false sense of self
 To hide from it
 is to find oneself in its very midst

To understand being
 is to recognise what is not
 to question what might be
 and to uncover what it is in itself

Being is always within the world
 it always goes ahead of us
 it is always there waiting for us

It is revealed, and concealed, in our language,
 in their words and in our words.
 What lies behind the words?
 How are those words?
 Are they happy or sad, tired or enthused?
 Do they tell what is
 or do they disguise?
 Is there more that lies beneath
 slumbering?

Who is right -you or me?
 I understand from where I stand
 and you understand from what you can see
 Through the understandings of each other we can see further
 we can ask new questions
 we can consider other possibilities
 we can uncover what lies in the darkness

The phenomenon
 lies in the darkness of the light,
 and in the brilliance of the dark.
 It is
 but it is hidden, disguised, taken for granted, not seen.
 Together we can look for revealings, ask questions,
 ponder, question again,
 dwell in our wonderings
 Together we can bring light to the darkness.

CHAPTER FIVE: THE HAPPENING OF THIS STUDY

The coming together of philosophy and method

Heidegger (1927/1962) declares that interpretive phenomenology is a methodological approach in itself. That is, the knowing and doing of interpretive phenomenology is the being-in-the-world of the research journey. He sees that the genuine will be found by the questions: “how primordially is it rooted in the way we come to terms with the things themselves?”; how far is it “removed from what we call ‘technical devices’?” (p.50). My understanding of ‘primordial’ is that the thoughts emerge directly from the experience itself. Once we start bringing rules, strategies and pre-defined ways-of-doing, we introduce technical devices that take away from what is genuine. Therefore, to talk of method in conversation with Heidegger is not to talk of a set of prescribed steps, but to uncover the understandings that are within the heart, within the knowing, within the thinking, within the doing, within the happening.

Gadamer (1960/1982) uncovers his understanding of Being as method through his exploration of the notion of play. He tells us that “play fulfils its purpose only if the player loses himself in his play” (p.92). Thus interpretive research fulfils its purpose only if the researcher loses themselves in their researching. Losing does not mean ‘becoming lost’, but rather being so engaged in the experience of the research that the experience has primacy over the consciousness of the researcher. Gadamer states “it becomes an experience changing the person experiencing it” (p.92). The notion of a hermeneutic researcher setting out step-by-step logical plans, and following them with exactitude is therefore a nonsense. The researcher rather engages in the play of being a researcher and becomes so engrossed in the play that they become lost to the play. The play, or the research takes on a happening process of its own. The researcher responds to the process as it happens around them. This does not imply the frivolity of playfulness that takes no concern for what is being played. Gadamer draws attention to the discipline of hermeneutical praxis, citing Schleiermacher’s distinguishment between “a looser hermeneutical praxis, in which understanding follows automatically, and a stricter one, which starts from the view that what follows automatically is misunderstanding” (1960/1982, p.163). The strict player loses themselves therefore, in

the rigorous play of always being open to misunderstanding, of always keeping ideas and understanding at play with whatever is 'other'.

How did I come to understand?

In 1995, two years into our journey of 'doing phenomenology', two fellow phenomenologists and I wrote a paper on our experience. From that paper is a comment by Deb Spence: "I think it's got to sit with the person's philosophy. To me that is absolutely crucial because the being and the doing is so intermingled. It has to be you. It's a very personal approach to research" (Smythe, Spence, & Gasquoine, 1995, p.188). It could be argued that all approaches become personal, yet I suspect that the nature of the play, the challenge to recognising ones personal horizons, the need to be ever open to the truth in understandings that are different to your own, the questions of the meaning of 'being', all involve the researcher at a deeply personal level. It is not task based research, it is a relationship. When my colleagues and I paused to reflect on our experience of doing phenomenology, the notion of 'revisiting' was uncovered as a common experience of our being. To come to understand interpretive phenomenology was an on-going process of revisiting - returning to the writing of the philosophers, returning to the words that had been 'too big', that had 'washed over me', returning to the data, returning again and again and again, circling in the hermeneutic circle. We recognised that we were 'soaking it in as we went', living with interpretive phenomenology, living with our own studies, living with the being of the doing. I described the creative nature of my journey as one of 'finding the patterns and textures'. We acknowledged 'the dictatorship of they', the sense that others can give the impression that there is a 'right way', leaving the researcher who is finding another way with a sense of vulnerability. We had begun to appreciate the nature of the writing, understanding that writing is the process (van Manen, 1990) and learning for ourselves how the process and the person become woven together as one.

In recent times I have come to understand that writing is the key to coming to understand the philosophers. When you read, you can fool yourself into thinking you understand. When you take a philosophical notion and seek to describe it in your own words, you come face to face with your own lack of understanding. In the engagement of writing you stretch beyond what you understand, you bring questions that may lead

to possible answers, you play with possible meanings, you draw on the interpretations of other scholars. Later, you come back to what you have written and see the gaps, the lack of clarity, and write again. You think you understand now, but a colleague reading your work asks ‘what does this mean?’ Your understanding must now be re-written in a manner that shows the understanding to others. It is a journey of trust and courage, for you must begin with sometimes only a glimmer of understanding, and you know that in the finished document there will be “inevitable imprecision and inexactitude” (Plager, 1994, p.76). That is why it is so important to the method to grasp the nature of understanding.

How did I learn?

You cannot sit down with a textbook and learn how to do interpretive phenomenology. Gadamer recalls how Heidegger began a lecture on skiing saying “Skiing is something that can be learned only on the land and for the land” (1985, p.49). Similarly, the only way to come to understand phenomenology is to engage in the experience by doing. The knowing that develops is both gnostic and pathic. It is gnostic in that it is related to “mind, judgement, maxim and opinion” (van Manen, 1995, p.8), for the research proposal could never have been written without such cognitive engagement. It is pathic in that it includes “those reaches of understanding that are somehow prediscursive and precognitive” (van Manen, 1995, p.5). It is a knowing that ‘just knows’, that ‘has a sense of what should happen next’, that makes intuitive judgements. It is a knowing that seeks out and values gnostic knowing, while at the same time trusts its own pathic responses. Van Manen (1995, p.4) tells us that “words have pathic power; that they can speak to us and say more than they can say”. The insight behind the gnostic words then becomes the pathic, and the pathic in turn informs the writing of new words. Knowing is an ever-changing, ever-growing interplay of understandings.

The gnostic/pathic interplay of coming to understand interpretive phenomenology is the soul of this thesis, creating the ever-present tensions. All the time there are questions: ‘am I being open?’, ‘have I recognised my own biases?’, ‘what assumptions am I making?’, ‘are my interpretations warranted?’. Knowing is always both knowing and not knowing. There is always the danger that the ‘not knowing’ will be overwhelmed by the sense of knowing, yet the questions toward ‘what is not yet known’ are the very

nature of hermeneutics. The paradox of knowing, yet not knowing, is the method. It is the “restless to and fro between yes and no” (Heidegger, 1959, p.75). What is right may also be wrong. What is clear may hide confusion. What is logical may be a re-ordering of the Being-of-everydayness that is unwarranted. What is a busy, efficient, by-the-book method may swamp the wonder that can open what is locked “by way of waiting” (Heidegger, 1959, p.90).

How can such a method be equated with rigour?

I have suggested to you that this method draws from an understanding that is always questioning its own understanding. The rigour of this method is therefore paradoxical. The common meaning of the word ‘rigour’ is accuracy, conscientiousness, exactness, meticulousness, preciseness, punctiliousness, thoroughness (Hanks, 1992). These words imply there is a standard and truth against which the method can be measured, yet hermeneutics calls into question the notions of ‘standard and truth’. Yet to say there is no rigour in hermeneutics is to deny the scholarly intent of being faithful to the salient guidelines (Plager, 1994). Benner (1994) talks of the stringent set of disciplines required for interpretive phenomenology and refers to giving the best possible account of the text, and offering audible and plausible interpretation that brings increased understanding. She cautions that “one must not read into the text what is not there” (p.xvii). She reminds us of the requirement for the researcher to show an understanding of self, as a means to avoid projecting their own world into their interpretations. She alerts us to the extremes of idealizing and villainising. She tells of the critical role played by you, the reader, as judge of the “fidelity, clarity, insightfulness and comprehensiveness of the interpretation” (p.xvii) and of deciding for yourself if interpretations are warranted.

As I begin to list criteria of rigour, I hear the voice of Sandelowski cautioning against making rigour “an unyielding end in itself” and calling for “the artfulness, versatility and sensitivity to meaning and context” (1993, p.1), encouraging us to soften our notions of rigour to include “the playfulness, soulfulness, imagination, and techniques we associate with more artistic endeavours” (p.8). Sandelowski (in Ray, 1994) states that good phenomenology has a “beauty criterion” (p.116). The tension of the method of interpretive phenomenology lies between the discipline and the freedom, the

comprehensiveness and the creativity, the unified whole and the fragmented disarray of parts. Each researcher must deal with these tensions in their own way, and let the study be itself, in itself, for itself.

Koch (1996) suggests it is the responsibility of the writer to “show the way in which a study attempts to address the issue of rigour [and] it is for the reader to decide if the study is believable” (p.178). She suggests that each researcher should choose the criteria they will use. Koch takes the term trustworthiness rather than rigour, and establishes her own criteria that the reader is able to “audit the events, influences and actions of the researcher” (p.178). How then have I dealt with the issue of rigour or trustworthiness? I have examined the criteria of those who have gone before me (for example: Omery, 1983; Sandelowski, 1986, 1993, 1995; Ray 1994; Benner, 1994; Plager, 1994; Rose, Beeby & Parker, 1995). I have embodied those understandings, and have come to my own description of ‘being trustworthy’.

What are the criteria of trustworthiness that I put before myself?

My story is one of living the tension of “the restless to and fro” (Heidegger, 1959, p.75) between the stringent set of scholarly axioms, and the yearning to yield to the freedom of the free-flowing thoughts. Firstly, my intent is that I tell you the story of this research in a way that enables you to understand what lies behind, what has provoked, what has guided me, hoping to give you understanding that will enable you to grasp what now lies captured on these many pages. (The tension lives in knowing that it is impossible to tell you everything. What assumptions have I made, thinking you will understand? What confusion have I laid before you? What have I forgotten to tell you that makes up a vital piece of the whole?) Secondly, I set myself standards of ‘being truthful’, of ‘being ethical’, of ‘being respectful’, and of not hiding anything from you. (Yet how can you know that I have maintained such integrity? How can I even be sure within myself that I have always put ethical integrity ahead of my own embodied aims?) Thirdly, I try to ‘show’ you rather than ‘tell’ you, when the telling would take away from the richness of the meaning. For example, I offer you the story before my own interpretation, to enable you to see for yourself, before my influence intrudes. I may include the direct quote of an author rather than offering my own summary of the text. (So how do I decide when it is important to show you, and when it is not? When does my ‘telling’ get

in the way? What stories, what references, have been left in silence in the cull of deciding what goes in and what stays out? What have you neither been shown, nor been told about?) Fourthly, I try to show you the meaning of ‘being safe’ in a manner that is dynamic, at play, held open and problematic, yet does not flood you with the clutter of detail. I seek to offer you something of ‘beauty’, but who is to say what is beautiful? The possibilities of meaning are what matter most, and what drive my decisions about the writing. (What possibilities have I not brought to question? What has been left within the darkness?) Fifthly, I write and re-write, and continually reflect on my understandings, in order to offer you the reader, a sense of meaning that resonates with your understanding. (Have I written for effect rather than to preserve the meaning of the text? Has the re-writing altered understanding in a manner that is unwarranted?) The linear presentation of these criteria in checklist form is a nonsense. The list of five ‘guiding principles’ have not dictated my actions one step at a time. Rather the principles, and their questions, have lived within me, self-reflectively, prodding me, encouraging me, guiding me, challenging me. Their presence, as questioning, should infuse every page.

The question still remains: can you trust this work?

I have offered you both assurances and doubt. I share with you the tension captured in Heidegger’s “restless to and fro between yes and no” (Heidegger, 1959, p.75). I do not ask you to accept everything I say as truth, for I myself keep open the questions of truth. I rather invite you to share this journey of exploration with me, to bring your own questions to each interpretation, and to arrive at your own understanding of meaning.

THE STORY

The beginning

This thesis began as a Masters Thesis, and was passed by the Massey University Department of Nursing and Midwifery Ethical Review Committee in March 1994. One year later it was transferred to a Doctoral Thesis, and resubmitted to the Ethics Committee. I chose to interview both midwives and doctors to uncover the meaning of ‘being safe’ in the maternity services, and then to move on to interview women who had been consumers of the maternity services. I decided to interview both midwives and

doctors, not as representatives of the 'them' and 'us' dichotomy of midwifery versus medical model, but recognising that both professional groups are involved in the business of 'being safe'. The nature of the maternity service means that women often need to access both midwives and obstetricians in their quest for safe care. It seemed that to uncover meaning it was important not to make assumptions about how either group of practitioners interpreted the meaning of 'being safe'. I needed to listen to their voices speaking for themselves. At the same time, however, I remained very aware that in this small hand-picked group of midwives and doctors, each voice was speaking for 'self', not on behalf of their profession. With their data gathered around me, they simply became nine individuals talking about 'being safe' in their common role of being a 'practitioner' in the maternity services. I then moved on to talk with women to connect their understandings of 'being safe' in childbirth with the voices of the practitioners.

How did I choose the participants?

I selected the practitioners from a range of different horizons, people who saw their world of practice from a variety of perspectives. I wanted practitioners I knew to be in the habit of offering insightful reflections. I tended to avoid close friendships, yet it felt appropriate that these people knew me well enough to feel comfortable sharing their tentative thoughts. I looked for 'key players', people who had earned the respect of colleagues. I did not include any midwife who at that time was a student in the degree completion papers I was teaching.

In choosing the women participants I identified networks of women I had contact with outside of my professional involvement, and began by asking two women known to me. One of these women asked me if I was interested in talking to any of the women she knew. I met these other women and heard their stories for the first time with no prior understandings of whether they perceived their birth experiences as safe or unsafe. I had no firm criteria for the length of time since they had had their baby for I believed the memories that are important to the woman stay with her. As it happened most had given birth approximately a year previously, although some of the stories focused on the birth of an older child. There were some women that I specifically invited because I knew their experiences had been 'unsafe'. I considered the possibility of defining the types of childbirth experiences I wanted in my study, but as the interviewing began I came to

realise that for the women, their sense of 'being unsafe' often had little to do with the sort of label I would have placed on potential participants. I decided to be open to whatever participants came my way.

What was the initiation process?

Once I had decided to ask a particular practitioner, I would put my request to them, send them the information sheet (Appendix A/B), give them time for consideration, ask again, arrange a time and place for the interview, meet with them, transcribe the tape, recognise patterns and themes, send the transcript and my interpretations back to the participant for comment or correction, dwell with the meaning, and then start the process all over again with another person. Thus, I was focused on the meaning of being safe from the perspective of one particular person for approximately four weeks.

Who were the practitioner participants?

The practitioner participants, in order of their involvement were

- A a midwife with many years of domiciliary experience
- B a midwife with expertise in high-risk pregnancy from Base Hospital X
- C a hospital based obstetrician from Base Hospital X
- D a midwife with expertise in labour and delivery, from Base Hospital Y
- E a hospital based obstetrician from Base Hospital Y
- F a midwife with expertise in teaching and independent practice
- G a private obstetrician, who practices at Base Hospital X
- H a general practitioner with a passion for maternity work, who practices between Base Hospital X and a small community maternity unit.
- I an independent midwife, who practices mainly in the community, or at a low risk community hospital

The community of midwives and doctors in the maternity services is small. To protect the anonymity of these participants it is inappropriate for me to offer a specific description of each person. All these practitioners work within the same New Zealand city. It is fairly certain, given the size of the population of maternity practitioners, that if they were to meet together, they would know each other, if not from having at some stage worked together, then from the various professional encounters. One practitioner

had been in practice for five years. The others had at least ten years maternity practice experience, and some had twenty-to-thirty years of experience. There were three males amongst the medical practitioners. The data are identified by the initial indicated above, and the person's profession. This is to enable you to situate the voice. The curiosity of my earlier readers to know 'who was speaking' prompted this differentiation. Nevertheless, I encourage you to hear the meaning offered by the person, rather than first labelling them as 'midwife' or 'doctor'.

How much should I tell you of the women?

Who are the women who have shared their stories of their childbirth experience with us? They are women with professional career backgrounds in nursing, physiotherapy, laboratory technology, occupational therapy, horticulture, business management, and pharmacy. It is only as I review this list that I realise how many of them came from health service backgrounds. I met them simply as women who had given birth. As they told me their stories, their view of the world was very much as a consumer of the health services, yet their prior understandings are likely to have influenced that experience. For example, the woman whose baby was born prematurely and admitted to the neonatal intensive care unit had visited that same unit many times in her role as a laboratory technologist. I did not ask them their age, but on reflection see all but two as 'older' women within the childbearing population. I gained the impression that all were married, or in stable long-term relationships with male partners. I valued their ability to tell their stories, and their boldness in speaking about the things that disturbed them. These women had the background and the confidence to do that. This thesis makes no claims that the combined stories are representative of the wider population.

Even though I recognise the limitation to this study of not telling you who each woman is as she tells her story, particularly from the Gadamerian perspective of situating each text in relation to its author, I have decided that these ten women shall remain anonymous in their individual demographic descriptions. Again New Zealand is a small community. When the women criticise their own practitioners it is important there are no hints as to who they might be referring to. When they speak of a very personal experience, it is important that their confidentiality is absolutely protected by excluding the clues that might reveal who they are. Their stories are very precious, and belong to

them. No story is attributed to any particular participant. It is deliberately not possible to piece together stories that belong to any one woman, for that could bring connections that identify her.

How did I interview?

I have struggled every time I have written the word 'interview'. I have stayed with that word because it carries the meaning of the researcher meeting with the participant for a specific purpose. I hesitate over it for it implies me asking a series of questions, me directing the focus and flow of conversation. To some extent that is true. I began the interviews with practitioners by asking them to tell me their meaning of 'being safe'. On reflection, it was a big question and a hard question for them to begin with, yet their answers suggest they had come ready to answer it. It also reflected an approach that at that time was more hermeneutic than phenomenological. I did have a list of other possible questions of a more specific nature, and on occasions was pleased to be rescued by a ready made question. With some practitioners the conversation took on a life of its own, yet travelled over similar ground to other interviews. There was one time when I had lost my voice. It had been a difficult appointment to arrange, so I went as planned. The practitioner, perceiving my difficulty, took on a talking role, and talked and talked and talked. Occasionally, I wrote another question on a piece of paper, but most of the time I simply nodded. It was such a contrast to a later interview where I felt like I was playing a game of table tennis. Every time I asked a question, the answer would come flying back, and it would be my turn to ask another question again. There was no 'right' way to gather the data. Each meeting was unique, yet patterns of commonality emerged. Every conversation resulted from the interaction between us both. Weber (1986) talks of the potential for abuse and betrayal in the interview experience, which at the same time offers the potential for developing trust and shared understanding. I needed these practitioners to trust me enough to tell me about the times when their own practice had seemed unsafe, yet I remained aware of the trust they invested in me, particularly when they shared a story from their own practice. One practitioner told me a story from practice that I believe others may have called 'unsafe'. As tempting as it was to include this story in my study, I chose not to. It was more important to protect the trust within our relationship than to expose even an anonymous practitioner (whose identity may well be accurately guessed in such a small population of practitioners) to the potential

abuse of public scrutiny. The nature of the situation did not raise any ethical concerns for me of knowing about on-going 'unsafe' practice.

The interviews with women were quite different from those with the practitioners. In contrast to the practitioner's experience of having been involved in hundreds of births, these women were very focused on their own unique experiences. They knew my interest was on 'the meaning of being safe' but that was too complex an issue to address directly. In the spirit of interpretive phenomenology, I simply invited them to tell me their stories, from beginning to end. When they came to a place in the story that they remembered feeling 'safe' or 'unsafe' they would dwell on it, yet we both knew that the whole of the story was a story of 'being safe or unsafe'.

The follow-up from interview

My intention was that there would be one in-depth interview, with the opportunity left open to return to the participants. I returned the transcript of the interview to each participant, and to the women a copy of the re-crafted stories taken from their transcripts, with the initial interpretations I had made, and a summary page that captured the 'things that seemed to matter'. I included a letter thanking them for their participation, inviting them to give feedback on any comments related to my interpretations, and in an encouraging manner, asking them if they would like to meet with me again to tell me more. Of the practitioners, one person posted their transcript back to me with minor corrections to the transcript. No one followed up the suggestion for a further interview. It was as though they had already done their thinking prior to the interview, had told me what was in their heads, and saw no need to tell me again. I recognised that the women participants who shared the stories of their childbirth, may have felt vulnerable and exposed on reading the transcript. I, therefore, phoned each participant several weeks after I had returned their stories to them. I quickly perceived a common response. They were pleased to have the story of their birth experience(s) written down, but they felt a reluctance to read it for themselves. They were busy, tired women, caring for young children. Many of them had not even taken the transcript from the envelope. I had just received a transcript back of myself as participant in someone else's research. I had absolutely no interest in re-reading what I had said. It raised questions for me of the power relations in the researcher-participant relationship. When

participants are expected to actively participate in the interpretation, are we asking too much?

I asked myself the question 'should I have done a second interview?' I felt I already had an overwhelming amount of data. I was reassured by the participants seeming acceptance of my interpretations, and the positive informal response I received when chance meetings came our way. I could have perhaps persuaded them to agree to a second interview, but for what purpose? Is a second telling necessarily 'truer' than a first telling? Were there important things they had forgotten? Had they been truly open? Were my interpretations of what they were saying in accordance with their own? At the time of the interviews I was led by the strong sense that the participants did not feel the need to have a second meeting. In hindsight, I remain comfortable with that decision. Swanson-Kauffman & Schonwald (1988) confirm that the marks of a good qualitative interview are best judged by the person being interviewed, who knows when they have offered in-depth dialogue. Hermeneutics does not seek to replicate the exact meaning and experience of another. The contribution of the participants was to give me their thoughts, which I was then able to bring to my own thoughts. Dwelling with my interpretations enabled me to sense the common themes and patterns that emerged. I now offer these understandings to you for your pondering. In this process of sharing thoughts and questions in order to come closer to the understanding of meaning, there is no "copy or reflection of some primary, unchanging reality but an interpretation or understanding" (Allen, 1995, p.178). Nevertheless, it is important, and will be discussed later in this chapter, that the interpretations are warranted.

What was my experience of transcribing?

For the interviews with practitioners I took on the task of transcribing the audio tape from each interview. Sandelowski (1994) draws attention to the ethic implicit in the process of transcribing, the need to make decisions about what is captured within the transcription. There was the odd time when a word was so faint that any attempt to capture it would have been a guess. It would have been unethical to 'make it up'. There were references to people and places that needed to be silenced in the transcript. There were the stutterings and stammerings of normal conversation, that did not need to be revealed in the record of what was said. I believe the effort of transcribing was the

major contribution to my overwhelming sense of 'enough' at the end of working with the data of the ninth practitioner. The immense concentration required left me feeling drained, yet at the same time I delighted in the embodied knowing I acquired from each transcript. They were within me. My mind could take me from one story to another, or prompt me if I'd left something important aside. It was a valuable investment of time and energy.

In the second round of interviews with the women, I paid for the tapes to be transcribed. It felt wonderful to be freed from the tedious task yet, at the same time, I realised I would have to find new strategies for absorbing the data. At that time, I had the good fortune to attend a workshop run by Max van Manen (1995). It was there I came to understand that a transcript was merely the means of capturing meaning, it was not an end in itself. It was legitimate phenomenological practice to take the transcript and from it to pluck the story that uncovered the meaning. You did not have to be bound to a word by word replica of what the participant had hesitatingly said. You could dwell with all that they had said, and from that re-tell the 'saying' in a way that revealed the meaning more clearly. The intent was not to change the meaning but rather to make the meaning more explicit, more apparent, more revealing. Van Manen calls this anecdotal narrative, and describes its purpose as being to compel our attention, to invite us to reflect, to involve us in an active search for meaning, to touch us, shake us, move us, and to help each of us to make interpretive sense of what it might mean (1990, p.121). Weber (1986) confirms this as a respectful practice, suggesting that verbatim quotes may rob oral language of its "power, clarity and depth, even its meaning" (p.71) and encourages the researcher to give fidelity to meaning.

This responsibility to finding 'meaning' gave me a new relationship with the transcript. I would bring the words of the transcript onto my computer screen and look for the stories they were telling. I would delete the noises of conversation that clutter the gaps between the real saying. I would track the threads of a particular story through the pages of the transcript and pull it into a coherent whole. I would take the story that was there on the page and gently craft and polish it. The tension was ever present between my desire to show the meaning of what was said, and the danger of distorting the meaning through the very method I was using to preserve it. As a respectful safeguard to this

process, I returned to each participant both the original transcript, and my edited version of the stories I had drawn from the whole. They were invited to inform me of any changes they thought should be made. During this time, I used one of the stories in a conference presentation (Smythe, 1996a), and sent a draft copy of the paper to the woman to ensure she felt comfortable with me doing this. She agreed, but asked that I could make the corrections she had indicated. She herself had polished the grammar one more time. It gave me the affirmation that it is in the spirit of respect that the polishing and crafting is done. As scholars, we edit and re-edit our own written work. Why then should participants not be awarded the same right to have their words subjected to the scrutiny of 'making the meaning clear, and the grammar correct'? Weber agrees that there is possibility of betrayal in giving ourselves as authors the right to examine our written words, if at the same time we expect our participants to "allow their spontaneous, tentative, oral language to be treated as written language" (1986, p.70).

How did I decide I had enough data?

How did I decide to stop at nine practitioners, and ten women? In my journal entry on the 3.9.94, after reflecting how tired the ninth practitioner and I had both been at the interview, I have written "*I want to say 'that's it' because I want to 'get on', and because it feels like I've got heaps of data, and I don't want to undervalue it. And I probably don't want the hassle of asking more people*". Nineteen participants, interviewed once, may seem like a simple accomplishment. To me, it felt like a huge accomplishment. I had come to know and to treasure the data of each participant in a very intimate way. I valued it, both for my own ends, and with a sense of being responsible for making good use of it. I could have gone on to interview more people, but I knew that with each new set of data, there was less and less chance of each voice being valued for what they had to say. I had more than enough to work with. It almost seemed greedy, and disrespectful, to seek more.

How did I analyse the data?

Van Manen (1990) talks of the dynamic interplay between research activities of turning to a phenomenon, investigating it, reflecting on themes, describing the phenomenon, staying orientated, and all the time considering parts and whole. That dynamic interplay makes the telling of the story of method difficult. The strategies that were engaged in

my process were diverse. I began by making interpretations of each transcript page by page. At the end of the transcript I would take a blank piece of paper and mindmap 'what seemed to matter'. As I gathered together these mindmaps' I came to see clusters or themes. The data of the practitioners was re-organised into these groupings. The stories of the women lay alongside as a series of discreet but related experiences. I then began my year long journey of writing out the data. In the thirteen chapters that emerged as the story or the data I came to see the interconnections, the influences, the interplay, and to sense within me the things that 'mattered'. I pondered on my ever-growing understandings from Heidegger (Diekelmann and Diekelmann, 1996, 1997). I came to know from having dwelt with the data, with the stories, with the meanings, with the feelings, and with the philosophical notions of Heidegger and Gadamer. There were no strategies or technical devices that could tell me how to 'make sense' of the data. I had to live the journey, I had to brew the understandings, I had to feel the feelings. It was the writing that took me on these pathways. It was the writing that helped me see what I was understanding, and which moved me forward to ask new questions in the interpretive process, to seek to understand still more.

How have I determined my interpretations are warranted?

The danger of keeping the process of interpretation to myself is that my biases may inform my understanding in such a way that the interpretations become unwarranted. I may, furthermore, not see the possibilities of interpretation that are right in front of me. It was always important that other eyes, and other minds, share my journey. My two supervisors are both midwives, and one is a mother of two children. They have read my transcripts, the stories crafted from the transcripts, and my many layers of interpretation. They have shared with me their responses, their questions, and revealed to me things I had missed. When my interpretation was unclear, lacking, or 'did not sit right', it meant I needed to go back and read the text again. My supervisors know the whole, from data to thesis, and are familiar with the context of the study. They have travelled with me faithfully, remembering the road behind.

When I wrote to the practitioner participants to request permission to include their data from the original masters study in the PhD study (Appendix C), I shared with them a summary of my understandings that had emerged from their collective data. I invited

them to respond if they felt the need to question my interpretations. I received the permission slip back from them all, but received no comments or requests for contact. I made the assumption from the silence that my interpretations at that stage reflected their own understandings.

It has been important through the on-going journey to formally and informally share the emerging notions with practitioner colleagues, to ensure my interpretations are warranted and evoke the phenomenological nod. Van Manen attributes the 'nod' to Buytendijk who described it as "a way of indicating that a good phenomenological description is something that we can nod to, recognizing it as an experience that we have had or could have had" (1990, p.27). These opportunities have happened formally by presenting my work to both masters and undergraduate classes of midwifery students and seeking their response. As a teacher, my on-going interpretations have journeyed with me day by day into the classroom, and have many times become the focus of discussion with undergraduate midwives, practising midwives, and with an interdisciplinary masters class. I had the opportunity to present a paper at the New Zealand College of Midwives Conference (1996a) and, as I read a story from my study, I felt the stillness in the room, I saw the quiet tears and the gentle nods of knowing. I have engaged in conversations with midwifery and medical colleagues, trying out my new understandings. I have sat quietly in the midst of conversations of 'being safe' to see how my interpretations 'fitted' with that particular situation. I gave the completed draft of the whole study to a wise midwifery friend and colleague who has her own experiences of 'being both safe and unsafe' as a woman in childbirth. I trusted that she would tell me how my thesis sat with her own understandings as midwife and mother. She enthusiastically affirmed that I had 'got it right'.

It has also been important to journey with fellow interpretive phenomenologists, who in this study have the added advantage of also having lived the experience of giving birth, and for some, having practised in the maternity service. Three fellow PhD students have spent time dwelling with my written interpretations, and have given me valuable responses. Our PhD support group has provided opportunity for discussion, and the refining of understanding through dialogue.

I have returned to two women participants, asking them to comment on my interpretation of particular stories before I included them in conference papers (Smythe, 1996a, 1996b). I returned to another woman because of the intimacy of the story she had shared with me. I needed to be sure that she felt comfortable with my interpretation, and its inclusion in the study. Several women in the study have gone on to have subsequent children while I have been working on this study. It raised the dilemma of the ethics of raising the issue of 'being safe' in the midst of such an experience. I chose to refrain from further dialogue with them over that period.

You, as the reader, will make your own decisions as to whether the interpretations of this study are warranted. I imagine readers from the medical profession will find a midwifery bias, and consumers will find a health professional bias. I accept that this is likely to be so, for while I can be aware of those influences, I cannot divorce them from my understanding. When your interpretation is different, I invite you to claim it as your own, and to bring your new understandings to the connecting conversations about 'the meaning of being safe'.

Were there any ethical dilemmas?

There was always the possibility that the search for the meaning of 'being safe' could lead me to ethical dilemmas of my own. What would I do if a practitioner told of their own unsafeness to practice (knowingly or unknowingly)? I was clear that my role of researcher did not put me in a judgement role, but what would I do if I perceived this practitioner was placing women and their babies at risk? Thankfully such a situation did not arise. Its possibility did, however, raise the recognition of the vulnerability of both the participant and the researcher. What was more likely to happen, and did happen, was the woman telling me of her concern about the practice of her midwife or doctor. In some cases, the woman had already made her complaint to appropriate authorities. In one case, the woman wished to make a complaint against her independent midwife but did not know how to do this. I was able to provide her with that information. Again, it was not my place to judge the safeness of the practice, but it was ethically appropriate for me to support and guide the woman to her choices of action. Some women, by choice or by accident, told me the names of their practitioners. Now, when I meet those practitioners in practice, I carry with me a sense of knowing them well, yet they are

unaware of that knowing. The confidential nature of the research process dictates that silence.

Did I collect enough data?

How does one know when enough is enough? Benner did 12 interviews each with 23 participants, yielding 276 interviews (Benner, 1994, p.107) I offer you a grand total of 19. I find some reassurance from Colaizzi (although realising he followed Husserl rather than Heidegger):

there are no external or pre-established criteria for determining when to terminate the approach phase. At most, it must be admitted that this point is a sense, a certain 'empty but distinct' feeling of being satisfied that the approach phase is adequate in the face of simultaneously experiencing the tension of its not being complete or final. (1978, p.70).

Benner talks of her large text from her 276 interviews providing redundancy, clarity and confidence, making her research more plausible and more reliable. My study seems so small in comparison. As I hover over the temptation to justify the number of participants by citing similar sized hermeneutic studies (Rather, 1994; Halldorsdottir & Karlsdottir, 1996), I realise that while size may influence the reader's confidence in 'what is common' within a study, in qualitative research, unlike quantitative research, size is not the 'hallmark of the worth'. Nancy Diekelmann tells me the larger her data base becomes, the more confident she becomes about the common, and the more exact and complex her descriptions and interpretations become (1998). It is a 'becomingness' that dwells in the richness and depth of the data, the circling and re-circling of understandings, the confirmation again and again of what matters most. My journey is only just beginning in its 'becoming'. I have begun to come closer to understanding the possible meanings of being safe. There were times in the writing that I had a yearning to take just one story, and write its meaning as far as it would go, into a thesis of its own. Each story is unique. Each story is a window to new understanding. Each story has such depth, and such a complex background to be unravelled. I experienced Colaizzi's 'empty but distinct feeling' with both phases of my data collection. I knew it was enough, while at the same time I knew it never would be enough.

Other phenomenologists (eg. Madjar, 1991) have included observational data. Could I, should I, have sought permission to observe the practice of midwives and doctors going

about the business of 'being safe'? I decided that I should not. My presence 'watching for safety' would be likely to influence the practice, maybe causing the practitioner to take precautions that were not necessary, giving the woman an altered experience. For the woman my presence might have been a constant reminder about 'safety' which may have caused inappropriate anxiety. I persuade myself that I have spent two decades participating in, and observing, maternity care. I have seen much about 'being safe'. At the same time, I acknowledge that observations of practice could have shown me embodied practices and responses that the participants themselves did not even notice because they were so taken-for-granted. The possibilities for observation lie in the future as an opportunity for each one of us to explore.

What of the unheard voices?

But what of the stories that haven't been told, the woman in poverty, the solo mother, the new immigrant, the voice of Maori? I invite these questions, and hundreds of others besides. Seeing what is missing from this work is as valuable as seeing what is there, for it will provoke you to questions of your own. How can a woman be safe if she speaks no English? How can a woman be safe if she cannot afford the transport to seek care? How can a woman be safe if her cultural values are ignored or insulted? How can a woman be safe if ... There are so many 'ifs'. May the questions provoked by this study live on.

Is this a scholarly example of interpretive hermeneutic research?

The intent of this chapter has been to offer you the evidence that this study is founded on the principles of both hermeneutics and its more specific interpretive phenomenology, and interprets method in a scholarly manner. There is paradox in that the evidence to support this intent is both shown and called into question. The method has tried to be faithful, but it continually asks 'has it been true?' Decisions had to be made, but those decisions continue to be questioned. Much has been said, but I know that so much more has been left unsaid. Heidegger tells us "the field of vision is something open, but its openness is not due to our looking" (1959, p.64). I therefore say 'the method of this study is something scholarly, but the scholarliness is not due to the rigour of method'. The scholarliness lives amidst the tension of paradox.

Knowing how
knowing when
but not knowing at all

Beginning anyway
with confidence
that is bred of ignorance

finding out
by being in the messy meaningful midst

going back
to understand the mis-understanding
to sharpen the blur
to make the words live

writing the feelings on paper
seeing the feelings in words
understanding and not understanding
taking a fresh piece of paper
writing again

reading the words
wondering
taking a word out
adding a word in
posing the questions
wondering

giving it over to you
still wondering

now it's yours:
your wondering
your questions
your glimpses
of seeing for the first time
what you already knew

CHAPTER SIX: THE ALREADY THERENESS OF SAFE/UNSAFE

Imagine safety as a commodity that is kept in the store cupboards of midwives and doctors, and at their discretion given away to pregnant women. That would mean it would be impossible for a woman to have a safe childbirth experience unless she visited a professional practitioner, and won their favour. That would mean that the practitioner would have the power to give absolute safety, or to withhold it. If a woman had not kept her regular appointments to receive her up-date measure of safety, society could rightly blame her for negligence if her baby was born less than perfect. If, on the other hand, a woman has demonstrated exemplary diligence in her quest for safety, and the baby is stillborn, then it is obvious that the fault must lie with the practitioner who has not ensured she received the requisite amount of safety. They could have given her more safety. They could have stopped that baby from dying. This is what happens when safety is made into a commodity or an object. This approach removes safety from the situation in which it exists. There is a difference between safety as an object, and 'being safe' in particular situations.

There are conspicuous flaws in the approach that commodifies or objectifies safety. From where did women receive their measure of safety in the preceding generations who had no access to a professional midwife or doctor? Certainly, we recall that some of these women died, but by the same token many lived to produce child after child after child, with assistance only from a kindly neighbour. They were safe, without the ministrations of professional care. I think of the parallels in today's world, the women who, for whatever reason, choose not to access the care that is available. They are subjected to the frowns of disapproval. If anything is less than perfect, it is their own fault. There are those, however, who flaunt the system of safety yet still remain absolutely safe. 'How can they be safe without having received safe care?' comes the bewildered cry of the experts. Then we hear the heartbreaking sobs of the woman who attended every visit, who had every test, who read every book, who sought care from the most skilled of practitioners. 'Why did my baby die?' she demands in anguish. We

turn to the practitioner: 'what did you miss? what didn't you notice? what should you have done differently? it must be your fault!' Finally, we acknowledge that there was nothing the practitioners could have done that would have saved that baby.

Safety is not a commodity to be bought from a practitioner, although a practitioner can make childbirth experiences safer. Safety is more than that. Safety 'is'. It exists as experiences. Safety is already in the experiences of pregnancy, in the progress of the labour, in the birth of a healthy child. Nobody can make that safety or take it away. It is constitutive of the experience. It has a being in its own right. It is already there when the woman goes to seek care from a practitioner, just as the unsafe is already there. Everytime the practitioner considers 'what is happening' it is already either safe, or unsafe, or a mixture of both. For those who are already safe, the visit merely confirms what is. It does not make it any safer. For those who are already unsafe, the visit may make that apparent and prompt action, or the unsafeness may stay quietly hidden. When it is unsafe, it is not the practitioner who has caused that to happen, although practitioners can practice in ways that add unsafety to safe situations. Unsafeness is already there, and constitutive of the experience. The unsafeness may already be beyond the reach of safe care. The issue is not the planning of safe care, or the measuring of safe parameters, or even the doing of safe practice, although all those are important. The issue lies in the 'being' of what is already safe or unsafe, or both. This study seeks to describe 'what is already safe or unsafe' that lies embedded within the lived experiences of women who journey through the process of childbirth, and the practitioners who offer them care. They are the experiences of persons in situations of being human.

Heideggerian Underpinnings

Heidegger tells us that when we consider a phenomenon, such as 'being safe in childbirth', we will only come to understand something of its meaning when we seek it in its Being. In other words, we must seek beyond the information that 'this woman is pregnant, under the care of this practitioner, who will demonstrate safe practice by this certain set of procedures'. We need to look beyond the existence of this woman and this practitioner and this set of procedures. We need to recognise that when they come

together in the name of 'being safe' there is a dynamic interplay between the being of the pregnancy, the being of the woman, the being of the practitioner, the interpretation of the procedures, and the situation of time and place.

Steiner (1989, p.57) states that at the still centre of Martin Heidegger's entire work and thought "Being is". He quotes Heidegger (from his Letter on Humanism 1945-46) declaring "But being - what is being? It is itself." Being is not planning, it is not carrying out the procedures, it is not reflecting on the information gained, it is not predicting. It is all of those intertwined, and much more besides. The phenomenon of Being is always in the 'is' of Being. We can look back and say "I was Being" and describe how that was, and we can look forward and imagine how 'Being' might be, but the moment of Being, the now, is what it is. It happens to us, with us, for us, because of us, and in spite of us.

Heidegger (1927/1962, p.39) tells us that: "Time must be brought to light - and genuinely conceived - as the horizon for all understanding of Being." He goes on: "Being, and Dasein [Being-in-the-world] is as it already was, and it is 'what' it already was. It *is* its past, whether explicitly or not" (p.41). Further to that: "Its own past - and this always means that past of its 'generation' - is not something which *follows along after* Dasein, but something which already goes ahead of it" (p.41).

The 'is' of Being is not, therefore, a mere chance set of behaviours. We act out our Being in the light of all of our being that has gone before. For example, if the practitioner is making the decision with the woman about whether her post-term pregnancy should be induced, the practitioner brings to that decision all the memories of other women who went on to deliver healthy babies without induction, and the **one** baby of hundreds who was unexpectedly stillborn. The memory of that stillborn baby is likely to go before every similar decision that they are faced with. It is within the Being of that practitioner, even if it remains unspoken and unthought.

Heidegger addresses the question of 'where does the *is* come from in the first place?' with his notion of thrownness. We are "thrown" into the world. Steiner explains this notion:

We certainly do not know whence we came into being, except in the most trivial physiological regard. No biology of parentage answers the real question. We do not know toward what end we have been projected into existence, except in reference to death. ...Yet it is just this twofold unknowing which makes the "thrown" condition of human existence the more emphatic and palpable. We are "delivered over" ... with... "responsibility toward that into which we are delivered" - to an actuality, to a "there", to a complete, enveloping presentness. *Dasein* must take up this presentness, it must assume it into its own existence. It can not do otherwise and continue to be (1989, p.87-88).

Our Being is our present, and our present is always open to thrownness. At any time, something can happen about which we had previously no thought or understanding. Once it happens however, it is part of our Being. For example, the telephone may ring in the midst of the woman's visit to the practitioner. Both are distracted. The one key question, the one key piece of information, may get lost in that distraction. The unsafe situation that is only just beginning to develop will not be noticed until the next visit. If the situation had not been thrown by the telephone call, the tests might have been ordered earlier, the intervention might have happened sooner, the outcomes might have been better. Thrownness is with us in our everyday Being. It is within the functioning of our bodies, especially pregnant bodies. It is within the weather; in our travelling on accident prone, congested highways; in the chaotic nature of the numbers of women giving birth at any one time; in the decisions of others that are thrust upon us; and in the consequences of the action or inaction of others that are left for us to sort out. The thrownness takes over and is encompassed with our Being. It puts us in situations that are 'already there'.

The thrownness of childbirth

Heidegger's notion of thrownness captures the nature of becoming pregnant. A decision can be made to try to become pregnant, but it is beyond our 'willing' to make conception take place at any precise time. It will happen when it happens. A woman

will be thrown into a state of 'being pregnant'. Hear this woman's story of her experience of 'throwness':

We'd been married for eight and a half years. We'd thought we'd have a family, but we'd never slotted it in anywhere. We'd wanted to establish our business, and our home. At Christmas last year we said "why don't we start?" I was lucky, we basically conceived straight away, and I knew virtually straight away I was pregnant. I did one of those home kits. It was inconclusive really, I was sort of half pregnant. So off I went to the Doctor's a couple of days later, and again it was inconclusive, so they said "go to the Lab for a blood test in a week". So I had a blood test, and I didn't hear from my doctor the next day. I waited a whole day, and then I rang him a day later. He was going off on holiday. The nurse was very blase, just, sort of "oh yeah, the result is positive". And I went, "oh, oh, what do I do!" I didn't know what to do. Here I was pregnant for the first time, and I hadn't read any of the books. Even though it was planned, it was sort of over-night planning. I hadn't gone off and taken folic acid for three months, I had no idea about any of that. And she said "oh well, just carry on, don't do anything different, and make an appointment to come and see the doctor when he is back in 10 days". And I just felt "that is not satisfactory". I didn't know what I was supposed to do and not do.

This woman made a clear decision to try to become pregnant. She was thrown into her pregnancy almost immediately, almost too soon. She knew she was pregnant, yet she needed to have that confirmed so she would know she was pregnant. She describes herself as 'half pregnant'. Being half pregnant speaks of tentativeness, of vulnerability, of feeling unsafe. The 'is' of pregnancy is that you either 'are pregnant' or 'are not pregnant'. There is nothing in-between. She was already pregnant, yet she could not feel safe in that knowledge until she had formal confirmation. The Being of the pregnancy (seen retrospectively) was safe throughout this time of coming to know, yet the woman felt anxious. She had to wait 'a whole day' to learn she was truly pregnant. Then she had to wait another 10 days to find out what she should do. She felt very unsafe, for she had no understanding of what to do to look after herself, in her very new state of 'being pregnant'. She did not understand that the Being of the pregnancy was in control and taking care of itself. She did not know that 'being safe is' just as 'being unsafe is'.

'Being safe' early in pregnancy is mostly covered up. The woman may not recognise she is pregnant for days, or weeks or even months. Until she does, the pregnancy that

'is', is not known to be in existence. In its hiddenness it relies entirely on its own being for its safety. Once the pregnancy is confirmed the woman is left to bide time with her pregnancy to a 'booking-in stage' of usually 10-12 weeks. Confirmation means the pregnancy 'is', in that it is known. Knowing you are pregnant does not, however, mean you are safe. It rather brings to awareness possibilities of being safe or unsafe, and leaves in darkness other possibilities of thrownness.

The woman/family, meanwhile, are left to come to terms with the recognised possibilities that being thrown into pregnancy has thrust upon them:

Initially there was sort of disbelief really , 'can it be true?', and sort of putting off the 'thinking about', 'the dealing with', all the consequences and the work related issues of being pregnant.

'Being safe' for the woman who is now pregnant becomes a complex mix of emotions. There is much to think about, much to deal with, many possible consequences to be considered. She and her partner/family become thrown into a situation which is now beyond their control. The possibilities of the pregnancy go on ahead to become part of the concern of now. For example, leaving work, leaving status, leaving financial security, are unlikely to happen till much later in the pregnancy, yet the thoughts and plans about the changed circumstances are in the 'now', even if it is in the tension of "putting off the thinking about".

Thrownness that is unsafe

The pregnancy itself may become unsafe. The woman, as in the following example, may have a miscarriage:

I had a miscarriage with my first pregnancy. It wasn't a planned baby, and I was surprised at how upset I was when it happened. It was very traumatic. I had a scan and they said "Look there is nothing there. You might believe, or your body thinks you are three months pregnant, but there is nothing."

In the end we phoned the guy on call at my local GP who was such a dick. Here was I reeling around in agony, I wanted to take all my clothes off, I don't know if that's an autonomic response. I just wanted to get everything off me. I felt I just wanted to pace and walk around. I was hot and thought I was going to vomit. And he kept sort of trying to counsel me

about having a miscarriage, "how do you feel about this?" It was just so inappropriate. I mean, I didn't want to talk about that right then. I just wanted to get rid of that pain. He gave me a jab in my leg, then I went really way out.

I went to hospital for a D&C [Dilatation & Curettage]. There was a Doctor there who kept quizzing me. He said something, and I responded in such a way that he seemed to be horrified. I think I said "I just want to get this out of me. I just want to get rid of it" He looked appalled that I would say such a thing.

After the D&C, I woke up and it was gone, it was absolutely gone, the pain was gone. I felt great. I said "well I want to go home". I had to wait for another couple of hours because I'd had an anaesthetic, and then I said "I want to go home, I feel fine". The nurse understood, she was very nice. But it was a bad experience, it was a really bad experience.

I think this is where my fear of labour came from because the miscarriage was so incredibly painful. I have broken my foot and had a nasty fracture, I mean it still hurts now - that was nothing like this pain. I think the miscarriage pain was because it was a horrible thing. It was upsetting. It's that deep nauseous, organ, unrelenting pain that nothing seems to help. You know, you can't rub it, you can't do anything. When I went in to labour in my next pregnancy, it was the same pain.

This woman had been thrown unexpectedly into a pregnancy. She was pregnant when she didn't plan to be pregnant. She went for a scan and discovered that the pregnancy she thought she had, was no longer a pregnancy. Once, there may have been safety, but now the unsafety was already there. She was now thrown into the loss of her baby. She had been pregnant. Now she was not pregnant. At every stage of her experience 'is' was already. The scan simply revealed the 'is' - the 'is' that said 'there is nothing here'.

In her story, the pain is the all-encompassing experience of the 'now'. All that matters is the pain. All that is unsafe is the pain. All that needs to happen to be safe again is for there to be no pain. The doctors don't understand. Their 'now' is the loss of a pregnancy. For the woman, that loss will go ahead of her, to be there waiting for her. It is now part of her life as 'mother'. It will travel with her. The grief is not the experience of now. It is overwhelmed by the intensity of the pain. That is what matters most right now. It is too late to make the pregnancy safe. It could not have been any other way. It

is as it is. The pain is taken away, and yet the pain remains. The pain goes before the next birth experience. The pain is met again, and known again. The pain is always already there.

When 'unsafe' is already there

The notion of thrownness is that when something happens to us, it is already there by the time we come to notice it. Even if it is not noticed, it is nevertheless there. This woman's story captures the uncovering of 'is' being already there:

It was my husband's birthday. We were having a party for him that night. That morning, I was fairly convinced I had a show. The midwife came, and I showed her what I had produced, and she said 'mmm'. We didn't worry too much, but that day I definitely puddled through, leaking all day, not realising what was going on. I actually thought I should have realised what was going on a bit better. I felt okay. I rushed around all day getting ready for the party. The people came, the party was in full swing. I was standing at the table cutting the cake, thinking 'this cake is full of alcohol' and thinking 'oh my God, this is not leaking, this is a flood'.

Afterwards my mum said to me 'I had a feeling' and a lot of people said to me 'you weren't right that day' and I look back and wonder if I was actually quite anxious. I went to the spare room and suddenly these grandmothers appeared and I said to my mum who's a nurse "is it urine?" I mean, honestly, it's really amazing what you deny. She said, no. My waters had broken.

I just wasn't ready, not at all ready for that, you know. I was only 35 weeks. I hadn't finished the things I had to do for work. I had five more weeks to go.

This story tells of the 'thrownness' of a pregnancy moving on to a labour. It was a busy and important day in this woman's life. She was too involved to wonder about the show she had had earlier in the day. In her mind she still had five weeks to go before she needed to consider the possibility of labour. The ruptured membranes showed themselves as a leaking all through the day. The uncovering of what was happening was not seen for what it was. This woman continued to believe her pregnancy was safe when it was showing itself as something else. When 'the flood' came, it still did not occur to her that her membranes had ruptured. She needed her mother to tell her. The 'is safe' changed to 'is not safe'. There were suggestions, cues, and finally a bold announcement.

This was all happening within this woman's body. It was noticed by others that she 'wasn't right that day'. Yet in her mind, she was alright. In her mind, there was no possibility that her membranes might rupture. In her mind was all that had to be accomplished in that day, and in the next five weeks. The 'is not safe' took over regardless of what was in the woman's mind. It happened anyway. It finally made its presence no longer possible to be unnoticed.

The covered-upness of unsafe

The experience of another woman is one of thrownness into a situation that throughout her pregnancy had remained covered-up:

During the first 8 weeks through till late in my pregnancy, probably 6 or 7 months, I felt very depressed quite a lot of the time. I just felt desperate sometimes, about how I could feel like that. Nobody else seemed to. And what say that feeling didn't go away - that would be terrible. Sometimes I was all right, and then other times it would just overwhelm me, just absolutely overwhelm me, and sort of incapacitate me so that I was always paralysed by this fear and depression. It was ghastly.

It was hard for my family. I remember my mother, the way she dealt with it was we'd go and do something: "come on, let's go for a walk" "let's go shopping" "do this, do things with me". And to a certain extent that was good. She told me after the baby was born that when she'd been a student nurse, 40 probably 45 years ago, they were told there was no such thing as being depressed, or having moods, 'that was the pregnancy', so that was the way she was dealing with it.

I think my husband spent a lot of time just feeling really confused and concerned. He just didn't know what to do. I don't think any of us did. The health professionals didn't have any solutions to offer. Perhaps there weren't any. I went to a counsellor on a regular basis while I was pregnant. It didn't offer any solutions but at least it gave me a safe place to talk about what was happening, with someone who was less affected by it.

When my baby was about 10 or 12 days old, the independent midwife was pushing my tummy as they do, and she found a lump the size of a large grapefruit in my abdomen, which was rather startling. The poor midwife was terrified. Momentarily I think she thought it was my uterus, but of course I was too well for that. We wondered if I had become constipated and I thought about that for a few days but then I realised that I was too well for that too. That size blockage in my bowel, I would be feeling really unwell, but I wasn't in fact, I was fine really. I had noticed that after I'd

walked a certain distance I felt this sort of deepened side ache and it wouldn't calm down until I got home and sat down and took a panadol. I really don't know what that was about.

I saw a specialist, and it turned out to be an ovarian cyst. It was removed when my baby was about 7 weeks old. The specialist talked about these things producing an extraordinary cocktail of hormones, so I wondered what effect that had had on my pregnancy. Not only was my body having to deal with the incredible hormone load that it needs to maintain a pregnancy, it was also having to accommodate this bizarre recipe of hormones that the cyst was producing. The cyst must have been growing while I was pregnant but as the baby grew the cyst was disguised by it. It's nice now to blame the cyst for all sorts of things, like the terrible sacro-iliac joint movement I had, and the depression.

I remember on one occasion feeling this strange lump here on the side of my pregnant tummy, which wasn't all that pregnant at that point. It was sore, and I thought "why would this be sore?", but of course the next time I saw my GP it had gone. I remember my midwife pushing my tummy and saying "what on earth's this, it doesn't feel like a head?".

It's interesting looking back. At 35 weeks the GP identified the fact the baby was a breech, and recommended that we needed a scan to confirm that. I had a scan, and I visited a consultant obstetrician, and none of those things identified this problem. After he had removed it, the comment of both the surgeon and the anaesthetist was 'its extraordinary size' and given its size, the fact it didn't impede the progress of labour. The baby was no longer breech when I went into labour, so I had been able to birth at home as planned, and it went very smoothly really. So that was extraordinary, just extraordinary. All these things happening in me, and I didn't really have any idea.

In this story the woman knew from early in pregnancy that something was wrong, that she was 'unsafe'. This is embodied knowing. Her mother, her husband, her doctor, her midwife, her counsellor, could all see that something was wrong, but at the same time understood that nothing was wrong that was unsafe. They were at a loss when it came to offering solutions because they had no understanding of the cause of the depression, or of her physical discomforts. The 'is' of this woman's experience continued, showing itself and hiding itself at the same time. Looking back, the cyst showed itself as a strange lump to the woman during her pregnancy, but covered itself up again by the time she went to the doctor. When she had a scan at 35 weeks, and was seen by a

consultant obstetrician, still it remained hidden. It is normal practice for the midwife to palpate the abdomen of the post-partum woman to ensure the uterus is returning to its normal size and place within the body. It was this practice that finally uncovered a large lump that should not have been there. The 'is' of the cyst was recognised for the first time, yet the cyst had been an influence in this woman's body for months.

The cyst was a possibility nobody had thought of. Without thought, without showing itself as itself, it had no possibility of being uncovered. It quietly played out its own havoc in this pregnancy. The woman knew she was unsafe, but with no validation of that she herself carried the burden of the related symptoms. Once the cyst was found, and credited with its extraordinary size and with the cocktail of hormones that it was likely to have produced, this woman's story is seen in quite a different light. There is now something to blame for the unsafety. There is now something to be understood. The woman is now absolved of tentative suggestions that it was all of her own making. Along with the recognition of how this woman was unsafe, is the further recognition of how she could have been even more unsafe. This cyst could have impeded the process of labour. If it had been recognised before labour, would this woman have been 'allowed' to birth at home as she did? Would she have been 'allowed' to labour at all? Would the possible unsafe scenarios that a cyst this size brought to mind have in fact altered the safety of this labour?

Where does the 'is' of safety (or unsafety) lie? Does it lie in the darkness, in what we cannot see or imagine but what is nevertheless happening, or does it lie only in what we can see, what we can imagine, what we can understand? Would this woman have been safer if the cyst had been uncovered earlier in pregnancy, or was it in fact safer the way it happened, when there was the assumption that there were no problems, and therefore the being of labour was allowed to take care of itself? Would the woman herself have felt safer knowing there was a large cyst growing inside her which was likely to be causing her depression and discomfort, or would the knowing have created an anxiety as bad as, or worse than the depression? Would it have been possible to surgically remove

the cyst during pregnancy? Would that have caused more dilemmas about being safe and being unsafe?

Where is the 'Being of safe'? It is in itself. It is a being that is assumed until it presents itself as 'being unsafe'. It is a being that follows its own course, that makes its own decisions, that ends in outcomes that may throw the recipients into disarray, surprise and perhaps a sense of terror. The Being of safe/unsafe is already there, whether it can or cannot be seen and predicted.

The practitioner and thrownness

The next story is from a midwife who tells of being thrown into a situation that had the potential to be unsafe:

I was very aware of stretching the boundary of safe practice at a homebirth a few weeks ago. And I realised how hard it is really because it was not very clear cut. The membranes ruptured, and there was meconium liquor. There was a point where I should have said "we're going to go to hospital now" and I didn't. I just thought "no, she's going to have the baby", and everything was set out, and everything was all ready, and I thought "I can't just go out there and say "change of plan", so I just carried on.

I realised that the G.P. wasn't really going to do anything, He looked straight at me and said "what are you going to do?", and there was this sudden shift, that he felt it really wasn't his problem. But he didn't say to me "well, now we must move", or anything, he just started getting resus stuff out, and getting organised, and seemed very confident and capable of that.

The baby was born at home, quite safely, and the baby was well. But did I take too big a risk? I don't know. Was it my fear of all the organisation, how would I actually do it. I would have had to run to the phone, and tell the family, and they would all panic, and I felt like I was trying to hold it all up in the air. And so perhaps I took the cowardly way out. I don't know, I don't know. Should I have just said "right, that's it"? Should I have just moved off there and then?

So I don't know. I had quite a lot of misgiving about myself afterwards, and I thought "what did I do then, did I take an unnecessary risk, or did I take a measured risk, and it was okay?" I don't know. [I-midwife]

Taking the premise that 'being safe/unsafe' is already there, and goes ahead of whatever is happening right now, this story reveals the uncovering of 'safe' and the ensuing dilemmas of practice. It shows that practitioners work with the tension of differentiating between what is normal, acceptable practice, and what is not. This family had chosen to give birth at home. The midwife and the doctor were there, with the intent of providing safe care. The assumption was that everything was safe because nothing had shown itself as unsafe. Then, the membranes ruptured, and the liquor was seen to be stained with meconium. Both the midwife and the doctor understood that this brought with it possibilities of unsafety. Meconium can be a sign of a distressed baby, a baby that is more safely born in a base hospital with a paediatrician in attendance and full neonatal services. Aside from that possibility, when a baby with meconium liquor is born, the meconium is sucked clear to prevent the baby from inhaling it and developing respiratory distress. Some would argue that this can be more effectively accomplished with the equipment available in a hospital.

This baby may have had meconium stained liquor for many days. The liquor had not previously shown itself in itself, nor had it announced itself through other signs, such as an abnormal fetal heart rate. Unsafety arose only in its showing, for in its being it had remained hidden. This story captures the thrownness of the 'now' situation. There was a baby soon to be born for whom many would consider a hospital birth more safe. There was a woman/family eagerly anticipating a birth at home. There was the possibility that this woman could give birth at any time. Even if the decision was made to go to hospital, time may have not made that possible. It would be even more unsafe to give birth en route to hospital.

While the priority in this story is on the being safe of the baby, there is a sense of other agendas of being safe. The midwife perceived that if she announced the unsafety of the situation the family would all panic. They would lose the safety they had created for themselves in expecting their baby to be born at home. For the midwife herself there is a real tension. On the one hand, it is much safer for her to do nothing, to trust that the baby will be fine and to continue to support the being of the labour. On the other hand,

there is the fear that the baby will not be fine, that she will live forever with the misgivings of having taken a risk that placed this baby's health in jeopardy, and that she will be judged and found guilty for having stretched the boundaries of safe care.

The end of this story is that the baby is fine. The decision that is hoped to be the safe choice, is seen retrospectively to be safe. Still this midwife is left wondering if it was okay. The being of safe/unsafe is abundant with possibilities that go before the situation. Some practitioners, recognising the possibility of meconium liquor in any labour, would decree that all babies should be born in hospital. Other practitioners, who see that the majority of babies born with unexpected meconium liquor have no problems, would be much more relaxed about this baby being born at home.

Where does the Being of 'safe and unsafe' lie? Does it lie in the events that are beyond anticipation or control? Does it lie in prevention - in the practitioners taking every precaution to ensure that any possibility can be dealt with effectively? Can practitioners prevent something that is already there, that is already in process of happening? Is the happening of safe perhaps an interplay between the 'Being of safe/unsafe' and the decisions and actions of the practitioner? Can a practitioner be held accountable for a 'possibility of being unsafe' that does not show itself until it is too late for any preventative action to be taken? Who decides whether 'possible' means 'specifically suggesting itself in this particular situation' or whether 'possible' means 'a recognition that the unsafe can occur in any situation'?

If the end of this story had been different, and the baby had been severely compromised through being born without access to neonatal expertise and technology, how would this discussion be different? The midwife would have still had to make the same decision 'to go or to stay' with the same information available. It is likely to have been decreed that she made an unsafe decision. There would have been voices that said "this baby could be perfectly well now if it had been born with immediate access to expert neonatal care". The family may have demanded to know why the transfer wasn't made to

hospital. The doctor seems likely to have responded “I left that decision to you”. The blame for the unsafety would most likely have been laid upon the midwife.

If the midwife had, on the other hand, made the decision to persuade the woman that she needed immediate transfer to hospital, and the baby had been born in the back seat of a car where it was impossible to suction the meconium effectively, with the baby subsequently getting severe respiratory distress, again it is likely that the unsafety would have been placed on the midwife. She would have been held responsible for not knowing the unknowable, for not correctly anticipating when the birth would occur.

If the plan for a homebirth had been counselled against in the first place because of such a possibility, would it have been safer? Equipment (similar to that used at home but perhaps more efficient) would have been available. The skilled personnel may or may not have been right there at the birth, depending on their being called in time, depending on there not being other demands on their time at the same time. It is possible that the woman may not have been as relaxed in the hospital environment. It is possible that her labour may not have been as effective. There are many possibilities, each of which could in turn have potential to undermine the safe-being of the baby.

The midwife and the doctor had a part to play in the keeping safe of this baby. The baby and the labour were meanwhile engaged in a ‘being safe’ of their own. It was the labour itself that effected the safe arrival of this baby into the world. The baby himself had been in good condition all the time, and did not inhale any of the meconium. That is where fundamental safety had its own being. That is what seems to get forgotten.

The showing of unsafe

The next story contrasts the homebirth setting with a high-tech, high risk, base hospital setting:

The woman was 35 weeks. The midwife who was looking after her, and I, said to each other "oh help, all these risk factors". "Why is she here?" we asked ourselves. "Why is she not downstairs in delivery suite?". "Let's put the monitor on", because we do a baseline on that sort of person, "and see what it says". Well blow me, the baby was good. There was the odd little tightening, nothing spectacular.

We still felt that intuition about this person, so we said to the staff, "after lunch we'll do it again". So we did it again after lunch, and it was even better. But we still felt that way, and we said to the afternoon staff, "watch it, watch this woman", there's the old intuition coming out, "these are the risk factors we've got here, you can't muck around with them" . We had told the medical staff that she shouldn't be here, but no, no, they were too busy to look at it.

So the afternoon staff put the monitor on again, and they got a trace that was a bit saw toothed, and there was this other bit that was fine. They wanted to ring me up, "is this sinusoid, or is it not?" They got out the books, no they decided it was saw toothed, but they got the medical people up, and the medical people signed it and said "yes, that's fine". And the midwives said "No, repeat it again".

So the night staff were coming on by this time, and they said to the night staff, "if you get one dip, take this woman to delivery suite, don't even ask, one dip". So, that happened, down went the dip, but everything was fine, except for that one dip. So they didn't ask questions, down she went.

They were still busy downstairs. Now this woman was on her own for sometime, and she was on syntocinon to bring her labour on, and the baseline of the fetal heart trace goes up like this, up, up, up, with those shoulder dips on it. By the time the person discovered she had this tracing it was awful. They did a vaginal examination, and it then gets another pattern, that saw toothed business, and then they rushed around and did a caesarian section. And that baby is her first baby, knocked off. [B-midwife]

Where is the Being of safe/unsafe in this story? We are told that this woman had many risk factors in her pregnancy, that is, many possibilities announcing the potential for unsafe outcomes for her baby. The midwives and the doctors were aware of this. The midwives had an intuitive sense that the baby was in some distress. They had a sense that the situation was about to become unsafe, and they believed it would be much safer for this woman to be in Delivery Unit when this happened. They kept taking fetal heart traces to get the evidence they needed to confirm their feelings. The evidence suggests possibilities of distress, but shows nothing conclusive. Perhaps more to the point, on this very busy day, delivery unit staff were as keen to keep this woman safe on the ward as the antenatal ward staff were as keen to get her somewhere safer. When the contractions of labour began under the prompting of the syntocinon infusion, this baby

announced to the world that indeed it was very unsafe. There was nobody there to notice. The staff were too busy 'being safe' with other women who needed their attention. This story has the sad end of a baby who was permanently brain damaged.

Immediately one looks for blame. 'They should never have started the syntocinon if they were too busy to stay with the woman'. 'They should have kept her on the ward until delivery unit was less hectic' 'They should have called in more staff'. 'They should have done a Caesar when she first went down to delivery unit'. There is a natural tendency to assume that this situation could have been prevented, that the baby could have been protected from harm. The question to ask is 'could it have been any different?' To become so very distressed so quickly suggests that this baby was already compromised before this story began. It was already unsafe. The unsafe went before making one more stress factor (contractions) too much for it to bear.

On the other hand, we see the myth of the safeness of the hospital uncovered for what it is. There was a thrownness about this day that threw the best laid down principles of practice into disarray. The care this woman and her unborn baby received in delivery unit was unsafe. It was unsafe because there was no choice but for it to be so. For a normal, healthy baby, a period of neglect while enduring beginning contractions is likely to be quite safe. For this baby, it was totally unsafe. Yet, there lingers the wonder that perhaps this baby was already totally unsafe. There are many questions, but there are no easy answers.

The unsafety that is always already possibly there

An obstetrician voiced his beliefs about the inherent unsafeness of childbirth:

What I like to tell students, and also women who say "oh, I want to have everything natural" is that it is normal that one woman in 20 dies during her reproductive life, dies during childbirth. The maternal mortality in the normal population without medical care etc is high, and you see that in Africa, Papua New Guinea, you see that in certain populations in North America . That is the natural state. Now some people say, "oh yes, but there are nutritional factors and social factors, and so on, it's not just the obstetrician with his forceps and caesarian section". That is true. It may be difficult to know which one is due to just obstetrics and which one is

due to all the other preventative measures. But you can't argue with a major placenta praevia, that's a certain death warrant. You can't argue with pre-eclampsia with renal failure, that's normally a death warrant, or a cerebral haemorrhage, or whatever. I think we need to realise that a maternal death is totally unacceptable these days, as is a fetal death, particularly if it occurs during birth, it's totally unacceptable. Where do I fit in, how do I see the birth? Yes, as something normal. But dying from it is also normal. [C-obstetrician]

This obstetrician voices the reminder that childbirth, left to its own normal 'being' has the possible outcome of the death of the woman and the death of the baby. Being-toward-death is always a possibility. Dying is a normal consequence of childbirth. Why then does he go on to say that maternal death, and fetal death during birth, in these days, is totally unacceptable? Unacceptable to whom: to the family, to the practitioners, to the establishment? Why is it not acceptable to let Being in its own state-of-being take its own course towards death? Is it no longer normal, in New Zealand, for a woman or her baby to die in childbirth? Is it because we know we have the knowledge, skills and technology to prevent death occurring? Or is it that we assume such powers? Have we forgotten that the Being-towards-death is already there, such is the nature of living a life? Any attempt that is made to promote Being-towards-life is an engagement, a battle, with what already is. It may succeed, or it may not succeed. If the battle for life is lost, does it mean the practitioner failed, and needs to be held accountable for failing, or does it mean that the being-towards-death overwhelmed the best efforts of the practitioner? The poet Walt Whitman offers these thoughts:

*Have you heard that it was good to gain the day?
I also say it is good to fall,
battles are lost in the same spirit in which they are won.
(Song of Myself, 18, 1855)*

Is there a manner of practice that is the same, whether the battle for the life of the woman or the baby is won or lost? Can there be applause for safe practice when the baby has died, and admonishment for unsafe practice even though the baby lives, undamaged? Is it possible to understand this manner of practice as being something different to the being safe/unsafe of the physiological processes of birth?

Safe or unsafe: it is already there

There are distinct entities coming together to create the 'Being safe/unsafe' of childbirth. The primordial phenomenon is that which is already there, that which goes on ahead. The progressive pregnancy/ labour/ birth is an entity in its own right that holds in its grasp the safety of both the woman and the baby. It is ever in the process of becoming. It is ever already there. It is ever safe or unsafe or both safe and unsafe. It throws the woman, the baby and the practitioners who offer care into situations which may be beyond their prediction and beyond their control. It is what it is.

The pregnancy
is

it grows
it is a hidden presence
it not known until it comes to be known

it lies hidden in its growing and being
until there is a showing
of itself
which may uncover what is
or may suggest what is
or may confuse what is.
or may tell lies

It may be safe
or it may be unsafe
or it may be both safe and unsafe.

It is what it is.
It is already there.
It is strong in its own being, its own growing, its own deciding,
its own happening.
It exists with the possibility of being-towards-death.
It may hover towards that possibility
or it may not.
It will choose for itself
or it will be thrown
in itself
hither
or thither

It will be safe
or unsafe
for itself
by itself
in itself.

CHAPTER SEVEN: THE SPIRIT OF PRACTICE

The practitioner is more than a person trained to act in certain ways in response to particular situations. To be a practitioner in the arena of childbirth is to take with one the knowledge that throughout the history of time, women and babies have died in their journey through childbirth. It is to take on the awareness that some degree of harm is a possibility in every childbirth experience. It is to adopt a spirit that strives to minimise that harm. It is to take a spirit-of-being into the world of practice that aims to practice safely. What then is the 'spirit of practice' that makes a practice safe?

Heideggerian underpinnings

Heidegger describes Being-in-the-world as being constituted by definite ways of 'Being-in' (1927/1962, p.83). He gives the following examples: having to do with something, producing something, attending to something and looking after it, making use of something, giving something up and letting it go, undertaking, accomplishing, evincing, interrogating, considering, discussing, determining. He describes this mode of Being as one of 'concern'. This notion opens itself to Being-in-the-world-of-practice. It would seem likely that 'concern' for the safety of the woman, baby, and the situation itself lies at the heart of practice.

Heidegger goes on to describe the deficient modes of concern: leaving undone, neglecting, renouncing, taking a rest (p.83). When concern is minimal, the Being-of-safe is likely to be at risk. Heidegger suggests that Being-in-the-world, with concern as its essence, is made visible as "care" (p.84). The concern a practitioner has about 'being safe' is likely to show itself as care. He talks of concern as "solicitude" (p.158). He suggests that the average everydayness of Being is characterised by the deficient and indifferent modes of solicitude: being for, against, or without one another, passing one another by, not "mattering" to one another. From the word 'solicitude' he goes on to describe two extreme possibilities of its positive mode. He describes 'leaping in' as taking away 'care' from the other, taking over for the other. King (1964, p.107)

interprets this as when someone (for example, the practitioner) ‘leaps in’ they take ‘care’ off the other, usually by taking care of things for them (for example, taking care of a woman’s decisions by telling her what will happen). King’s interpretation suggests that this would have the effect of throwing the woman out of her place as decision maker, and having the practitioner make the decisions in her stead. The practitioner, therefore, takes over what the woman could have, and maybe should have, taken care of for herself. On the other hand, there may be times when in the need to be safe, the practitioner must leap in with their own decision of what needs to happen. In ‘leaping-in’ care of the woman becomes dominated by ‘what the practitioner thinks is best’, yet King suggests ‘leaping-in’ may be done in such an unobtrusive fashion that it may pass un-noticed by her. ‘Leaping ahead’, in contrast, goes ahead of the other, not to take away their care but to give it back to them. It helps the other [the woman] see themselves in their care, and become ‘free for it’ (Heidegger, 1927/1962, p.159). In this mode of care, the practitioner would help the woman see the possibilities of care, inform her of the risks and benefits, and give the decision over to her. ‘Leap-ahead’ caring therefore equips and frees the woman to make her own decisions. Heidegger suggests that in average everydayness, solicitude maintains itself between these two extremes of ‘leaping in’ and ‘leaping ahead’. He tells us the guides of solicitude are considerateness and forbearance, along with their deficient and indifferent modes. What then are the descriptions offered in this study of ‘care’ related to safe practice?

Defining the spirit of safe practice

At the beginning of each interview with the midwives and doctors I asked them “what does ‘being safe’ mean to you?” When I started interviewing the women of this study, I quickly found it was not appropriate to ask them this same question. While they had reflected deeply on their own experience of childbirth, they did not have the same depth and diversity of reflections to enable them to capture their understanding in a statement. Their understandings, in a more tentative manner, emerged from their stories. Listen to the statements from the midwives and the doctors describing the characteristics of ‘being safe’:

To be safe for the woman means that I know that there's something wrong, and I do something about it. You know what to look for, what to be aware

of, and know what to do about whatever situations there are. You are vigilant, and not just in relation to taking a temperature or a blood pressure or listening to the fetal heart. It's more a complete awareness of the woman's responses and condition. It's far more total than just recordings. [A -midwife]

I look at all possible angles that might happen, and also anticipate as much as I can what might happen, for her and for the baby, and for the pregnancy. And I make sure that I am doing all those things, in my mind I'm turning them over, so that I can give her safe practice, so that she can feel that it's safe practice. [B-midwife]

Well I think safety really requires a lot of knowledge, where the limits are, and I think we are always in the quagmire between doing too much and doing too little. And we never hit it quite right of course, but I think there are reasonable limits. We all strive to hit it right. And I think it's a whole life's struggle to get it right, to get as close to right. [C -obstetrician]

It's having the knowledge to do the job that you are doing, and being able to practise to the best of your abilities, using all your knowledge. And it is working in the facilities where you feel safe, with the equipment that you need, with the back-up that you need. [D -midwife]

I would say safety is the protection of the good health and wellbeing in mother and baby. The problem with the policy of "being safe" is that it involves apportioning risks, and over-treating a very large proportion of people in an attempt to pick a group that include those that have problems and are likely to relate to safety [E-obstetrician]

I think it means a number of things. Like it isn't a very simple concept, or sense at all. It's got multiple dimensions. I think that one of the important things about being safe is to feel confident in your own abilities and knowledge, so that you can have a firm sense of what you're doing, as far as you can possibly do it, keeping the mother and her baby safe. [F-midwife]

I think it means knowing your patient well, having talked to her very thoroughly about her background, about her pregnancy, about her history, her family's history; knowing her as much as you can possibly do. And being very thorough in your clinical examinations so then you know what you're dealing with. I think it also means knowing my limits and competence level, not being afraid to ask for help. And I think it means being vigilant to a patient's condition, watching for change and acting from change. [G -obstetrician]

I guess it means undergoing adequate training, knowing your limitations, and working within those limitations. And having in place adequate

support and back-up, and being able to access that back-up. The things you do for safety may differ, depending on the institution you're working in. [H-gp]

Well being safe I guess means doing everything with the ultimate aim in view that as far as humanly possible, that mother and baby, and the family, have a successful outcome from the pregnancy and childbirth experience. And it's really hard to decide how far along the continuum you need to go. Should you do a whole lot of things, just in case, or should you have the belief that it is a safe event, and you just need to keep a watchful eye. Those are things that are continually being thrown up, that you have to keep examining in your own head. [I -midwife]

When weaving these descriptions together, the multiple dimensions of 'being safe' become apparent to us. Firstly, there needs to be knowing before one can be a safe practitioner. One needs knowledge and abilities. More than that, one needs to be confident, and able to translate understanding into effective practice. Alongside that, one needs to know one's own limits of ability and boundaries of scope of practice and to ask for help when it is required.

There are some underlying believings about practice that come through. I use the word 'believing' to capture the active, engaged nature of 'beliefs' that are always open to change. The motivation of safe practice is to keep the mother and baby safe. To achieve that safe practice, it is important to know the woman, and thereby enable her to feel that the practice is safe practice. From a theoretical stance, it is important to apportion risk, yet this creates the dilemma of overtreatment of many for the benefit of the few.

There are the specific ways of behaving in safe practice: keeping a watchful eye, being vigilant, being thorough, examining in your head, anticipating, looking for possibilities from every angle. These practitioners speak of an engaged active alertness to a situation that is everchanging, that is ever showing itself (or not showing itself), that is ever open to possibilities of becoming unsafe. The ways of behaving are described as much more than a set of tasks, they are about a total awareness of what is going on, right now, and in the everchanging 'now'. The behaviours of being safe are the embodiment of the integration of knowing and doing.

Perhaps the key to understanding 'being safe' is in 'knowing there is something wrong and doing something', but at the same time 'finding the safe balance between doing too much and doing too little'. Skilful, wise judging is required. To do too little might be to under-estimate the unsafeness of the situation, whereas to do too much might be to create unsafety in a situation that had been relatively safe in itself. It is a lifetime's struggle to get that judgement right.

Underpinning the attributes of 'being safe' are all the influences of Being-in-the-world of practice. 'Where' is safe, and 'how' is safe, and how may 'being safe' be disrupted?

These attributes, described by the participants, all fit comfortably within Heidegger's notion of 'concern' as the essence of 'Being-in-the-world'. Listen to the parallels with Heidegger's different ways of 'concern' that echo from the ways of 'being safe' just described by the participants. Where Heidegger talks of '*having to do with something*' the participants describe their business as 'having to do with protecting the good health and well being in mother and baby'. Their '*producing something*' is about keeping the mother and baby safe. They describe '*attending to something and looking after it*' as 'keeping a watchful eye, being vigilant, and being thorough'. This involves '*making use of something*', in their words 'making use of resources, expertise and back up'. Heidegger suggests concern is also about '*giving something up and letting go*' described by one participant as 'giving concern over to a more experienced practitioner when one's own limits are reached, and letting go'. Where Heidegger talks of '*undertaking and accomplishing*' we find the parallels of 'effectively engaging in the provision of safe care, which involves knowing when something is wrong and doing something about it, and all the time watching for change'. Concern is more than 'doing'. It involves '*evincing, interrogating and considering*'. The participants acknowledge this in their descriptions of 'knowing what you are dealing with, talking to the woman very thoroughly so you know her and her background, looking at all possible angles, turning them over in the mind, examining in your own head'. It would appear that Heidegger's 'concernful' behaviours are closely intertwined with the participants' understandings of 'being safe' that emerged from the initial descriptions that began each interview.

This chapter will move on now to focus on each of the dimensions of 'being safe' uncovered by the initial beginning descriptions: knowing, believing, behaving, judging, and being-in-the-world of practice. It will explore the data in greater depth to bring to light the meaning of 'concernful' practice, to capture the spirit of safe practice.

Knowing

You start off not knowing at all, and you start off with someone telling you "this is safe, this is not safe" so you sort of get these little boxes, 'this is the safe box and the non-safe box', so clean and tidy. Becoming safe is about more than that. It's about clinical knowing, when you put the book knowledge, and the journal knowledge, and the research, into the practice domain, and ... I was going to say "alchemise", that's not a word, but there's an alchemy that occurs in there with the knowledge that turns it into a clinical knowing, that isn't just a theoretical knowing, and it's devilishly difficult to describe. But it does, it almost alchemises so that you can use it in a way that is more than just applied. Application is a very direct behaviour. It's more, I can't describe it any other way, it's a clinical knowing, and it's those clinical knowings that are the basis, I think, of safe practice.

When I went into independent practice for myself my learning curve about what was normal was vertical. I really thought I knew about birth, and I did know a lot about birth. What I didn't have was the clinical knowing that comes only with practice and discussion of real cases. I did a lot of consultation with peers around findings, to try and find out what the norm was, trying to fill that hole with some clinical knowing, that is different from what you read in books. There are always wise practitioners who have heaps of knowledge that they are willing to share, and accessing the wise is an important part of being safe.

You also take advice from yourself in 'what does it feel like in your gut?' Always, the first time you do something that's a little bit different, for me anyway ... it's scary territory. It frightens the lights out of me, and I'm always relieved when I get to the other end and think "oh yeah, that worked alright", and I'm always ready to sort of 'whuip' jump back into my known area, if the slightest thing isn't going right. It probably makes me like a scared grasshopper.

Like babies grow in spurts, and because of the fragmented way that my antenatal practice has come over the years in the big institutions, I never saw anybody all the way through the pregnancy, until I started to practice for myself. And I had this terrible paranoia when I first started to practise, that somewhere in the early thirties [30 weeks gestation], and then towards the latter part of pregnancy there'd be these patches where

baby didn't seem to have grown. And it wasn't till I talked to other practitioners who said "that's alright, babies grow in spurts" that I could relax and wait for the next time without rushing her off for a scan to see if there was a problem.

That sort of stuff, you don't see that in the text books, you actually have to ask people about that, to find out about it in a way. It's the oral tradition again, isn't it, and it's not well explicated. And you can make a mistake, I would think, quite easily, or put down to just a flat patch in the growth spurting, with the spurty type growth that fetuses do, when in fact there is actually poor growth going on. So there are areas when you can sort of get trapped if you like, because of your knowledge of the normal, and the abnormal mimicking the normal. That's just the way it is. I mean we can't actually undo that, and so part of feeling safe is coming to accept that, and knowing that you are occasionally going to miss something at its earliest onset, and only pick it up a bit later. And hopefully it will only ever be one of those very sneaky things that sneak up on you, rather than anything major.

You come to learn that you can't always tell in advance and that's the trouble with that sort of maternity stuff, that around birth you do most of it with your eyes shut really, don't you. And whether that's a safe decision is often only known in retrospect, because it can only be known in retrospect. [F- midwife]

Gathering together the knowledge and skills to become a safe practitioner is a complex process. It encompasses all of the 'concernful' attributes. It quickly goes beyond the simplistic notion that the practice reality can be neatly divided into what is safe, and what is unsafe. The word 'alchemy' is used by this midwife. Alchemy is the process of transmutation, or changing something so completely that it takes on a completely different form. The aim of alchemy was once to turn other metals into gold. Other metals were readily accessed and available. Gold was much harder to come by, much more precious. This midwife talks of the transmutation of all the readily accessed kinds of knowledge about safe practice, into something that is of quite a different nature, into something much more precious. She calls it 'clinical knowing' and declares it the basis of safe practice. She describes her own process of achieving clinical knowing, with emphasis on accessing the wise, consulting, discussing, considering. They are behaviours of concern, of a Being that is motivated by the need to know, so that the knowing can determine and accomplish safe care.

The all encompassing nature of clinical knowing is reflected by the ‘knowing in my gut’ feelings that confirm clinical knowing to the self. This knowing is embodied. It is much more than a rational accumulation of knowledge. It is an engaged concern that involves the whole of the practitioner. The test of a decision is ‘how does it feel?’

The example of monitoring the growth of the fetus, again reveals the complexity of clinical knowing. Textbooks, and tools of measurement are based on the assumption that a fetus will grow at a steadily progressive rate. Wise, experienced practitioners say, ‘no, they grow in spurts’. Assuming that the ‘spurt’ theory is a safe understanding, how then does one measure spurts? How does the practitioner determine whether the Being-of-growth of the fetus is a ‘safe Being’ or an ‘unsafe Being’? This midwife talks of the ‘abnormal mimicking the normal’. In Heideggerian terms this is a semblance (Heidegger, 1927/1962, p.51). Heidegger describes concealment by disguise as “the most frequent and most dangerous kind, for here the possibilities of deceiving and misleading are especially great” (1925/1985, p.86). It seems to be normal when in fact the fetus may be experiencing abnormal growth. The unsafe is covered over by the semblance or disguise of safe. The knowing of practice must therefore, strive to evince the ‘what is’. The mimicking, the semblance, the being fooled by ‘what is not’ is a trap for the safe practitioner. That is the way it is. That is the being-of-practice.

The darkness, that which is at that moment beyond our knowing, our feeling, our seeing, is always in the midst of practice. This midwife says that “*around birth you do most of it with your eyes shut*”. There is much that you can know, that you can surmise, that you can even predict, but you can never really know until time reveals it. Even with modern technology, the most the practitioner can ever see of the fetus is a semblance, or an appearance as “an announcing itself by something which does not show itself” (p.52). The fetus can never be seen in itself, for itself, until it is born. That is the nature of the being-of-practice. That is the motivation for concerned behaviours. That is the type of complexity that breeds the spirit of safe practice.

At the same time, there is a knowing that informs practice that is much more concrete:

There is a particular Professor that I was trained by whose work was the base originator of influence on me. In 1958 he reviewed what actually

happened to babies in England, and the sorts of things that were actually a risk factor, that demonstrate risks in an epidemiological sense. For me he has always been a very good role model. I think he was a very good obstetrician and a very safe obstetrician, and he worked by rules which were established through quite a lot of his research, risk factor research. That's certainly influenced my practice a lot. [G -obstetrician]

This perspective of knowing relies on the scholarly scientific community to make rational sense of the possibilities of practice, and from that basis, to make predictions of what is likely to be safe practice. These identified risks, translated into safe practice guidelines, become the rules of knowing. You know what to do, because research has identified a significant risk, so you take precautions so this woman and this baby may avoid the risk. Evidence based practice is a knowing-of-practice that lies outside the practitioner. It is pre-packaged, pre-evaluated, pre-organised into plans of care. It is the expected practice of the professional group. It assumes that the original evidence is valid and reliable. It assumes that it is safer for a woman to receive intervention to avoid risk than to 'take the risk' of doing nothing, thus not introducing possible harm. It takes away from the individual circumstances. It is a knowing that is both strong and sure, yet may be false and harmful. It is a worthy influence on the knowing-of-practice, yet there are other influences competing. There are possibilities of tension, of conflicts of evidence, of conflicts of knowing. They come together in the alchemy of transmuting evidence into safe practice.

The believing about practice

Knowing and believing are closely linked. Believing is perhaps on a deeper, more fundamental level. Beliefs demarcate the boundaries for each practitioner about what they know to be unsafe practice:

I guess I'm about 80% along the way to birth being normal, and 20% is the abnormal end. And was it Marsden Wagner [WHO consultant for maternal and child health] who said "some babies die", that's probably too flippant for me, because I think "yes, some babies do die, but other babies die or are compromised because perhaps things weren't done that should have been done". There's no blanket ruling on that. It's not very black and white.

Like I always tell the women "it's like a big lovely golden sandy beach with a grey lake, and when you put your foot in the grey lake, then you're off. And maybe you could have got to the other side and there'd be no problems, but I'm not prepared to take the risk".

I guess I have a growing sense of, you know, maybe I think there's a bad marble in everyone's basket, and how long till mine turns up. Or, how little I know sometimes. And it's one of those jobs, when it's going well, you think "I don't even need to be here", when it's going badly "I don't want to be here". [I -midwife]

The practitioner works from a base of concern for the woman and the baby. For this midwife, it is that concern which guides her decisions of practice. She shares her metaphor of the golden sandy beach encircling the grey lake. When she is with the woman on the golden sandy beach she recognises that she hardly needs to be there. Everything is gloriously safe. She has a strong belief, however, in the importance of her role as lifeguard. The metaphor of the grey lake speaks of a sense of knowing, just by looking, that it is unsafe. Lakes are not normally grey. Is the greyness from pollution, or from the on-coming storm, or from the enormous depths of ice-cold water? This midwife stands with the woman on the golden beach and, like the vigilant lifeguard, does not let the woman into that water. She may not be able to foresee exactly what would happen if the woman swam in the lake, but she believes the risks are too great.

At the same time, she knows that the nature of birth means that every now and again the odds are that she will come face to face with the bad marble in her basket. There will be a sad outcome. It is likely to be one that nobody could have predicted or prevented. It will just happen. Being a practitioner in the maternity services is fraught with responsibility. Most times, that feels okay. Sometimes it doesn't. In the midst of a crisis there is no escape. Sometimes the practitioner must plunge into the grey lake in a heroic effort to save life, and risk their own drowning in the process.

Ways of practice: watching, anticipating, doing, doing just because, reflecting

While knowing and believing guide practice, we must also consider the ways of practice. The ways of practice are not necessarily planned undertakings, but rather an

embodied mode of being in the situatedness of practice. The ways are about watching, anticipating, doing, doing just because, and reflecting.

Watching

I say "this might be your sickest woman, but watch this woman here, this woman here and that woman there, you need to watch them, because they are reporting that their movements are less. This woman has had a bleed before, she may not be having it now, but watch her, watch those things" [B-midwife]

Watching is an engagement, a knowing alertness. It involves a sense of knowing what you are watching for, and an alert attention that understands that although there is nothing to see 'now', that could change, and that change could go unnoticed without 'watching'. While watching implies 'looking with one's eyes', it is more than that. It is an embodied watching that includes listening, touching, smelling. Just as the night watchman is on the alert with the whole of his body, even to the awareness of the tingling down his spine that senses what he cannot see, so the practitioner takes their watch. Watching implies a solicitude, a readiness to leap in and take over care, or leap ahead and give care over to the woman. Watching is not watching unless it is underpinned with the being of concern. Watching is vigilance to the being of safe/unsafe.

Anticipating

Watching is bred from the anticipation that something could change, yet anticipation is more than simply watching. Anticipation thinks ahead to the possibilities, and begins to make tentative plans:

A person with high blood pressure, you know they are going to go down a certain road, and there are several tracks in that road. And this person who you have never met before, and who you have to assess instantly, might go down this road here. You know the needs that they're going to have then, so you anticipate those needs before it actually happens, so that they can be prepared for them. It's not that I'm going to tell them all the things that are going to happen to them, because I'm not. Why scare them half to death, especially if they don't need those things. It's probably from experience, but it's also from planning out. Planning 'is this going to happen?', 'what might happen?', 'let's plan for this, let's hope it's going to be normal but let's plan for this'. And then suddenly those things just start to fall into place. And you think, ah ha, this is it. [B -midwife]

Anticipating draws on clinical knowing. It predicts potential needs, and sensitively prepares the woman for the possibility of those needs arising. It is solicitude that leaps ahead, not to take the care away from the woman but to let her also be involved in what might happen, so she may be able to participate in effective decisions if the possibility eventuates. At the same time, it is solicitude that is alert and ready to leap in, if the crisis suddenly arrives. Anticipation respects the darkness that covers what cannot be seen. It looks for semblances or appearances of the thing itself. It makes plans based on how the thing itself might be. It is always attending, considering, discussing, evincing, determining. It is always in process. It is a being-of-safe.

Doing

Knowing, watching and anticipating are the precursors to the doing, and are encompassed within the doing. Yet the doing is more than that:

Your main thing is to know when you've got a problem, and then know what to do about it. You see, I go to a birth, and I assess the woman, and if there's something there that needs adjustment, and I feel I can do it, then I do it. And then if I feel I can't, then I do something else about it. I don't see it in terms of safety as such, I mean, I see it in terms of 'how's the mother, how's the baby'. I think that pregnancy and birth are normal functions, and there are times when things don't go right, and so therefore you have to do something about it.

So you have a practitioner who knows what to look for, what to be aware of, and knows what to do about whatever situations there are. If it's a minor thing you'd use alternative remedies, and if it's something more major, well then you have to refer to the obstetrician because that's where their skills are. I don't respond to anything as a routine, I just respond to what's happening. I mean I don't do anything arbitrarily. I just respond to what's happening, because you never know the sort of hidden potential for the woman you're looking after, or even the hidden inadequacies. So you just have to be alert to things. But you can't say, oh well this is happening, this is what I do, because that's not what I do necessarily. [A-midwife]

This domiciliary midwife offers a clear picture of how closely the doing is related to the understanding of what is going on, to the watching, the anticipating, the discerning. There are no ready-made recipes for 'doing'. First you must clearly establish what is happening with the woman and the baby in this particular situation. Then you need to

recognise the range of skills you have to offer in terms of resolving a problem situation. Linked to this is the need to clearly recognise what problems are beyond the scope of 'doing' of the midwife. If the birth process has moved from normal to abnormal then the doing needs to be transferred to the skilled hands of the obstetrician. The concern of the midwife includes a willingness to 'let go the doing' when the doing needs to be in the hands of someone with different skills.

Doing and understanding are woven together. They need to work in harmony. It is in the doing that the spirit of practice is made visible in a more tangible mode, for it is in doing that care is revealed. Note the harmony in this description of leaping in and leaping ahead. There is a continual alertness, the practitioner is ready to leap in should a crisis arise, but at the same time they are always searching for the hidden potential or inadequacies of this particular woman and baby, in this particular labour. There is recognition that if the hidden can be uncovered, the Being is free to be itself. There is no take over, unless the situation itself demands to be taken over.

An obstetrician talks of the importance of the pre-planning that facilitates not only prompt action but also safe action:

I think, from a medical perspective, you need to really impress upon new practitioners the need to go through the basics of history, know your patient, talk to your patient, listen to your patient, and examine your patient carefully. That's something that should get reinforced everytime they see a woman and present her. And to pick out of that any features which might be regarded as 'at risk' features, or to recognise the normal if the normal hits you. And to think about the people that you're dealing with rather than to sort of herd them through, like sausages on a sausage machine.

In terms of being safe for procedures I think one needs to, each time you do something, mentally have a check list of safety features that you tick off, like before doing a forceps delivery there are five different things you go through before you are able to say you can safely do that. And I think they just need to be taught and taught and taught, and regarded as integral parts of care. And there are times when they are going to be unsafe because they are busy or hassled or they're rushed. I think everybody's made life threatening, or near life threatening errors at times. I know I have. And you've got to try and learn from the mistakes you do make. [G-obstetrician]

This is advice from an experienced practitioner about the solicitude of the doing-of-practice. They first describe the kinds of behaviours that facilitate leaping ahead, that they do not presume to know the woman or the situation that presents itself, but rather through talking, listening and examining, find the potentials and possibilities. At the same time, there is caution that if a leap-in situation arises, one must be able to respond almost without thought, with a knowing that is in the actions themselves. A personal readiness, a programming for action needs to be established. A set way of doing something in this situation may be much safer than working-it-out-as-you-go. Leaping-ahead, and leaping-in are opposite modes of practice, yet both are integral to 'being safe'. Leaping has connotations of springing vigorously. There are unsafe possibilities in such vigour. One can only hope that the landing will be on safe ground. Once the leap has been taken, there is little that can be done to change 'what is'. The practitioner may leap with the best of intentions, but the outcomes may not always be safe.

Doing just because

So far I have presented you with a story where each new notion of practice is bred from, and dependent upon, the previous notions. More and more, it seems a nonsense to separate them out as distinct from one another. This notion of 'doing just because' reveals the complexity of trying to understand the behaviours of practice. It suggests that at times they may be beyond understanding, yet not beyond faith and trust:

There was somebody I worked with the other week who was saying that for some reason unknown to her, she decided that someone who was booked for a homebirth should go to hospital. There was no real reason for that, she just said, "I think you'd better go to the hospital". The woman said "I'd rather go to a little hospital", and she said "No, I think you'd be better off in a base hospital", and she didn't have any very real basis for that. The woman went into labour, and off they went into the base hospital. The baby arrived with the cord very tightly around the neck, was significantly depressed at birth, and needed significant resuscitation.

Now you can only explain that stuff by intuition. Like there isn't any other way to explain that, there was nothing clinically that would give you any knowledge about that. During labour, the baby was fine. It was just a short cord that was around the neck very tightly, and the baby was depressed. It was fine, like it was in the right place, and again the paediatrician was on the floor, right there, outside the door, just passing.

[F-midwife]

Assumptions are made that the doing-of-practice is based on evidence, on experience, on policy, on the woman's choice. This example is a doing not based on any of those. The plan for this woman not to birth at home, nor to birth in a small hospital, but to birth in a high-tech base hospital was based on no more than a feeling experienced by the midwife. There was no reason to support the advice the midwife gave this woman. There was every possibility that either the midwife, or the woman, could have discounted this 'feeling' as nonsense.

The darkness of this situation, when brought to light at birth, was that this baby had a very short cord, which resulted in fetal distress at birth. There was no way that could have been uncovered prior to birth. There was similarly no way the paediatrician could have known to be outside that particular room at that particular time, yet he was right there when he was needed. There are no logical explanations. The midwife was 'being safe' by trusting her feelings about the darkness. The woman was 'being safe' by trusting the advice of her midwife even though she had no evidence to support it. The paediatrician was just there because he was there. 'Being safe' has a being beyond logical, evidence-based explanation. 'Being safe' sometimes is simply a doing towards what feels safe.

Reflecting

The behaviours of practice do not stop at the end of the day, or at the end of the case. They travel with the practitioners as they re-run the video in their mind, as they look back on what happened, what they did or didn't do, and wonder 'what if?'.
And sometimes I look back, you know - induced a labour and it hasn't gone well, and it's ended up a section, and think "should I have done that?" But I guess we try to practice as safely as we can. And you've got to try and learn from the mistakes you do make. [G-obstetrician]

Anticipating is looking forward in time, reflecting is looking back in time, determining whether one's practice was as safe as it could have been. It is the considering and the discussion that happens when the dark has become light. Now one can see what was previously covered up. Now one can understand. Now one can recognise what had been

safe all the time, and what had been unsafe all the time. Now one can acknowledge the consequences of doing too much, or doing too little. Reflecting is unlikely to change anything for the situation that has been, but it might change something in the future. Heidegger tells us the past of 'being a practitioner' is not something that follows along after, but something that "already goes ahead" (1927/1962, p.41). The behaviours of practice that were found to be safe will go ahead of that practitioner, just as will the action or lack of action that in hindsight is seen to have led to unsafe outcomes. It's about learning from the mistakes. It may be that the learning that goes through the process of alchemy becomes the wise knowing of practice.

Judgement-making

Why has judging arisen out of the category of 'ways of practice' to stand on its own? It is an action, based on knowing, just like the other modes of practice described. Indeed one may ask, can it be separated from watching, from anticipating, from doing, for surely judging comes before and follows after any particular action? I am reminded of T.S. Eliot's 'still point':

*At the still point of the turning world. Neither flesh nor fleshless;
Neither from nor towards; at the still point, there the dance is,
But neither arrest nor movement. And do not call it fixity,
Where past and future are gathered. Neither movement from nor towards,
Neither ascent nor decline. Except for the point, the still point,
There would be no dance, and there is only dance.
I can only say, there we have been: but I cannot say where.
And I cannot say, how long, for that is to place it in time.*

from Burnt Norton, Four Quartets

At the still point a judgement is made. Yet the judgement is entwined in all that was known before and all that is come to be known after. At the still point the judgement is of the 'now', but the now has gone, with a new 'now' in its place as the judgement moves forward. Without the judgement, there would be action or non action of a different kind. The judgement at the still point has made this action (or non action) what it is, yet who knows how that action (or non action) would have been without the still point of decision. Who can place that judgement in time - was it made in its watching and anticipating, or was it made in its doing? How was it made - was it made through

logical deduction, or was it leapt upon as the thing to be done? Is it the still points of judgement that transmute unsafe to safe, or perhaps safe to unsafe? Without judgement, there would be no action other than the Being-of-happening. Being-safe/unsafe would be free to determine its own being-towards-life or being-towards-death.

Let us look to the still points of skilled judgement in the following extracts:

I don't always use monitors when a woman is in labour, and I probably go a lot by gut feeling and perception of that patient, and I feel quite safe. When I make a decision that I'm not going to monitor the woman I actually feel very safe in that decision. I do trust my feelings, trust my perception, or whatever ... I think there's lots of intuition in midwifery. I think that sometimes you actually do things because you think there's something wrong here but you don't actually know what's wrong, or you just get the feeling "I've got to do this" or "This person is going to be alright". I think you probably get vibes from the woman, because I think some women know that there's something wrong, and others don't. And so sometimes in fact you practice by picking up their vibes, and you know that you have to do something. [D-midwife]

Where is the still point in deciding that one baby needs to be monitored through labour and another does not? This is an experienced midwife who has learnt to trust her feelings. Her feelings are based on the gathering together of many subtle cues, perhaps without her consciously recognising that she knows what she knows. Her understanding is fine-tuned enough to recognise the knowing of the woman who senses there is something wrong with her baby, and also alert to the woman who does not have that knowing. The skill of this midwife's judgement is that amidst the busyness of a delivery unit, there would be many still points of judgement. She would not 'just not think about' putting a monitor on a woman, she would have decided there was no need to put the monitor on. If you asked her how she decided, it is likely she would find it hard to give you a specific answer. Her decision is likely to be trusted regardless, because experience has proved it reliable. Her still points are a hallmark of her practice.

This next general practitioner talks of the nature of some of the judgements of his practice:

I guess I do take a few risks, but I always calculate the risks, and you often discuss that with the patient. Like for instance, if I've got a woman

having their second or third baby, who's forty one and a half weeks, and wants to be delivered, they've had enough, and have got a soft stretchy cervix, head well down, I think it's a bigger risk for them to have to go off to the base hospital and have an induction. In consultation with the woman I say "look, this is generally not the practice we do at this community maternity unit, but I think this is a low risk procedure. If you are happy to take that risk with me, are you happy for this to happen?" I don't know how that would sound in court if anything went wrong, it probably wouldn't, because the woman's taking your advice, but you haven't necessarily given her full informed consent. But I mean, I would take those risks. One day I'll get caught out. [H -gp]

The still point of the decision to take a risk is another hallmark of skilled judgement. It leaps ahead to consider what is best in this particular situation, for this particular woman. It weighs up all the possibilities of 'what could go wrong' and finds none of them are convincing enough not to take this risk. It recognises that the risk is as much for the practitioner as for the woman. That judgement could be held up in a court of law one day for others to decide on its wisdom. It will be difficult to take the people of the court back to the still point where the judgement was made. Would the people of the court ever understand how such a risk could have been so calmly taken when they hear of the disaster that followed? Perhaps it is not possible to ever return to the still point. One can recall it. One can describe the things that led up to it, and that followed it. One can defend it. But the still point, the moment of thoughts becoming judgement (which lead on to the cascade of events that follow), that still point can never be reclaimed. One can only say "there we have been" (T.S.Eliot, *Burnt Norton*).

Skilled judgement stands out, for itself, in itself:

It was a homebirth. The woman had made no progress at all. Her sister was fluffing around. I didn't pick it up right away that that's what the problem was, because her sister was being very attentive. And so eventually her labour stopped. I took the woman aside and I said "well, what's the problem?", and she said "well, it's my sister and I can't ask her to go home". I said "I'll ask her to go home", so I explained to her that labour had stopped and it would probably be a good idea if she went home and let the woman have a rest. What it turned out was, that this girl had been sexually abused by her brother, and when she had told her sister, the sister denied this could have happened to her. So there was all this hostility between them. As soon as her sister went, away went labour and she had a nice normal birth. So you see, just changing that factor

made the difference. Otherwise what are you going to do, are you going to transfer? [A-midwife]

Another practitioner in this situation might have been so intent on the labour slowing down, and so focused on the text-book possibilities and the text-book solutions, that their judgements and subsequent actions could well have changed this normal labour to one of a cascade of interventions. This midwife, however, leapt ahead and explored what was happening in this specific situation. The woman, when asked, knew what the problem was. The problem was easily removed. The labour proceeded normally. Skilled judgement protected the safety of this labour and birth, and yet the actions were far removed from the direct physiological processes. Skilled judgement, at the still point, maintained the 'spirit of the dance'. It knew what mattered most. It knew the disguise of the sister's attentiveness.

Being-in-the-world of practice

The practitioner may have the intent and the abilities to practice in the spirit of 'being safe', but is that enough? How does the world in which they practice constitute safe/unsafe practice? Heidegger suggests that when the world of practice is present-to-hand and ready-to-hand, in its authentic state it withdraws (1927/1962, p.99). That means the practitioner is able to practice in the way they want to practice, because everything that is there to support such practice is on-hand, ready, and able to be used without thought that it is there, ready and waiting to be used. For example, if it is decided that the labouring woman will benefit from time in the spa bath, and the spa bath is available, unoccupied, and functioning as it should, it is in its state of readiness and is taken-for-granted. It is only when something "stands in the way" of our concern" (p.103), when what we need from the world of practice is not 'to hand', when it is unready-to-hand, that we encounter the world of practice. If the spa bath had had a sign on it 'out of order' the world of practice would suddenly have 'come to matter'. In other words, when the concern of practice may be acted out in its fullness, the world of practice becomes irrelevant. It is only when things (meaning equipment, other practitioners, time) are not there, are not working, are in disarray, and the practitioner is unable to act in the 'concernful' manner they would choose to, that their world becomes

taken notice of. It is then that they see “for the first time *what* the missing article was ready-to-hand *with*, and what it was ready-to-hand *for*. The environment announces itself afresh” (p.105).

How does the environment of practice announce itself to the practitioners in this study?

I think mainly when it doesn't feel safe, it continues not to feel safe for a while. And that might be factors like you've got seven people coming in all at once. Instantly I don't feel that's safe, because I haven't got a handle on everybody. So if I haven't got a handle on everybody, neither has anybody else. That's one factor. A second is if you've got a lot of junior medical staff who really don't know what they're doing. You can't be watching them all, all of the time. They don't always come and say to me, this is what I'm going to do. And so that makes it very difficult. And then the practice of people who do things without thinking. I mean a doctor sometimes only has to say "do this" and if you're a very junior midwife, you do that. You don't question what the practice is. [B-midwife]

What stands in the way of safe practice for this midwife are her memories of too many women being admitted at the same time, and a lot of junior practitioners who don't know what they are doing, and who do things without thinking. The admission of a woman, and a junior practitioner are not unsafe situations in themselves. It is only unsafe when the numbers of them increase to a level that changes the being-of-practice from being ready-to-hand to unready-to-hand. When this midwife is deprived of the time required for her to ‘get a handle on each woman’ then something has stood in the way of her safe practice. Without such a ‘handle’ she cannot leap-ahead, she can only leap-in blindly. Similarly, when there are too many junior staff, their numbers stand in the way of her concern for supervising their practice. It is only in not-being-able-to-supervise that she recognises the authenticity of their potential unsafeness.

An obstetrician describes what stands in the way of the concern of his practice:

The easy toing-and -froing in consultation and care is something that is a very enjoyable part of our life, of our work. It is really very satisfying to go in and help a younger or a less experienced colleague in dealing with the situation which he or she thinks is dangerous (and it may well be), and unusual, and rare, and complicated, and difficult to make a decision about, to go in, to work through the decision with them, and to help them with the eventual steps that are required, and to go home. That's actually

part of O+G and that's part of being a specialist, and it's one of the better parts.

Sometimes I feel really brassed off because in retrospect, in reviewing the clinical situation, opportunity: a) to be involved, b) to alter decision making, and c) to improve the outcome, might have existed two weeks or two months before, and you just feel grumpy about being called in, and in these days to take on the responsibilities, from a point in time that you have no influence on the actual choosing of the time, and then having to deal with the possible poor outcomes.

I think we all accept that we are all going to make mistakes, and somebody making a mistake, I don't feel bad about being called into help that situation. But somebody who's been neglectful over a long time, that really is a difficult one to deal with. It's difficult to do collegially, in terms of patient information, and maintaining trust of colleagues, and not dropping everybody in it, and all those issues that come into it too, which you shouldn't have to do. [E-obstetrician]

His concern for safe practice is undermined by other practitioners who stand in the way and block his opportunity to promote, maintain or regain safety by asking for his help at the wrong point in time. When he is finally asked for help the unsafe situation may be beyond redemption. He feels helpless, and is frustrated by his knowing that earlier in time he may have been able to be helpful. The timing of referrals is taken-for-granted, it is what he is there for, until the timing is wrong. It is wrong timing that uncovers neglectful practice, that makes him vulnerable in his world-of-practice, that undermines his ability to accomplish safe outcomes, and that surrounds him with personal/professional dilemmas.

The 'where' of birth is described by this midwife in terms of what 'stands in the way':

Definitely the home feels much safer to me. And I think it's because I don't cope very well with authority. I've got quite a fear of authority, and in hospital I'm always feeling that I haven't done something. Like the fear of the computer is terrible for me. Having the baby is no problem, but I think "how am I going to put it on the computer?" And all those constraints of time, and "you should have them out of there". Whereas at home that just doesn't even come into it. I feel very much safer at home. When I get into the hospital with someone I actually start to fall apart a bit, and I have to actually think, well this is the same, just do the same things. [I-midwife]

This midwife feels her practice is safe in the homebirth setting. She starts to 'fall apart a bit' when she goes into the hospital setting. Things like authority, computers, time constraints, other people's opinions, stand in the way of her 'concernful' practice. She is distracted from what matters. Her feelings are contrasted by the general practitioner:

I do have some safety concerns at home. I mean obviously you would only deliver people at home who were extremely low risk, but, as I said earlier, some of those risks are not entirely predictable, and some of those events aren't entirely predictable. Some people say, well what's the difference between delivering at home and delivering at a community maternity unit. Well there's not a lot of difference, but there are some differences. You can always get an extra pair of hands. They can call people in quickly. You're in a building where the ambulance drivers know where to find you. You've got a resuscitation table and equipment associated with it. I think it's a slightly different ball game. I'm sure if I actually started doing home deliveries I'd probably get quite confident, it would be just another hurdle. I just haven't bothered. I don't think I will bother really. [H -gp]

This practitioner bases his thoughts about homebirth on imagined un-ready-to-hand situations. He knows what matters most to him about the environment of birth. He knows that these are the things that could stand in his way as huge barriers to safe practice. He is not saying that you cannot deal with these situations effectively in the home. He is rather saying that his anticipation of them being ready-to-hand when needed does not give to him the feeling of confidence that is integral to 'concernful' practice. To attain that confidence, he would have to become involved for himself, he would have to go through the vulnerable process of learning to trust. The things that stand in the way are the hurdles of practice. He appreciates that he could learn to jump these hurdles successfully, but has chosen not to.

The thrownness of birth means that even for a practitioner with the best intentions, what 'stands in the way' may sometimes be their own limits of endurance:

Monday night I got 3 hours sleep, Tuesday night I got 3 hours sleep, Wednesday I got 7, Thursday I got 4, I was just exhausted in the afternoons at work by then. I feel that I can't give as much to General Practice, and I just hope that nothing serious comes in. I'm a bit worried about that sort of situation, when I can't be bothered, I'm too tired. It doesn't happen that often. That happens at a bad run about 3 or 4 times a year. [H -gp]

What happens when a practitioner has reached exhaustion, and another woman rings to say she is in labour? What happens when the ordinary work of the day must proceed despite the fact the practitioner has not had enough sleep to 'be bothered' if something with the possibility of seriousness passes their way. Some practitioners have arrangements with colleagues for support in such situations, but it is not a legal requirement. There is nothing to stop a practitioner working hours on end without sleep. Compounding the issue is the plea from the woman to 'be there for her'. Does the woman stop to consider if her trusted practitioner is too exhausted to deliver safe care? Who should decide when a practitioner is no longer safe to practice due to exhaustion? In the spirit of safe practice a practitioner's exhaustion is surely a fundamental consideration to the concerned practice of the practitioners themselves. If they are too tired to think, too tired to anticipate, too tired to be alert, then it is their responsibility to have a strategy in place to ensure the woman has her care handed over to someone else. It is the responsibility of all practitioners to support each other in enabling this to happen.

What is the spirit of practice?

The spirit of practice is one of concern. The concern is for the wellbeing of the woman, the baby, the situations of care, and for the self as practitioner. Concern has many attributes. It is deeply rooted in an alchemy of knowing. It is motivated by strong beliefs about what is safe, and what is not safe. It is demonstrated in the embodied modes of practice of watching, anticipating, doing, doing just because, and of reflecting. It finds the still point in the moments of skilful judgement making. Concern leaps in to take over in a situation of crisis, but wherever possible leaps ahead to foster a spirit of freedom for the woman and for the being of the process. Concern constitutes itself, but is also constituted by the world of practice. Things can stand in the way of the concern of the practitioner, undermining their ability to accomplish safe care.

All of this has been uncovered in the positive, with the assumption that practitioners want to be safe, and will be as safe as they are able. Heidegger reminds us, however, that concern in its average everydayness is also to be found in its deficient and

indifferent modes (1927/1962, p.159). The spirit of practice so far described may be manifest in some practitioners most of the time, or in all practitioners some of the time. It is what is aimed for, hoped for, taught about, expected. It is not, however, the experience of some of the women of this study, nor even of the practitioners reflecting on the practice of others. Chapter 9, on Breakdown, reveals the deficit modes of the spirit of safe practice. The spirit of safe practice is akin to an ethic of practice. It is a striving, a sharing, a sensing, toward the embodied understanding which upholds the right of every woman to receive safe care.

The spirit of practice
wants to do its very best
wants to save the woman from all harm
wants to have the perfect baby
wants the woman to feel safe
wants to be seen as safe
wants to be safe.

The spirit of practice
never sleeps
never gets discouraged
never gives up
never takes short cuts
never ceases from vigilance

It has a knowing
as precious as gold

At the still point
the spirit is born again
in the judgement,
living again
in all its consequent
being
and
showing

The spirit

So
vulnerable
to what stands in its way

So
easily misguided
by the disguise

So
blinded
by the darkness

The spirit of practice
where is it right now?
in the humdrum of everyday

CHAPTER EIGHT: RELATING

The woman becomes pregnant. She relates to the thought of her baby that will one day be born, and to the feeling and showing of the baby within her. Her own body has a new relationship with itself. The woman is likely to be together with others - she will share the pregnancy and baby with them. They are already there, thrown with her into this new arrangement of family. At some stage the woman is expected to choose who she will relate to for care during her childbirth experience. Once that choice is made, she finds herself in the midst of new relationships. The practitioners she chooses are themselves in relationships with other practitioners. For the woman and her practitioner, all may not go as planned or hoped. The thrownness of the experience may mean that the woman ends up in a situation being cared for by unchosen, unknown practitioners. New relationships will need to be formed, often in the midst of personal crisis for the woman. Then there is the relationship between the person (be it practitioner or woman) and the technology of care. Who takes control in this relationship - the person or the technology? How do all these relationships impinge on being safe or unsafe? How do relationships alter the being-of-self? How do relationships come to make a positive difference to the experience?

Heideggerian Underpinnings

Relationships begin with self, and happen to self, yet by their very nature they are about being with others. Heidegger (1927/1962, p.154) defines 'Others' as not meaning "everyone else but me", "they are rather those from whom, for the most part, one does *not* distinguish oneself - those among whom one is too". In other words, when one is in a relationship, as for example a woman is with her midwife, the woman does not distinguish the midwife as a distant 'other', but will see her as her own midwife, her own partner, a person within her own world. The woman sees the relationship in terms of her own being. Heidegger goes on to declare "the world of Dasein is a with-world" (p.155). The midwife is there too. There is a 'there-with' sense for both the woman and the midwife. Dasein, in this world of Being-with-others finds itself "in *what* it does,

uses, expects, avoids” (p.155), in those things with which it is *concerned*, in those things that *matter*. The woman does not see the midwife as one sees plastic fashion models in shop windows - static, with no impact other than the visual presence. The woman rather sees the midwife “ ‘at work’, that is, primarily in their Being-in-the-world” (p.156). The midwife, or doctor, engages in the practice of ‘being safe’, and the woman lives out her own being-of-pregnancy. Being-with-others is about the solicitude of leaping-in, taking the care away from the other (when appropriate), and about leaping-ahead, giving the care back to the woman. Solicitude is guided by considerateness and forbearance to the other, or by inconsiderateness and perfunctoriness. There is, therefore, potential for a relationship to build and strengthen, or to neglect and harm. Steiner (1989, p.91) interprets Heidegger’s meaning: “Thrown among others, enacting and realizing our own Dasein as an everyday being-with-one-another ... *We come to exist not in our own terms*, but in reference to, in respect of others”. A woman therefore will describe her experiences of childbirth not merely with the camera focused on her alone, but with the others of her experience, perhaps not only ‘being there’ but at times taking on the leading roles. Her experience will exist, and be described, by means of her multiple relationships with others.

How many ‘others’ are there, and when do they become too distant to the relationship to matter? Heidegger suggests that when the ‘other’ shrinks back into inconspicuousness, from ‘Jane, my midwife’ to ‘the staff on this ward’ to ‘the maternity services’, the other becomes ‘they’ and the ‘they’ takes on a dictatorship of influence:

Dasein as everyday Being-with-one-another, stands in *subjection* to Others. It itself *is* not; its Being has been taken away by Others ... These Others, moreover, are not *definite* Others ... The “who” is not this one, not that one, not oneself, not some people, and not the sum of them all. The ‘who’ is the neuter, *the ‘they’* (1927 / 1962, p.164).

Heidegger describes this relationship with ‘they’ as “the inconspicuous domination by Others” (p.164). He shows us how it is:

We take pleasure and enjoy ourselves as they take pleasure; we read, see, and judge about literature and art as they see and judge; likewise we shrink back from the ‘great mass’ as they shrink back; we find shocking what they find shocking. The ‘they’, which is nothing definite, and which

all are, though not as sum, prescribes the kind of Being of everydayness (p.164).

The power of the 'they' lies in the averageness with which "it prescribes what can and may be ventured, it keeps watch over everything exceptional that thrusts itself to the fore" (p.165). The 'they' is said to constitute "publicness" which "controls every way in which the world and Dasein get interpreted, and it is always right" (p.165). Therefore, Heidegger says, "the Self of everyday Dasein is the they-self" (p.165). The Self has been taken hold of by the they-self, which has been dispersed by the 'they'. It is important to recognise that Heidegger's notion of 'they' is neither a good nor a bad relationship with the self. It simply 'is'. It brings to our awareness the recognition that our understanding, and our possibilities, are constrained or set free, in our relationship with the 'theys' of our world.

It follows that in uncovering the Being-of-safe/unsafe we must look beyond the Self of Woman, and beyond the Self of Practitioner, for neither experience their world as isolated entities. We need, therefore, to consider the they-Self. Whoever speaks of self, also speaks, whether implicitly or explicitly, of the influence of the other people they engage with. For example, the woman brings with her her family, her midwife or doctor, her close friend, whoever is in some way involved with her 'being pregnant'. The attitudes, advice, support, concern, of all of these people will colour her experience of 'being pregnant'. They are part of the being of her pregnancy. They are relationships that matter. If they are good relationships they will bring with them the solicitude of considerateness, enhancing her experience of 'being pregnant'. If they are relationships where there is little concern, little understanding, little support, her 'being of pregnancy' is likely to become vulnerable. She is likely to feel less safe. Further to that, we need to be alert to the inconspicuous 'they' which dictates what is right, what is wrong, what is safe, what is unsafe. 'They' might speak through the magazine read in the waiting room, in the dramatic emergency of birth in the television series, in the frown from the woman at the checkout at the supermarket, in the expectation that 'of course you will want to breast feed your baby'. 'They' know, and their knowing pervades stealthily. 'Their'

input may help or hinder the 'being of safe'. Let us then examine the experiences of 'relating' from the data.

Intimate they-self relationship

The woman is most often the first to come to a recognition of possible pregnancy. She then shares her possible pregnancy with others:

Two years on, I became pregnant again. It was totally unplanned and unexpected. It took us both by surprise. Initially it seemed really bad, in that I hadn't really anticipated having another child. As time went on I started to feel accepting. I sort of thought, 'well, if this is what's going to happen, then so be it'. It started to feel quite right, you know, in terms of timing, and we accepted it.

This time I guess I knew that the likelihood of having genetic abnormalities increased once you hit forty, so it was that that made me decide I had to know this time. I felt like I was in a different age bracket, and there's more of a statistical risk. I suppose that was that whole unplanned part too, I felt like I hadn't really given the baby as good a start as I could have done.

One night the midwife rang up and said "I need to see you". I just felt really horrible. I thought 'well things aren't right'. The midwife came. My husband had had to work late, he came in towards the end. So she sat down, and sort of said, "well, things aren't o.k", you know, that the screening had come back, that the baby did have genetic abnormalities, and, what did we want to do. I felt really confused, I really didn't know what to do. I think, you see, my decision to not have an amnio with the previous children, was that I would not have chosen to have an abortion. So in choosing to have a cvs [chorionic villi sampling], that was always, yeah, that well things would come through. But I guess I never really wanted to seriously consider it, although I knew it could well be an outcome, I can't honestly remember. I remember that they were very fair with the information that they gave us.

It was not an easy decision to make. For me, I actually would have been happy to have continued on with the pregnancy, because for me, I sort of thought, 'well there are women who have babies like that, and that there are things that those children bring that can add to life'. You know, part of me was really scared about what would it mean to me as a person, to us as a family. But it was my husband who was really - it really scared me for our relationship too, because he was quite dogmatic about, that we shouldn't go ahead with the pregnancy, and all his reasons were really sound ones.

I think I was more connected to the baby than he was. That was revealed when we actually did go into the hospital, and they had a woman who is sort of like a counsellor. You see, I was really scared about our relationship. For me I just remember times of real sobbing, real sadness. My husband didn't have anything, you know, the gates went up - bang. I was really horrified by his hardness, and his resoluteness. Part of me was thinking, 'I don't really know if I really want to love this man anymore', you know, 'this is how cold he is'. But I knew that there was a soft part of him, a really feeling part, which is what I really love about him.

It was really good, because the counsellor basically, she asked him some sort of question, or I said to him, 'I need to know if you're feeling anything'. That's when he burst out into tears and said "I just can't think of it as a human being, it's just too painful". I realised then that he was basically denying, it was his way of coping. But part of me felt a relief that he was this person, and I really did know who, and who was important to me. I guess it was his resoluteness, that in a sense carried us through it. Because I also was aware that if I'd made that decision to continue on, that I might not have his support. And that wasn't a really nice space to be in either, because part of me feels horrible that someone else has that degree of influence over your body, that you feel that submissive towards them. It also made me aware that for our relationship, could, though I doubt it, have the potential to jeopardise itself.

I suppose it did feel right, but it was so sad, it was just horribly sad. I suppose part of me still feels, like, 'callous bitch'. I don't feel like I'm a murderer, but I do feel ... I don't like that part of me.

If I had got pregnant again, yes, I think I would have another cvs. Oh, but no, hang on, I suppose, oh ... and then I think, well, 'perhaps I might not'. I really don't know, I honestly don't know. Isn't it funny, you think you're dead set about things, and then you suddenly discover that you're not.

The Being safe/unsafe of this story lies in the they-self. That is perhaps why it is now so hard for this woman to know what she would do next time, for she has come to know that it was never her decision to make in isolation. It was the they-self who lived through this sad time. The story begins with her finding herself thrown into an unplanned, unwanted relationship with a new pregnancy. She and her husband work through the consequences of having another child, and come to look forward to this new relationship. The woman meanwhile is under the dictatorship of 'they'. She knows that being over 40 she is expected to take steps to find out whether this baby has any genetic abnormalities. She obeys the 'they', even though she made confident decisions not to

have genetic testing with previous pregnancies because at that time she had decided she would not have an abortion. The 'they' convinced her that this time it was different, her risks were greater.

When the news was brought that this baby did have genetic abnormalities, it was the relationships, both real and potential, that became the focus of concern. She had begun to form a close relationship with this new baby. She knew that relationship was precious to her, no matter what. Her husband, on the other hand, was able to convince himself there was no relationship to be maintained. For him, the abortion would take the father-baby relationship away as though it had never been. His motivation was to protect the precious relationships he and his wife already had with their other children. They were what mattered most. The crisis meanwhile took its toll on their own relationship. They had made opposite decisions, decisions that could not be compromised. If one won, the other lost. It was the counsellor who was able to help them uncover in each other the same pain, the same sense of loss, the same love for each other. Their own relationship was at the heart of their Being-with-one-another.

Where was the 'they' in the decision of what to do? Research by Gregg (1993) on prenatal testing talks of the double-edged sword. Though women welcomed the freedom to make prenatal choices, "they discovered these choices were accompanied by social and internal pressures, and feelings of ambivalence and guilt" (p.68). Were there 'theys' of family, friends, community, church who would be outraged at the decision to have an abortion, thereby taking away the trust to share this crisis with their wider networks? On the other hand, were there also equally powerful 'theys' who would have held them in on-going judgement for allowing the baby to be born, to be a burden to them and their community, and a huge cost to society? Would either of these 'theys' have voiced their feelings face to face, or would they in their quiet inconspicuousness have persistently undermined relationships? How far was this decision dispersed?

The imposition of the relationship of technology

If this story had happened 100 years ago, it would have been different. It is technomedicine that has made the announcing of genetic abnormalities possible. Without technology, this family would not have known about the unsafeness of their baby until it had come to them in the relationship of a newborn child. 'They' would have had no influence to bring, no opinions about the right to life of the child. The child "would have been" and would have continued in its own being, until death.

Smith (1996) interprets Heidegger's writings on technology:

In the instrumental and anthropological approaches [to technology], everything depends on our manipulating technology in a "humane" fashion, but, Heidegger says, we cannot consciously control the *essence* of technology, for the *essence* of technology determines the way we perceive ourselves and all beings; hence we always come along too late in our attempts to control it (p.238).

He goes on to talk of technology "bringing forth", "as a mode of revealing", and as a "form of causality - to be responsible for, to occasion" (p.238). "It sets upon Nature, unlocks it, exposes it, and challenges it to do man's bidding. Matter is transformed from its natural state and kept at the ready in its new state until it is needed" (p.239).

The consequences of this transformation are further described:

... man eventually loses control over this fated mode of truth; thrown into this realm from the beginning, he takes a relationship to it only subsequently. He is himself ordered by this mode of revealing, but it is no longer part of his handiwork. This is late-modern man's destiny, a fate from which he can never extract himself from his own endeavours (p.241).

Smith tells us that, with this understanding, we should not curse technology, but rather attempt to free ourselves from it by opening ourselves expressly to "the *essence* of the technology" (p.243). Where do we look for the 'essencing' of technology that would free us? Perhaps it is in uncovering the insidious control of technology, and in recognising that it does indeed transform the Being of Being. Perhaps it is in remembering the value of the Being of Being, recognising what might be lost in its giving away. Perhaps it is in recognising before the decision is made, the possible

consequences of handing over the very Being of the pregnancy to the exposure that is attainable by means of technology. In this instance, technology is akin to the press photographer's camera flash intruding in the intimate, darkened room. It brings to light, and makes known, what has been a private secret. Its flash does not in itself change anything, yet it changes everything. Nothing can ever be the same again, and yet it is in itself just the same.

Technology, as in this story, transforms a pregnancy that would otherwise have had its Being as normal, until the birth revealed otherwise. The normality is taken away as technology brings light to the darkness, and reveals the genetic make-up of the expected child. In this story the exposure took control of relationships. The ability of technology to expose, brings a societal control - in some situations almost forcing the choice of genetic testing for the thought-to-be-at-risk woman. The woman hears many loud voices dictating what women should do. While there is hope that her baby is normal, she can choose not to listen to the voices. Once, however, the technological exposure is made, the voices become louder, more urgent, and address her directly. Her experience is dominated by the they-self. Technology has robbed her of her hope. Others may say technology has given her choice. Technology disrupted the 'being-with' relationships of this experience into 'being-against', 'being-persuasive', 'being-unsure-of-the-other', and 'not-liking-being-with'. Technology is much more than simply a tool.

Technology is met in so many situations related to childbirth. It is not simply there in the background, waiting to be called upon. Technology, as this next example shows, has come to dominate 'the way of practice'. It has become the dominant partner in its relationship with practitioners:

Nobody in our hospital, house surgeon or registrar level, can diagnose a miscarriage without having ultrasound scans. As a result I actually believe patients get worse treatment than they need, because they come into hospital at lunchtime one day, and they can't get an ultrasound appointment till 5 o'clock, and then somebody goes home, and then they have to have a full bladder so they drink a lot, and then it means they can't get to theatre until ten at night, and at ten at night there are so many people waiting to go to theatre that they don't get done during the night, and they stay in hospital over-night, and eventually get to theatre after the

morning lists the next day. They go home at 5 or 6 o'clock the second day, when in fact they should have been dealt with, and sent off, at 5 o'clock the first day. [E-obstetrician]

Because the technology is available to obtain an appearance of what is inside a uterus by means of ultrasound scan, it has been decided that a scan needs to happen in the safe care of women who miscarry. The scan becomes the arbitrator of care. Even when the expert practitioner knows the woman would receive better care, and still be safe, without a scan, there is no escape. The being-of-the-world is that the ability to scan is there, therefore, it must be done. It demands. It determines. It controls. It now has the history of 'being there before' for the house surgeons and registrars. They know no other mode of practice. Technology has claimed them. They are subservient to it, indeed they could not function without it. The older practitioner sees what has been lost, what has been given away, and at what cost to the woman. His younger colleagues no doubt assume technology has brought better care. He carries the knowing that care in the age of technology is sometimes worse. But who wants to listen? Who would dare confront the power and control of the technological age? How can the practitioner hope to be 'with' women when such things stand in their way?

The woman-practitioner relationship

There are complex influences on what sets out to be a simple person to person relationship. Nevertheless, there seem to be simple things that matter:

My doctor and my midwife were both very serene, at ease, and that rubbed off on us. Both of them have got a sense of humour and that helps too. They would explain exactly what was happening, and they didn't explain it in a patronising fashion. And they both listened to us. Whenever I said you know "I have had enough of this" or "I am..." , I didn't even have to say I am in pain, he knew, he instinctively hooked into what was happening and he seemed to know the right time. Looking back his suggestions with the gas and the epidural were brilliant timing and when I said to him "I have had enough of this pushing, I am not getting anywhere with this, do something", he didn't stand there and argue the point and say "no give us another half hour". The relationship mattered, absolutely, completely ... not knowing what I was getting into. We knew him so well after 15 years.

He gave us a referral to a midwife. I wasn't particularly worried if I had a midwife because I really didn't understand terribly much the function of the midwife before I had a baby. We asked him who he got on with. That was the criteria for us: the midwife must get on with our doctor. I valued the antenatal contact with her. We were building up a relationship, because we didn't know her. One of the things that she added was that she went through in a lot greater detail and for a lot longer period with us about what we both expected and sort of just trying to align us really. Also sort of feeling the territory on how dogmatic she thought we might be about things. I kept saying to her "you know really my philosophy is 'what will happen will happen' and we are going to take the best advice we can get and I am not going to sit there and argue the point with anybody. And I am not going to be one that sits there and says 'no I am not going to have pain killers', I am probably more likely to say 'give me the pain killers and I want them and I don't want an argument'.

But I actually felt, we both felt, very at peace with what was done and the order it was done. Things were explained to us, I didn't ever feel unsafe. I would definitely go for shared care again. I would go for the same people and do exactly the same thing.

The relationships this woman describes she and her husband had with both her doctor and her midwife speak loudly of concern. First, there is their manner, serene and at ease, and with a sense of humour. She says that "rubbed off", that the 'witness' allowed her to draw on their calmness and humour, and claim it as her own. She goes on to describe the solicitude of leaping ahead - of explaining in a way that did not put her down, but that enabled her to feel involved, of listening both to her words and her body, and that had the solutions there, ready-at-hand for when they were needed. The doctor's solicitude was such that he trusted the knowing of the woman. When she said she had had enough, he respected that judgement. His solicitude had its ground work in the long conversations that the midwife had had with this couple antenatally. She had already uncovered for the couple, and for the doctor and herself 'what mattered'. They were all in this together, working together, liking each other, supporting each other, listening to each other. The woman looks back, and says with confidence "I didn't ever feel unsafe". I believe it was the 'concernful' Being-with that arose from each person that established the feeling of being safe.

The tension within solicitude

Whose concern matters most when the midwife lays a decision in front of the woman?

The midwife was always saying "well you need to decide". She didn't make decisions for us. It felt a bit frightening. I know I did need to decide because it was actually me that had to do this. There was no point in anyone else making the decision, but that didn't necessarily make them easy decisions for whatever reasons. I decided not to have syntocinon [to assist the delivery of the placenta]. It didn't really worry the midwife one way or the other what I decided, so what we agreed was that if there was any indication whatsoever that I needed it, she would go ahead and give it, but otherwise I didn't think it was necessary.

With Vitamin K [to assist immature blood clotting mechanisms in the baby] the midwife was very clear about her point of view. She likes Vitamin K to be given. She produced evidence of why she thought that, and also told us of a situation which she had been involved in when Vitamin K wasn't given and subsequently it would have been good for it to have been. So in the end my baby had a half dose. It was important for us to be involved in considering those sorts of decisions.

This midwife works from a leap-ahead stance, enabling the woman to make her own decision. That is, until a decision arises for which the midwife is afraid the woman will make the wrong choice. She had been with a baby who had not had vitamin K, who in retrospect was seen to have needed it. The possible scenario could have been that the baby had a brain haemorrhage, with subsequent brain damage, or even death (Darlow & Nobbs, 1993; McNinch, 1997). On the other hand, this woman would have heard another 'they' caution about the possibility of Vitamin K causing childhood cancer (Cole, 1995). How is the Being-of-safe made safe when the relationship comes to deal with such decisions? Should the practitioner strive to remain strictly neutral and lay open only the scientific, objective, proven information? Is it even possible to find such unbiased information, or to present it in an unbiased way? Should they instead expose their own lived understanding, telling of the baby who had been thrown into an unexpected, unprepared for, crisis? Vitamin K is another example of technology taking control. There are no agreed upon truths about the complete safety of Vitamin K. There is evidence that some babies will be thrown into a situation that their own blood clotting mechanism is inadequate to cope with because it has not yet had the opportunity to synthesise Vitamin K from its own diet. The essence of this technology is that the dose

of Vitamin K will leap-ahead to be there, to prevent the possibility of a problem arising. The question is "but what else does it leap-ahead to do?" The answer to that lies hidden. It is safe and not safe to give Vitamin K. It is safe and not safe **not** to give Vitamin K. It is a decision with no truth to guide it. It is a decision based on possibilities. Having, or not having, Vitamin K may make absolutely no difference to the Being of a baby, or may make the difference between life and death. In their concern for the baby, does the practitioner leap in and persuade the woman to what they honestly believe is the best choice, or do they stand back to enable the woman to freely choose? When safety lies in the darkness, who can see more clearly? This woman is left remembering her fear of making those decisions of the darkness.

The possibilities of relationships

There is power within relationship, the power of knowing and understanding, the power of telling in a certain way, the power of being the practitioner:

There's always still that power differential between the woman and the professional, which makes it very easy to abuse the choice of the woman. If you say "I really believe you should have this" the woman will believe you and say "yes, that's fine, I don't really want to, but if you say so, then I will do that". You may move into intervention that you can justify, but it may not be strictly necessary, and it may be against the woman's true wishes. [F-midwife]

The practitioner-woman relationship is very open to the tentative hopes of the woman being over-ridden by the practitioner. How easy it is for the woman to think 'they know best' and for the practitioner to agree that their experience of childbirth is vastly superior to that of any lay person's. The paradox is, however, that the person with the potential to know most, for example, about the subtle behaviour changes of her unborn baby, is the woman. The dilemma for the practitioner is that there is both the wellbeing of the woman and the baby to be concerned about. There is one relationship, but it is about two individuals:

Some of the time I feel that it's us that are the advocates of the baby. You start out thinking the woman is the advocate for the baby but there are times when I feel that it is us, and I've noticed that more in the high risk. The woman has risks that are there, and you say to her "this isn't doing your baby any good". And they can actually have a selfish attitude, for

themselves: 'well I'm fine, and so my baby's fine'. And I'm saying "no, and these are the reasons", and I back it up. [B-midwife]

I often get the feeling that there's nobody else who is advocating for the safety of babies. Some might say "well the risks are really what happens to the baby, they are not your responsibility. You've got no right to be an advocate for the baby. Nobody asked you to do it". And I think to a certain extent that's true. However if risks exist and we don't point them out, I think somebody could rightfully say that they were let down by us as health professionals for not informing them of what the risks might be.

In clinical practice you see safety issues being over-ridden, in one sense by wishes of patients, but many times the wishes of patients are actually being misinterpreted. No patient ever wants their baby to be in bad shape, but the weight of evidence, or the information that's been presented to the couple has actually not had any risk strategy in it. We've often had these professional battles about whether there is or isn't a risk, and who is responsible. I think that as a specialist group that is one of our jobs, to identify what those risks are, and to make sure people know about them. [E-obstetrician]

Here we have both a midwife and a doctor voicing concern that the woman may not always make the safest decision for her baby. The question is “who is with whom?” and “who is for whom?” in these relationships. The baby has its Being within the woman. Their Beings are intertwined, each with the other, and yet they are separate. The woman is both a shield of protection for her baby against those who would harm it, and a barrier holding back the safe care that she may interpret as harmful. Nobody can ethically do anything to her baby without her permission. There may be times when it appears that unless something is done to her baby, harm will befall it. If she decides ‘No’, what happens then? How far can concern for the baby be taken? The obstetrician suggests that some practitioners do not take it far enough, that they have not shown a clear enough picture to the parents of what lies in the darkness. The problem is the darkness. They can only talk of possibilities. They can only say ‘this might happen’. They can only talk of appearances, not of the thing itself. The problem with the technology which is generally employed to deal with possible risk is that it takes away as it gives. For example, a scan in pregnancy takes away the hiddenness, the surprise and the hopefulness of a perfect baby of the wanted sex. A monitor in labour takes away the woman’s ease of walking around, and in revealing fetal distress may take away the un-

interfered with labour. A caesarean section takes away the natural birth. How do you convince a woman to allow things she genuinely values to be taken away, for a risk, for a possibility? On the other hand, when the baby is born in bad shape, how do you convince the parents, and the Court, that what has now been taken away from them in their less-than-perfect baby is worth the trade for what they kept for themselves in the process of giving birth?

I believe the answer lies in the relationship that is based on concern for both woman and baby, and that leaps ahead to uncover all the possibilities that seem to lie ahead, no matter how unappealing they may seem at the time. It is what lies in the darkness that matters most. The darkness is not 'bad', it is simply that which we cannot see, that which we do not yet understand, that which is still to come. It is the mystery that draws us to 'wonder', and to be open to the 'what if?' questions. The concerned relationship, the they-self of woman-and-practitioner, will strive together, recognising that there is darkness, yet seeking to find the glimpses of insight that might bring understanding to the mystery.

A midwife talks of her experience of uncovering the darkness, bringing to light that which lies hidden:

I've always known about the emotional and sexual wall, and the sexual nature of birth, and I've always known how important it is, and those sort of things, but I didn't really get a sense of what a difference it can make when you can go through the process with the same practitioner, and develop enough rapport and trust to be able to start to talk about those things and make some plans about "what if?" It can range from not being able to push the baby out because you have to open your body so widely, to seeing the abuser's face, and all sorts of things. And I hadn't realised how important that single trusted person right the way through was for the satisfactory coping of all of that stuff. I get a sense that the problems associated with the physical and sexual abuse issues may in fact be minimised by having the same person all the way through, and that they may never become a problem for the woman because it's been dealt to before the birth and the breast feeding actually happens. [F-midwife]

The darkness of physical or sexual abuse may be covered over by years of repression, yet those may be the issues that stand in the way of safe and successful childbirth. If

they are sensitively uncovered during pregnancy, and appropriately dealt with, they may never become a problem. Again, it is the relationship that is held up as the means of uncovering. If the woman comes to know and trust the midwife, she may reveal her most intimate secrets. Similarly, with trust established, the midwife may be able to ask the questions that uncover for the woman the memories that stand in her way. It is what lies in the darkness that is being sensitively and privately brought to light.

Viewpoints on knowing what is safe

What lies in the darkness may be understood in a tentative, intuitive manner by the woman. How easy is it for her to offer such uncertain understanding to the practitioners? This is one woman's description of knowing that one of her twins, in a pregnancy where the membranes had ruptured at 21 weeks, was more at risk than the other:

I suppose it always does go through your mind that it is a high risk pregnancy. Like I don't think I ever really knew that this baby would die, but then in other ways in the very back of my mind I always knew that she was the one that wasn't going to make it, if that was what was going to happen. It is hard to describe why you think things like that but...

It was always difficult to get the CTG on the baby that died. I think it might have been because she didn't have the fluid around her because you need the fluid to make it work. Maybe that was part of why she was difficult, and she always really got annoyed too. I think it was because she didn't have any fluid to cushion her, and the monitor was pressing into her or something. We used to call her the trouble maker because, you would put it the CTG leads on and she would duck and dive away as if she was trying to hide.

They always said that the other baby was the leading twin because she had her head down and that she would be the one with the ruptured membranes because it is usually the leading twin that has the ruptured membranes. I remember thinking: 'I just can't imagine that she is the one that is like that' because she always seemed to be so peaceful and stable whereas the breech twin seemed to have something bothering her. And we always joked with them all and said:

[us] well how do you know?

[them] well it is always like that

[us] and how do you know that the one that has got its head down is going to come out first?

[them] well it just always happens like that

And then the day that I was in labour I could tell they were having a big fight about who was going to come out first because they were juggling positions. They had stayed in quite stable positions all the time and then suddenly they seemed to be wriggling and moving, as if they were deciding who was going to come out first. And when we did the CTG the position of even the leading baby had changed and moved upwards. I told them that I was sure they were fighting about positions. You always had this feeling in your mind about what is going on.

They don't always listen to you. They think that the mothers are silly or something and they don't know. And I said "I am sure that this time it is not like that". They do change positions and so I don't know if she was always the leading twin but she was the breech one. They always assumed that it was the other one.

When they did the Caesar the baby they took out first wasn't the one who had had her head down. It was the breech one. She was the one that was engaged. She was the one who had no liquor. She was the one who died just a few hours later. It was as I thought.

This woman knew that one of the twins “*seemed to have something bothering her*”. She could even explain some of the reasons for her understanding. The practitioners had their own understanding. They knew what normally happens. They put their trust in the belief that ‘it always happens like that’. This woman tried to tell the practitioners about the ‘feeling in her mind’. She knew they had not listened to her. She knew they thought she was silly. Time revealed that her understanding that something was bothering the baby that was in the breech position was the right understanding. Her ‘feeling in the mind’ proved trustworthy. The practitioners’ certainty in how it always happens, proved wrong. This story opens up the possibilities within relationships, and the things that block them. If the practitioners had been willing to believe that this was a sensible, concerned woman, who had an embodied relationship with her twins, understood more than the scans could show them; if they had been willing to take notice of what she was saying; if they had been open to the possibility that what ‘always happens’ might not happen this time; then the relationship could have been instrumental in revealing what, alone, they could only surmise. We could argue that in this situation, even if they had known what was really happening, they still could not have saved the life of this baby. It would not have changed the outcomes. The question remains, how safe does it feel for a

woman to have her insights ignored? How safe does it feel for a woman who must give her body, and the lives of her babies, over to practitioners, who she knows, in the 'very back of her mind' have got it wrong? Listening, trusting, and being open to the possibility that 'feelings in the mind' may be more trustworthy than the evidence of past experience, are likely to make 'being safe' more safe.

An obstetrician adds a contrasting opinion to the meaning of relationship:

I have a serious view, which would be held out of court, that is: that continuity of care is not always good for people, because in all of these situations one needs to be able to step aside, as a professional rather than as a friend, and to make decisions on a professional basis. [E-obstetrician]

Here, there is the suggestion that the continuity-of-care practitioner becomes so enmeshed with the experience of the woman that they may not have the most appropriate view of what is going on. 'Stepping aside' removes one to a place where I suspect the voice of 'what should be done' is much louder. The practitioner will hear the inner call of the standards of practice of their own profession, and the policies of their place of work. They will feel the tug of what is 'right' and what is 'wrong', what is 'safe' and what is 'unsafe'. The inner voices of responsible, safe practice are what it means to be a professional. They are voices that speak of the collective wisdom, the middle of the continuum, the tried and true, the known statistics, the scientific research that determines what is to be called 'safe practice'. 'The voices of the profession' compete with other voices. There are views of consumer groups such as the Homebirth Association, views of the media, views of the woman's family and friends, views of religious or cultural groups. These are the views that compete with the professional sense of 'what is right'. These are the views that undermine the principles and policies of what is thought to be safe care. These are the views that the practitioner in close ongoing relationship with the woman is likely to become enmeshed in. How does the practitioner determine which views matter most? Even when there is only the woman and her practitioner in the room, there are many others who make that relationship all that it is, and all that it is not. It is perhaps not so surprising that when in the midst of so many silent, yet dominating, conversations, the woman tentatively offers a 'feeling of

the mind', it passes by almost unnoticed. The obstetrician who made the comment above recognises that there is tension in the debate over 'which view matters most'. If a practitioner gets too close to a woman so that he or she cannot see beyond the closeness, their vision becomes limited. If however, as the mother of the twins discovered, the practitioners are not willing to come a little closer in their listening and their trusting, they too fail in their vision of what is there to be seen. Gadamer reminds us of the dangers of "not seeing beyond what is nearest" (Gadamer, 1965/1982, p.269), and encourages us to seek an horizon which knows and values both "what is near and far, great or small" (p.269). It is in the movement of the play between the many possible views that 'being safe' is most safe.

Practitioners relating with practitioners

Many woman, somewhere in the course of their care, will find themselves in the care of more than one practitioner. It is a situation where, as the woman earlier in this chapter remarked, it is important they get on with each other. An obstetrician expresses her opinions about choosing the independent midwives she will work with:

I think it can work very poorly, if the practitioners don't agree, and I think it would be untrue to say that everybody gets on with everybody. They don't. And I think what tends to happen in private practice as I know it, and I guess as some of my colleagues know it, that particularly if you have the choice of an independent midwife with whom to work, we'll choose people who we know and get on with. And staunchly avoid people who we know we don't. I have heard that that upsets the midwifery review board because they say that the midwives with whom we work are just being doctors' handmaidens, but it doesn't work like that at all. They're doing their job, I'm doing mine. But I have great confidence in the practitioners with whom I work, that if they're worried, they'll call me, and I guess they'll sort of call us if they're concerned. And I think that's important. I feel very unhappy working with some people because I don't know them, or because I don't feel happy about their care. [G-obstetrician]

Being safe for this obstetrician is again about relationship. It goes beyond simply knowing the midwife. There is an expressed belief that to be safe it is important to have control over the choice of the practitioner who will share in the responsibility of care. It is important to know that she is a safe practitioner, and it is equally important to know that the relationship will be an effective one. The tradition of practice is that the

midwife stays with the woman in labour, and the obstetrician visits intermittently until required to be there for the birth. Even though they are not a constant presence, if they have accepted the responsibility of care, they are still accountable for whatever is happening in their absence. If a situation should change, and they are not informed of that change, they have no way of participating in the related decisions. For example, the midwife may note a change, and choose to take no action. The obstetrician, had they been informed of the change, may have made a decision to intervene in some way. The obstetrician therefore feels very vulnerable leaving care in the hands of a midwife whom they do not trust to appreciate their need to be kept fully informed, and fully involved in decision making. As this obstetrician describes, she will only feel safe when she knows the midwife will be alert to problems, and will be open in sharing her perceptions. Knowing and trusting are the essence of being safe. Perhaps also, sharing a common ear for the 'theys' of practice.

The doctor-midwife relationship has a long history of the midwife being the subservient partner. In New Zealand, since 1990, both the midwife and the doctor have equal access to be practitioners in their own right. Nevertheless, their history goes ahead of them:

I've got a delivery coming up soon with a G.P. whom I haven't met. I feel like it's always me, that I have to go along to them and say hello, and all that. They never come to me, or ring me up. [I-midwife]

This midwife recognises the traits of subservience that linger in her relationship with doctors, yet her belief that it is important for there to be a 'relationship' prompts her to be the one to make the approach. The following statement more boldly voices the tension that underpins relationships:

I don't know, but I think even if you are a wonderful midwife, and you work very hard, and you take home double the salary of a senior Consultant, then it's very hard to justify. When they get stuck, who do they call, the Consultant? I mean firstly, if you really want to be independent, I mean truly independent, that means you can sort it all out. And it is quite clear that the midwife is truly independent up to a certain stage, and then

...

But it's crazy that those who pick up the case when it gets difficult, when it requires specialist skills, people certainly employed in the hospital system, not those in private practice, but those in the hospital system, earn half of the top earners. That is not right. I think I earn enough, and anyone who

wants to earn more, well that's fine, but I think it also sets a message. I mean basically you get paid for what you are worth. And if you get paid double, you are worth double. And I just don't believe that independent midwives are worth double an obstetric consultant. Of course there's lots of politics involved in the whole thing, and how independent midwifery came about, because of the time in New Zealand, and I know, it will change, because obviously it's also very expensive to the taxpayer. I don't think I could do much about it, except wait. [C -obstetrician]

These comments reveal the economic tensions that fuel inter-professional debates. The obstetrician draws attention to the skills of the specialist, who is called upon when the woman requires obstetric assistance. He raises the question of how much these skills are worth in comparison to the skills of the midwife. He recognises the politics involved. How do economic tensions influence the relationship between obstetricians and midwives? The independent midwife loses money when she hands a client over to an obstetrician. Does this bias her decision of when to hand over? Independent practitioners earn their fees on a case by case basis. Does this mean that the high earners run the risk of exceeding the safe limits of caseload? The next participant further describes the political tensions:

Midwives are cost effective, they're primary health carers, so like all over the Western world, and even in the third world, midwives are on a comeback, and they're supported by WHO, which is very strong. So when you get into a situation like that, and you've got a monopoly group [the doctors] that's had all the control, and are threatened and they're getting more and more threatened every day, well then they get to the point where they are really being threatened, that's when they get vicious. And I think that's the stage we're in now, they're really vicious. And so, they're out to try and crucify midwives, I mean it's the sort of same kind of witch hunt that's been going on ever since homebirth started here. We don't call them witch hunts now, but that's what it's about. So I mean it's a power struggle.

But I do feel the climate today is really threatening. I can remember one time a domiciliary midwife had a stillbirth, and it was a case of whether they were going to do something about it, and apparently an influential obstetrician of the time said "oh well we won't do anything about it because she, the midwife, isn't the one we're after"- which was me. And I know that when I went out to a birth for a long time after that I was looking over my shoulder, you have this sort of feeling of fear. Not that that's stopped, because you're skating on thin ice, but on the other hand it

put me in a position where I was feeling fearful . Today it's different in that it's all done behind a smiling mask, whereas in those days it was just outright hostility, but the threat is still there. [A-midwife]

This is a midwife with a long history of being involved in the political skirmish between midwives and doctors. While key players have become known identities in this battle of power, it is a battle between the 'theys', between the political ideologies, between the monopoly group and the 'comeback' group, between groups out to retain or to gain what they consider to be their rightful territory. Where once it was vicious hostility, now it is all done 'behind a smiling mask'. This is the arena where 'being safe' is taken over as a weapon.

The political 'theys' go ahead of every midwife-doctor relationship. This was the comment from one woman about choosing caregivers:

The doctor recommended that I get an independent midwife, and gave me five names of midwives she had worked with before. Although there has been a lot of publicity about midwives, I don't think I would have done it without her suggestion. None of my friends had at that stage. One friend had asked her obstetrician about it and he put her off. The reason was 'the cost to the taxpayer' which I thought was a bit cheeky really because he wasn't there much at the birth, and she was paying his fee independently of the taxpayer. If she was entitled to an independent midwife then that is her business. It is interesting that there is that sort of competition.

It is the 'they' influencing choice. The doctor suggested to her she have a midwife, a midwife from a known list. Her friends had never had midwives, which presented a sense of the untried, untrusted territory. The recommendation from a doctor made it a safe choice for the woman. The obstetrician of a friend, however, had brought the decision right back into the political arena, and provoked guilt at the thought of 'wasting' all that taxpayer's money. It is the history and the politics going before which create concern to the extent of placing barriers in front of possibilities. The argument of this woman's obstetrician moved beyond the concerns of practice to be laid at the feet of the 'they' of society. 'They', all the taxpayers of this country, it is suggested would not want their money wasted on paying midwives. It raises questions about who in society has the power to determine safe care. Is it ultimately the politicians who pass

the statutes, and organise the funding? Are they the 'they' who finally determine the type and number of practitioners any one woman shall engage to provide her care? And if they are, where do their vested interests lie?

One woman in this study has become familiar with the politics of childbirth. Her child was born severely brain damaged, a situation from which she developed a strong commitment to do what she can as a parent, to ensure that other women receive safer care than she did: "I just say 'safety' and try to get through to parents that it is a really big time, a special time." Her response to her association with the political arena of childbirth is this:

It feels sometimes in the whole drive for the political stuff that goes on, that if a few babies get damaged and bumped off, it is worth it. The response of the Consumer Lobby to us is sort of "who are these parents, how can we shut them up", not "this was a terrible thing, what has happened to them and what can we learn from it". It is more just "these people are stuffing up our plan" and there hasn't been a sense of sympathy or a feeling for our child.

Political power plays stand in the way of human-to-human relationships. Wrestles over power, status and territory may strip relationships of their sense of what really matters here, for this person, at this time. Political tensions may dominate possible relationships and set up conflict before the relating even begins. Such tension is already there, declaring, demanding, undermining, complete with smiling mask. It seems there is a kinship between politics and technology. Like technology, political tension steals from the very essence of Being. It erodes and sabotages 'concernful' practice. Women who trustingly seek care are thrown into a world where the political tensions 'already are'. The woman can only make a relationship with a practitioner subsequent to the political climate that exists. Neither her, nor her practitioner can avoid such political influences, they must simply learn how to live with them. It is how it is.

Relating to unknown others

The vulnerability of the woman in this political world of childbirth is uncovered in the situations where a woman is thrown into needing to relate to unchosen, unknown others:

There are only a certain number of choices you can make and then somehow the system prevents it. I think one of the things that horrifies us both is the fact that with the health professionals we had a choice about, we couldn't have asked for better care, the midwives, the GP, the paediatricians, the obstetrician. It was the people we didn't have a choice about who we remember most negatively.

After our homebirth my baby needed to be admitted to SCBU [Special Care Baby Unit] because of some degree of respiratory distress, and I was admitted to the postnatal ward. I don't know how much of it was my anticipation of being treated like that and how much of it was actually being treated like that, but you know this sort of business of 'silly woman, fancy having homebirth, of course this was going to happen', to the point where the following day one of the midwives on the postnatal ward, whose care I had been allocated to saying "oh yes, now you are the failed homebirth aren't you". Absolutely, extraordinary, and she didn't have any idea why I was in there. I remember her saying "well why are you here?"

It was those people by whom we were let down, the people we didn't have a choice about. All the others whose professional help we sought we couldn't have asked for better care really. I find that quite sobering.

The midwife described in this story was relating to a 'failed homebirth' with all the baggage she carried about such women. In fact this had been a very successful homebirth. This midwife was placing barriers in front of this relationship before it had even begun. She showed her opinions to the woman, before she allowed herself to see this woman for who she really was. This relationship was doomed from the beginning. It brings to light all the other unchosen, unknown relationships that a woman is thrown into through her childbirth experience, and reminds us of the potential vulnerability those strangers present to women. It affirms again the value of a relationship that is based on concern.

The woman, relating to unknown self

Throughout all of this, the woman is in a private, developing, changing, mysterious relationship of her own, with her own body, and with her baby-to-be:

I pushed for an hour and a half and the funny thing was I instinctively knew I wasn't getting anywhere. They were egging me on like "it is going great" and "we can really see you doing it". The doctor said later that I had been wonderful. But I instinctively knew I wasn't getting anywhere. I

knew that something should be happening and it wasn't. At 12 o'clock I looked at him and I said "I am sick of this, just do something, I don't care what it is, I don't care what you do, just do something. I feel like I am not going to have the baby, like this baby is not happening, it is not real for me and it's just not here". And he said "ok" and at that stage he called the specialist in.

The specialist had a look and said: "oh well I think we are in for a caesarean but we will have a go with forceps" and they started bringing forceps gear in and he said "no, no we will go to theatre'. So they prepped me for a caesarean and gave me a complete nerve block. I am pretty sure they explained what was going on, at which stage I wasn't particularly interested. I just really felt like I wasn't going to have a baby. I was just there to pass the time. They took me down to theatre. They put me on the table and strapped me up and everything. That didn't really bother me. I know a lot of women don't actually like that but I was just at the point where I couldn't care less.

They didn't actually tell me what they were doing and I said "what are they doing?" My doctor said "they are having a go at doing forceps first". I knew something was happening because I was actually moving down the bed. They were actually pulling on the baby's head and literally pulling me down the bed, so I knew something was happening, but I couldn't see anything.

This woman was in a body that was her own, but not her own. She instinctively knew that the pushing was not achieving what it needed to. Even though this was her first experience of birth, she was in tune with what was happening, and what should be happening. At that stage, she gave her body away to technology. Her relationship to it changed. She 'shut off'. She lost her interest and her care. She was simply there, passing the time until it was over. Technology took away the 'Being-of-birth', so much so, that the only indication she had that her baby was about to be born was feeling herself moving down the bed. Are there consequences for the woman giving away her relationship with the being-of-birth? Are there ways of maintaining a sense of relationship, even when the body is in an anaesthetised state? Does the concern of practitioners recognise the loss? Is technology claiming the natural state of birth and transforming it into something which it was never meant to be? Or is technology the hero, who releases this baby from its trapped journey, and frees this woman's body from pain and despair? Was this sacrifice of giving away the 'experiencing of natural birth'

worth the cost of disassociation? Was it the technology that was really to blame? Could the 'experience of birth' have been reclaimed?

Amidst this complex notion of the woman being self and body as separate entities, another woman tells of a unique and startling experience with her own self:

I had a really strange experience, which I haven't told many people. I actually sort of became semi-conscious and felt like I had left my body. I don't know whether this is a very common thing but it was almost like the end of me being an individual and suddenly being a mother. I was hovering above the bed looking down at myself in a pregnant state. It was really weird. That is when I went into labour.

There is mystery in relationship. Did this woman really leave her body on the bed? Was she really able to look down upon herself? What is the relationship between self and body? How many other women carry their secrets of such happenings? Are there questions that will always be beyond our understanding, beyond any sense of what is or is not safe?

So what has 'relating' got to do with 'being safe'?

Merleau-Ponty (1962, p.454) states "We are involved in the world and with other in an inextricable tangle" and reiterates this with a quote from de Saint-Expery: "Man is but a network of relationships, and these alone matter to him" (p.456). When a woman is thrown into pregnancy she is already within a network of relationships, people who share the thrownness of the expected baby. When she chooses to seek care she opens herself to the involvement of another inextricable tangle of relationships. The midwife or doctor that she chooses, may seem to be one person, an autonomous practitioner, but they are themselves part of yet another tangle. All these relationships bring with them the 'theys' that declare safe from unsafe. All these relationships come before their beginnings. They are already there before the woman and practitioner meet. They go ahead, they bring the wisdom and the mistakes of all past relationships with them.

A relationship is not about 'me and you'. It is about me and my relationships, and you and your relationships. Each of us brings the powerful voice of 'they' to declare the way

forward. The political 'they' is virulent in undermining the Being-of-safe, in transforming the 'concern-for-safe' into a tool of political warfare. There is distortion, disguise, manipulation, propaganda. The natural Being-of-safe is covered over. Relationships are further distorted by the power and control of technology. In its potential to expose unsafe, or to make unsafe safe, it demands to be employed. It has both woman and practitioner in its grasp. It takes over, and in taking over, takes away the essence of the Being. Even when it changes nothing, its power of opportunity to expose, to alter, to make safe, changes everything. What was once simply Being, is now able to be opened to scrutiny. New decisions are uncovered, new consequences are made possible, be they good or bad. The simplicity of nature revealing in its own way, in its own time, with its own good or bad consequences, has gone from us. There is a technological tangle that binds us, that brings a relationship of its own. The technology is far too precious to be cast aside. It has its own power of staying. Through this tangle, the woman and the practitioner, and the practitioners with each other, still strive to build relationships that are of safety-promoting concern. It is in a climate of trust and of knowing, that the practitioner is most effectively able to leap ahead, discerning what might possibly lie in the darkness. It is in this same climate that the woman is also free to give voice to her intuitive knowing of what she perceives lies in the darkness. In discerning the darkness, and giving voice to the mystery, practitioners open new possibilities of care. Will the new understandings lead to safety? It is tempting to blame relationships that are disinterested, arrogant, or dominating for all the breakdown of safety, but it is not that simple. I believe a 'concernful' relationship can make the experience safer, but it may not. Being safe is about relationship, but it is more than relationship. The possibility of thrownness is always already there, no matter how 'concernful' the relationship, nor how safe the spirit of practice.

Hello, how's it going?
 "fine"
 Yes, it seems fine.
 "good".

The darkness lies quietly
 unrevealed
 unnoticed
 not to be concerned about.

Technology comes hammering
 You could have seen
 You could have known
 You could have anticipated more clearly

Politics whines persistently
 whose side are you on?
 don't let down the profession
 don't leave yourself open to attack

'They' say
 yes, but how sure were you it was fine?
 what if you've got it all wrong?
 what if you've made a mistake?

She comes to visit you again.
 You sit together for awhile.
 Yes, you say, the weather has been hot.
 Yes, you say, your garden needs some rain
 Then you tell her of your wondering,
 your wondering if what seems to be fine
 is as fine as it seems
 She looks at you silently
 thoughtfully
 pondering
 She takes a deep breath
 and then she tells you
 She tells you how it really is
 She tells you how she's felt
 She tells you of her fears
 She tells you everything there is to tell.
 You sit together,
 the telling done.
 Neither of you know what's really going on
 But together you will decide what to do.
 It seems much safer now.

CHAPTER NINE: BREAKDOWN

If practitioners always practised safely, if childbirth was known to be safe for babies, if all women were seen to emerge from their experience, of being pregnant, giving birth, and mothering a new baby without complications, if they told stories that said 'I was safe, I felt safe, I am safe', then this thesis would never have been written. 'Being safe' in its 'concernful', effective mode is of no consequence. It is there. It is accepted as how it should be. It simply is.

Paradoxically, 'being safe' is revealed to us when a situation is not safe. 'Being safe' is uncovered and brought to light when it is taken away, or is there in a tentative, ineffective, indifferent mode. The stories of 'being unsafe' are where we will see most clearly the meaning of 'being safe'. We will see concern through the stories of neglect, care through the lack of care, mindfulness in the unmindful, skilled judgement through the poor judgements.

- Gadamer (1976, p.235) recounts Heidegger talking of the loss of a pocket knife. He describes its being missing as something different from it simply being no longer present. The emptiness caused by the loss is where the meaning of having a pocket knife is found. Everytime the hand automatically seeks out the knife that was once such an integral and taken-for-granted tool in life's daily activities, its meaning will return afresh. In its absence, it reveals so much more about itself than in its presence.

So it is with the phenomenon of 'being safe'. When it is not present, we understand the meaning of what is lost. This chapter gathers together the notions of the previous three chapters in the uncovering of some of what was lost by the women of this study. These are the stories that I believe I have a moral obligation to put before you.

Heideggerian Underpinnings

Heidegger never supposes that concern is always 'for the good'. Concern 'is'- it is possibilised as both for the positive and deficit modes. Heidegger talks of the deficient

modes of concern: leaving undone, neglecting, renouncing, taking a rest (1927/1962, p.83). When he goes on to talk of solicitude he suggests that Dasein [Being-in-the-world] “maintains itself proximally [nearest to] and for the most part in the deficient modes of solicitude” (p.158). His belief is that it is these “deficient and indifferent modes that characterize everyday, average Being-with-one-another” (p.158). Consider our response to reading the newspaper day after day, watching the television news night after night. There are always fresh tragedies before us, locally, nationally and in the wider world. How often is our response any more than fleeting attention? It is not that we are not concerned. It is rather that in our everyday, average Being-with-one-another, there are other matters that claim us, like preparing a meal, talking with our family, getting organised for tomorrow.

Does this help us to understand how it could be, that practitioners’ practice is sometimes neglectful, or inconsiderate, or even indifferent? It is not that they are not concerned, it is rather that at times their concern for the woman seems not to be what matters most. Let us go back to the very notion of a phenomenon. Heidegger tells us when an entity shows itself it may show itself as something which it is *not*, it may show itself as a *seeming* or *semblance* (p.51). Therefore, it follows that a practitioner may seem to be practising from the basis of being concerned, of aiming to ‘be safe’. If, however, all their beliefs, motives, intentions, and decisions could be brought to the light of day, the phenomenon of ‘being safe’ may be revealed as one of a deficient and indifferent mode. It may be that other things are mattering more, or ‘being safe’ is not mattering enough. It may be that the situatedness has undermined the positive concern of the self, and left in its place practice that even the self would describe as unsafe.

A phenomenon that is covered over may *announce* itself by something that does show itself. Heidegger calls this ‘appearance’ (p.52). There is a difference in a ‘semblance’ which seems to be the thing itself, but may not be, and an ‘appearance’, which announces the phenomenon yet does not necessarily show it in itself. The practitioner in their quest to be safe has the challenge of deciding whether what seems to be (for example, an abnormal fetal heart rate) is the thing itself (fetal distress). If the

deceleration of the fetal heart is an appearance, and is the real fetal distress announcing itself, then they are wise to act. If, however, it is merely a semblance, and is in fact a misplaced transducer picking up the maternal heart beat, then what seems to be fetal distress is not at all. The need to differentiate between semblance and appearance is fertile ground for the breakdown of safe practice.

This chapter examines situations that have been described as unsafe, and begins to uncover how the breakdown in safety came about.

Breakdown in thrownness

The woman may be thrown into unsafety by the very nature of the physiological experience of childbirth. It seems that practitioners are not always open to accepting such possibilities:

I had not long found out that I was expecting twins. At 21 weeks I woke up in the middle of the night and I could just feel a trickling. I thought 'oh my goodness I am bleeding', because that was what it felt like and I got up, and it wasn't blood, it was just fluid. It was 4 o'clock in the morning so I rang the hospital and spoke to the midwife who was on duty. She said "oh maybe you might have ruptured your membranes". She said "just go back to bed and put a pad on and sit up and if you feel any more coming out give me a ring back, well give me a ring back anyway but just see if it is continuing to happen". It didn't. Nothing more happened, so in half an hour I gave her a ring back and she said "oh well I want you to either come in here in the morning or go and see your own doctor and just see what has happened". And so I did. I went to my own doctor and he examined me and said "there is no fluid coming out or anything like that". They just sort of thought maybe it was just a bit of incontinence. I thought 'oh, well maybe it is'. I didn't really know anything about ruptured membranes at that stage. I mean I would know now because I know what it is like.

After that first concern, almost every day at one point in the day it would just trickle, just a little bit, and then I'd just lose fluid. It was like you had lost bladder control and you couldn't control it at all. It would be just like a little trickle and then the rest of the day would be fine. And then it sort of got a little bit more, a little bit more all the time. After about a week I was getting really sick of it I suppose because you just didn't know when it was going to happen. You could be out shopping or anything, you didn't know. I went to the doctor again, and he still thought that maybe there

was pressure going onto my bladder when they move or something. So he didn't do anything.

After about another week the fluid changed. It was sort of like a little tiny bleed, just a really tiny tiny one and then it changed to a pink colour. I thought 'well this isn't right' and so he ended up sending me to the Base Hospital. I went to the hospital and again you are trying to describe, 'what does it look like?, what colour is it?' and they are going "oh yeah". And they examine you and there is nothing there because it only happens once a day. And they go "oh well, we think it is ok, we will send you home". And then they talk to the registrar and the registrar suddenly sort of got this idea in his mind "oh well, that is ok there is nothing there now but where is it coming from? We really should find out. So you had better stay overnight and wait and see what happens".

I stayed overnight and when it happened that evening I actually got the nurse and said "well it has happened again, do you want someone to come and do what they have to do?" She looked at it and said "oh that is liquor, yes that is certainly liquor". She gets the doctor and he does his little liquor swab and his examination. Finally it was good to know what was actually happening. And that was basically "you are staying here until the rest of the time, until you deliver. We will put you on steroids and antibiotics".

The more people I talk to the more you realise how risky it was wandering around all that time beforehand when you didn't know. But they don't know that there was anything that you could really have done.

But there was one thing I found all the way through is that all the doctors, this is no one's particular fault, like everyone was the same and I noticed that they did it to other women that were in the ward as well, is that they all go now "what was it like? what colour was it?, what was this like?, what was that like?" They try to get you in your ignorant way to describe what you have seen and they won't actually look at it themselves. As soon as one nurse actually said "well can I just have a look at your pad", and she goes "oh that is liquor". And you just think 'ohh'. They did it to another girl who was in the other bed and she had sort of bleeding. They were trying to decide whether she had ruptured her membranes and they kept on asking her "well what does it look like?" because it was only happening every so often. She would go "well it is sort of like...", and they would say "well how much is it?", and it is really hard to decide how much and what colour and all this sort of thing. Once she went up to a nurse and showed her, and the nurse looked at her as if she was some really weird person. I thought it would be much easier if they could just like look and say "oh that is what it is", or this is old blood or new blood or this size or this amount, because they should know.

How was this woman's experience unsafe? She was expecting twins. She had been thrown into a pregnancy situation known to have more risks than a singleton pregnancy. The first of these risks announced itself with the first trickle of fluid. This woman was thrown into 'being unsafe'. From her perspective, all she knew was that something was happening that she didn't expect to be happening. When she rang the first midwife in the middle of the night, the midwife responded in a manner of concern. She kept open the possibility that this was the appearance of something serious. She kept the relationship open. She recommended safe action to be taken the next morning. The G.P. was next in line to continue the concern of safe practice. All he had to go on was what this woman told him. There was nothing to see because there was nothing to see right then. He made the assumption that that meant there was nothing to be concerned about, that it seemed to be safe. He offered an explanation of incontinence of urine to validate his lack of concern. He tried to take away from the woman her perturbed concern with his decision that 'it did not matter'. When the trickling continued it was no longer easy for the woman to go back and tell someone whom she knew had already not believed her. When the fluid changed to a tiny bleed, the woman had her concern reinforced, she had a reason to go back, she had an appearance of the bleed to describe. She knew it 'wasn't right'. Her words suggest that she had to persuade the doctor to believe her before he would. When she got to the base hospital, again there was only her story to be believed, and again it wasn't believed. From the practitioners at the hospital's observations it 'seemed' to be alright. They listened to her describing something she had experienced, but she did not understand enough to use words that would convince them. They were set to send her home again, unbelieving, unassured, unsafe. It was the registrar who called a halt to this situation of breakdown and believed her sufficiently to wait for the appearance to reappear. This woman goes on to reflect that even when other women having similar experiences had something there to show (some liquor on their pad), there seemed to be a reluctance on the part of practitioners to look at the evidence for themselves. The practitioners preferred to demand descriptions from women who felt they had no words to describe them.

Breakdown in this story is primarily about thrownness. The membranes ruptured. It happened. There was no escape from that happening. The negligence in this story is that when the unsafeness announced itself, it was ignored by two layers of practitioners who were blinded by a semblance. They were blinded by semblance because when they examined this woman there was no liquor to see, they took that semblance, that pretence that all was safe, as their guide for practice. The irony of this story is that the woman was not believed because there was nothing to see. Her observation of practice, however, showed her that when a woman did have something to show, the practitioners did not want to see it.

Unsafeness may be there when the practitioner least expects it. The announcing of it may be intermittent. It is the woman who will be most sensitive to subtle changes in her being-of-pregnancy, yet she is the one least likely to understand what the changes might mean. Safe, 'concernful' practice is open to announcings. It heeds the woman. It gets as close to the announcing as it is able, bringing the wisdom of knowing to the interpretation of what is going on. The practitioners of safe, 'concernful' practice remember that all may not be as it seems. In their wisdom they recognise that 'what matters to the woman' is most likely something that should also matter to the practitioner.

Breakdown in the spirit of practice

The assumption is made that the practitioner will be concerned about the woman and her baby, that they will want to know, that they will want to help, that they do care. The following woman's experience did not leave her feeling that her practitioner acted this way:

The day after the birth I felt alone in that big place bustling with people. The midwife, who I thought would be in the first night to help me showed up at about 5 o'clock and said "Hi, how are you?" I thought 'oh God, wow, at last, she has arrived, I can talk, I can find out things, and ask her everything'. And it was like "How are you? Fine. Right. Well. I have to go. Don't want to get caught in the traffic" In and out in a minute.

I assume when you are in hospital, because you have an independent midwife they don't really allocate you a midwife. My midwife never came

again, I never saw her again. So she deserted me, and I wasn't really getting ...well ...I'm not one to ask, not one to push the bell. Perhaps I should have pushed the bell a bit more. I felt lost and alone.

They tried to help with breast feeding, but he didn't latch on, and they tried, but they just, you know, taking this very bruised little head and whacking it against my breast. Then he would get upset, and they would stop and put him back in his crib. They just weren't there. I felt rejected. They mentioned I should try to express. That was another thing perhaps I should have read up on. I can see some of it was my fault because I should have read about it more at the time, but you don't really think you need to because you think 'everyone is there' 'staff will be there', but I think I didn't have anyone. I didn't feel like anyone was particularly interested. Finally a nurse gave me a nipple shield to help with latching on. She helped me with that, and he did seem to be latching on, he did seem to be getting something. And sort of the advice "oh, try to wean him off later on". And so this solved the immediate problem, he seemed to be getting something, and his weight wasn't dropping. He put on a little bit to go home.

Even right from the word go I wasn't feeding him enough, but I didn't know that. It was normal for him to be upset at that time of the night, and I had fed him before, why try again now? I had just fed him. I think right back then he was trying to tell me he was hungry, but oh no, it will come, and so I came home.

I had this sort of thing, well you feed new babies sort of four hourly or when they ask, you know, on demand. He just didn't demand that. He slept so much. He would fall asleep on the breast, and fall asleep for ages ...that is what babies do. And then of course, my midwife couldn't come to see me, and sent someone else who came. She was ok, but... She arrived, and she tried to give him some. She gave some more suggestions about the nipple shield, and tried to cut it down. But the whole time, nobody watched me feed. Nobody sat, I know it is pretty boring, but nobody sat and watched what I was doing for a feed. Then she said "when do you want me to come again?" She must have felt I was confident, 'she obviously thinks she doesn't need to come every day' 'the original midwife wants to come, but she can't come today'...I was finding it was quite a sort of gap. I think it was only four days, but at this stage it did count.

Finally the original midwife came to see how I was getting on, took one look at the baby, weighed him, and said "my God, you have to get some food into this baby" He was very scrawny, and there were spots and things, well, you didn't know what to expect. They asked the question "are the nappies wet?" but not "how wet?". I had no idea they were supposed to be that wet. "They are wet, yes" but not "how wet". I did say "they

would have a little spot here, you know, orangy as though he was dehydrated.” She said “well they get that after they are born” but this is about a week now, over a week, and still to be having that. It had been left so long until we finally realised. When the original one finally came back and weighed the baby, he had lost so much weight. He had just been really dehydrated.

This story was told with deep emotion. The tape was stopped as the tears flowed. There was no doubt in this woman’s mind and heart that this was a story about practice that was ‘unsafe’. Here, we see the deficient, indifferent modes of concern. The contact this midwife had with this woman was very minimal. The woman needed her support and guidance with breast feeding. There was so much she didn’t know, and so much she didn’t know she didn’t know. The woman only had semblance to guide her. Her baby seemed to be feeding. She had no way of knowing the difference between the sleep of a well fed baby, and the sleep of a dehydrated baby. She did her very best for her baby, yet she conveyed in her words and in her emotion that she knew that things were not right.

How was safety missing from the midwife’s practice? The primary answer is ‘you cannot provide care without being there’. Maybe this midwife had a rush of other births, maybe she had a deficit of sleep, maybe it was physically impossible for her to visit. Whatever her reasons, the impression remains that even when she did visit she still ‘wasn’t there’, that this woman’s safety still did not matter to her. The midwife did not show the practices of ‘being open’ to safe/unsafeness, to the possibilities that this woman and baby were having problems, that this woman needed to talk to her, to ask her questions, to receive her feedback. This woman desperately needed a ‘concernful’ visit from a midwife, yet when the locum midwife asked her how soon she needed another visit, it was very hard for her to reveal that longing. She wanted to appear as though she was coping, yet she knew that she wasn’t. Perhaps she also knew that although she wanted help, neither of the midwives’ visits met her need. Did it matter that the original midwife was not able to maintain continuity of care? There was a sense of disappointment, a sense of being let down by ‘my’ midwife, yet little promise of receiving ‘concernfulness’ even if the original midwife had been able to come. Is it not

possible that the substitute midwife could have shown she cared, shown she recognised that feeding 'mattered', shown she was there to help this woman 'leap-ahead' by listening to her story, answering her questions, and telling her more of the things that would equip her to breast feed effectively?

Within this story is the semblance of 'safe practice'. The midwife did ask if the baby was having wet nappies. The answer was 'yes'. The midwife took that to mean the baby was not dehydrated. It did not mean that at all, for there had been no shared understanding of what 'wet' meant. When the woman described the appearance of the orangy spot on the nappies, the midwife did not pursue what that might mean in a baby one week old. She ignored the cue to dehydration. The baby became markedly undernourished and dehydrated before his appearance announced itself as being unsafe.

The way the woman tells this story suggests that she was the one blamed for the state of her baby, that she was the one who should have known, that she was the one who should have told the midwife her baby wasn't feeding properly. One can only ask 'where was the watching, the anticipating, the attending, and the skilled judgement of the midwife?' The spirit of 'concernful' practice seems to be missing. The two midwives caring for this woman and her baby came and went, seeming to be maintaining safe practice, but not seeing the unsafety before them. You do not see if you do not watch, if you do not listen and hear, if you do not ask the right questions, if you do not take with you a genuine concern for the woman and her baby. If the spirit of 'concernful' practice is missing, unsafeness is left to take its own course.

How does the woman determine the trustworthiness of the care she is receiving? How can she know that the reassurances of a practitioner are false? How does she live with the guilt when the unsafeness that was there all the time is finally revealed? If she does perceive a breakdown in the spirit of care, how does she deal with that?

Breakdown in relationship from the woman's perspective

The previous story told of a woman who never felt 'in relationship' with her midwife. This next story was told in a manner where 'the relationship' seemed to be the breakdown factor right from the very first visit:

When it came to choosing a homebirth midwife basically I got the only one I knew. I thought she would be good. The first time I saw her, I wanted to know about the birth. I didn't give a toss about the pregnancy, I was going through that, but the birth scares the hell out of everybody. I wanted her to tell me about all sorts of things, but instead she said "oh, we won't discuss that now, we will discuss that next time I see you". Everytime I'd try and ask questions, it was like "well you don't need to know that, you don't need to worry about things like that". Well it is my body. Surely I have a right to know. I wasn't stropopy enough to say "I want to know" and they fobbed me off bit by bit.

Like I asked her about episiotomies, in fact I told her that I didn't want one. I felt quite strong about that. She basically told me I was being stupid, that in a first birth it is highly likely that you will have one, that they are no big deal, and she didn't know what I was worrying about blah, blah, blah. I told her that I had read stuff that women can have quite a lot of problems later, and that I know my body. If things are going wrong, they usually go wrong on me. And she said: "oh, don't worry about that, and anyway we do have to cut people quite a lot." Right there and then, she just blew everything away, and made me feel like a child. It wasn't me deciding anything. It was like: this is how it goes and you will fall into these categories and we will do this. I began to feel really constrained about what I could ask, and what I could say, without being ridiculed.

When I'd been labouring at home, and things didn't seem to be going well, she said to me: "Well, what do you want to do? I have got to hear it from you." So I said to her "what do you think" and she said "well it's up to you." I thought "well thanks a damned lot for your help."

When I went to theatre for the trial of forceps, my midwife came too. I thought she was there for my support. The whole time I was told nothing. It was "oh it's such a nice day". I didn't give a shit what the day was like. I was having a baby. I wanted to know what was happening.

When I asked her if I had been cut, if I had had an episiotomy, she laughed when she told me I had been. My mother and my sister had both had forceps deliveries with no episiotomy. I know it is rare, but it wasn't a silly question. It was something that was important to me.

When I went home, I still had horrendous stitches, and after a week I still hadn't been to the toilet. She gave me something like a tube with cream in it and you shoved that up, but nothing happened. I was eating bags full of dates and prunes, I was feeling really sick, and nothing was moving through. I kept saying this to my midwife, but I got the impression from her that I was being a hypochondriac, like 'women give birth all the time - come along'.

I was in so much pain that I'd almost black out. I said to her "look, I am in all this pain", and she said "oh yes" and said she'd let me go for a while. It was two weeks later when in desperation I went to the doctor. I said to him "something is wrong". He didn't make much response, so I said "look, could you examine me" and even then he was a bit reluctant because I had stitches. I said "look there is something wrong you know" so he finally examined me. As soon as he saw for himself, he referred me to a Gynaecologist that afternoon. He examined me, and told me I had a haematoma that was huge, absolutely huge, like he needed two hands to explain how big it was. He took me to theatre straight away and evacuated it.

My midwife came to see me right after I came out. I felt like saying "what are you doing here!" because she had never said anything, and had almost not believed me. It felt like she was being a bit hypocritical to come round now as if to say "aren't I the caring midwife"

I kept mentioning to my husband that I thought she was pretty shit but he thought she was really good, because she was supportive to him. It took me quite a while to work out that it was okay for him to feel like that, but that is not how I feel.

My midwife made me feel unsafe right from day one. Looking back now, I would not have her. My friend who had had her said she was great, but they didn't have a problem. She could not cope if there was a difficulty, and that is just so wrong. Now I don't trust her as far as I could throw her. It would have been really difficult to change her because of the precursors to it. There wasn't another homebirth midwife. And you can't believe that someone is going to do those things. I kept thinking 'oh no, she doesn't mean that', 'oh no, she really won't give me that drug', 'oh no, no, no, she probably means I have got... 'she knows best.' You place so much trust in those people. You think they have got a degree, they know best, they have done this thousands of times.

They say you have choice, but you haven't really. If you choose a home birth, you have to choose someone in your area, and you have to choose someone whose books aren't too full. That might leave you with people who aren't so good. It's just a shame that her and I didn't get on. She delivered my friend's baby perfect.

The relationship between this woman and this midwife did not work. I have the impression that if the midwife was to tell her story, she too would say 'it didn't work'. There was a tension right from the very beginning. The midwife took control of what would be discussed. The woman felt put-down, patronised, and did not feel heard. The woman no longer felt her sense of self in this relationship, rather she was dominated by the terms of the other. The story of the episiotomy captures the breakdown. This woman knew her own body. She knew that it was important to avoid an episiotomy. When she tried to tell this to the midwife she wasn't heard. The 'they' of 'common knowledge' took over, 'they who know that primigravidas often need an episiotomy'. This woman went on to have a forceps delivery. 'They', that is, us in the everydayness of practice, know that it is mostly routine to have an episiotomy with a forceps delivery. The woman knew that it is possible not to. It seems that possibility was not considered. She had, without being asked or told, an episiotomy. Her midwife did not understand what a huge disappointment this was to her. The fears of this woman became her reality. She developed severe pain around her episiotomy site, and a huge haematoma. The midwife came to see her when she came out of theatre. For this woman, it was too late for her to start listening to her then.

This is a relationship that never got the asking and listening right. The woman began by trusting that the midwife knew best, that she would do what was right, that she would share similar notions of how birth should be. Even when she heard her midwife undermine that trust, and saw her midwife stand by as the trust was betrayed by others, she still needed to feel she could trust her. The one time when she wanted to be told what to do was when the midwife refused to tell her what to do. The midwife insisted that the woman decide for herself that it was time to transfer to hospital. Again, she felt betrayed.

There is a sense that a barrier grew between this woman and this midwife. They came to not like each other. They came not to want to relate to each other. Yet the woman had severe perineal pain. She tried to tell the midwife. It seems the midwife didn't want to know. The midwife judged the situation to be the normal pain of episiotomy. It seems

she did not look for herself. It seems she did not believe the woman's description of the pain. The appearance of a developing haematoma was there, yet it was left to the woman herself to pursue its seriousness. Even when she did that, she still had to convince the doctor that there really was something wrong, and that he should look for himself.

Heidegger talks of the solicitude of leaping-in and leaping-ahead (1927/1962, p.159). If a relationship is such that the practitioner does not listen, does not come to know the hopes and fears of the woman, does not respond to her anxieties, then the mode of care can only be one of leaping-in, and can only be based on the semblance of what the practitioner thinks should be happening. It lacks attention to the things that are 'mattering'. It traps the woman into a passive role of accepting inappropriate, unsafe care, rather than freeing her to involve herself in the accomplishment of personalised care that promotes all that is safe. Nevertheless, there were times in this relationship where the woman needed and wanted the midwife to leap-in and take care away from her. She wanted the midwife to 'tell her' it was time to transfer to hospital. She needed the midwife to leap-in and rescue her from the developing problem of the haematoma. Leaping-in and leaping-ahead are both positive modes of concern. It always depends on the context, on the situation, on the urgency, on the things that matter.

This midwife had a good relationship with the woman's husband, and a good relationship with the woman's friend. She was able to form good relationships. It was just this particular relationship that didn't work. What mattered to this woman did not always seem to matter to the midwife. At the same time, the woman 'didn't give a toss' about what seemed to matter to the midwife. When different things matter, and the concern of one goes in a different direction from the concern of the other, there may be no connection at all. Unconnected concerns do not reach together to make the bridge that fosters safeness.

Breakdown in relationship from a midwife's perspective

Relationships are never one-sided. There is always the story from the other side of the relationship. A midwife (not the one referred to above) gave her impressions on what it is like being the midwife in relationships:

I've had quite a bad scene on lately of having clients that I've really found difficult. I get to the stage where I can't bear to go and see them sometimes, and I actually have to force myself to go and see them. And that's awful. It shouldn't be like that, and it's probably unsafe for the woman. I don't know how to best work out an escape clause. Like how do you say to someone at 32 weeks "look I don't want to look after you anymore". Doctors don't do that. It's not the same, is it. They see them in a consulting room for two minutes, for blood pressure, urine, and the physical type things. Women don't do those same things at doctors anyway. They don't unload it all.

One or two of them that have been particularly difficult, I realise that they really wanted me to be their friend, and when it became apparent that I wasn't going to be their best friend, then the only thing I could be was an enemy. That's what I find the most difficult. I get quite intense about it, and I can't just laugh it off. Like I sit there and seethe with anger about them sometimes. I think they're just eating up my life. They don't seem to have any awareness that I've got children and a family, and I want to do other things as well. That I'll give my all to them, but I don't want them ringing me up four times a day, to tell me inconsequential things. And then accuse me of being distant when I don't respond 100% enthusiastically.

Maybe I try and do it too much, I don't know. And sometimes I go into people's houses, and I don't even want to say anything. I just sit there and think "you tell me that, you ask me what you want". And they're all sitting round staring at me, and I think "I don't want to do it". I don't want to tell them all how fantastic it is, and all that. I just think "Well here I am. It's bloody eight o'clock at night, and I'm here sitting in your wretched house (laughter) I feel quite resentful sometimes, you know. So much is asked of me. And sometimes I don't want to do it. [I-midwife]

This midwife acknowledges that sometimes a relationship between a midwife and a woman does not work, and that feels unsafe. She is a midwife who tries to work from a leap-ahead stance, to free the woman to take her own responsibility, and to be involved in making decisions. It means passing over information, it means working through the 'what if's' of possible situations, it means being there to answer questions and concerns.

It is a giving over of self. The consequence this midwife describes is that some women seem to want, almost to the stage of demanding, her undivided attention, her total availability, her full concern for all the problems of their complicated lives. They want her to be their best friend. It is too much to ask. She is left feeling as though they are eating up her life. As soon as she becomes resentful or distant, they respond with enmity. If they perceive she is not totally for them, then they assume she is against them. The barriers to effective relationship are in place. The care becomes unsafe.

Young (1997) in his interpretation of leaping-ahead, describes it as tough love, a tough-minded kind of critical objectivity “which facilitates (but never seeks to compel)”(p.106). This captures the striving and the tension of being in such a relationship. It is much more than what Dreyfus has termed the *Beatles* ‘let it be’ (Young, 1997, p.104). It is an engagement from which the self (the practitioner) has a sense of what is acceptable, and what is not. When, in the process of facilitation, the ‘other’ (the woman) breaches those boundaries, the ‘toughness’ has the choice of either getting tougher, or of compromising important personal standards. It is a tension of finding the safe balance between compromise and toughness. If there is too much compromise, or too much toughness, there is likely to be breakdown of safeness.

The story of this midwife, and of the previous woman, both describe the feeling of being trapped. There seems to be no escape from the relationship that has broken down. Heidegger talks of Being-with-one-another as being about ‘opening oneself up’ or ‘closing oneself off’ (1927/1962, p.161). In a relationship where both parties have closed off to the other, concern is likely to thrive in its deficient and indifferent modes. That is, it doesn’t really care at all, it doesn’t pay much attention, it doesn’t put much thought or effort into the things that need to be done, it doesn’t seek to engage or understand the other person involved in the relationship. Heidegger suggests that in such a situation even the self gets lost, in such ways as “aloofness, hiding oneself away, or putting on a disguise” (p.161). Which means that even though one or other may be feeling angry, betrayed, or frustrated, it is likely that those deep feelings will be disguised by distant, polite behaviour, or some other semblance of the

client/professional relationship. How it really is for either party remains covered over. The breakdown is there, but it is unlikely to be seen for itself unless it is provoked into appearance. The question is, how much does such breakdown matter to 'being safe'? Is it possible to care for people you don't like with fairness and respect in a way that is safe? Are there levels of engagement with deficient detachment at one end, and over-involvement at the other end? Is there a level of breakdown that can still foster a safe experience and a more profound level of breakdown that is beyond 'being safe'? How does the woman or the practitioner, or a concerned on-looker, make such a judgement?

Breakdown in dual relationship

For some women, the problem is not so much the one-on-one interaction with a practitioner, but the fact that their care is being shared by two different practitioners:

I went to an Obstetrician with my first child, I think because I was scared. He was a nice guy, but it is the usual thing of being in there for two seconds, and never asking anything because you know he has a waiting room full of people, and you had to wait three quarters of an hour past your appointment time. The visits didn't seem important things to do. I suppose he did talk, he was reasonably friendly for a consultant, yeah he wasn't bad.

I had shared care with my GP as well. That probably didn't work out that well because I guess one felt the other was going to take responsibility or do something, and they hadn't. I would go down the track not knowing what hadn't been done. No-one booked me at the hospital for instance. They both presumed the other one would do it. It was a bit like being tossed around. I should have gone to him full, or somebody else full, but not split between the two. I felt with the GP, that it was a bit of a money making venture.

It seems that 'relationship' is too rich a word to describe either of these two interactions with practitioners. They were busy people who completed the tasks of each visit. The consultant was reasonably friendly, constrained in developing the relationship further by the time factor, he was always running late. The woman accepted such a relationship. Her vulnerability lay in the gap that lay between the two practitioners. When one person takes full responsibility, they know they have to watch everything, anticipate everything, do everything. When a second person shares the responsibility, there is always the danger of one assuming more of the other than is so. The 'failure to book'

gave rise to the lack of safety by two practitioners, each of whom assumed that relevant actions would be done by the other. Other practices would be 'covered over' in their neglect. The woman, who never received a certain kind of care from either, never knew that it should be received. Her phrase 'being tossed around' carries with it a sense that the responsibility for her care was being tossed back from one doctor to the other thereby freeing each doctor of feeling responsible. If both doctors feel they have passed responsibility over, no-one is then responsible. The blurring of relationships, and the subsequent confusion over who is responsible is swarming with potential for breakdown. It provokes an indifferent mode of care.

Inter-professional breakdown

Relationships in the maternity services are not just between the woman and the practitioner. Many key relationships exist between the practitioners themselves:

What's happening a little bit lately that you actually write things down, and things are done differently. And that's really frustrating if they are high risk patients, such as a previous Caesar, and if you consulted with the Consultant as well, and you've actually proscribed a certain protocol of management, and you find 4 hours later that something else has been done.

I had a hypertensive last week who I induced at term, gave prostaglandins, ruptured the membranes at two in the afternoon, and wrote in the notes, spoke to the midwife, and said, "down to Delivery unit and start syntocinon now". And that was two in the afternoon, and when I rang at six, they said that they hadn't started the synto at half past four, because she was niggling. And I sort of think, that may be fine, but nobody rang me and asked me to find that out.

That's the problem. I mean, I'm the one still carrying the can, if something different is happening from what I've actually ordered, and that worries me. And sometimes those things are made I think for political reasons, you know, "we think differently and think better, so we'll just go ahead and do it". But I'm still the one carrying the can. I don't like people changing my decisions without consulting me. I mean, I'm happy if they ring up and say "this is what's happening". I don't like them to just do it without telling me. [H -gp]

The General Practitioner shares his concern that politics have become a barrier in his relationship with hospital midwives. He describes an example of midwives changing the

written plans he had made, without asking, or informing him of the changed circumstances. How do midwives 'think differently and think better'? The political answer is that midwives value and promote the natural processes of labour. If a woman indicated she was beginning to go into labour on her own, they would be reluctant to interfere by starting a syntocinon infusion to provoke contractions. They would want to give the woman the opportunity to do it for herself. Why did they not phone the doctor and tell him this? They did not phone because the political belief generally held is that doctors practice from the medical model, and would therefore believe that the outcome is what matters most, to get the baby delivered. A doctor, according to the midwives' belief, would not linger in starting syntocinon. If they had rung him, their opportunity to give this woman a chance would probably have gone. Instead, they adopted the political strategy of not asking, of quietly buying some time. The doctor's distress is caused by his belief that they assumed they knew how he would respond to them, and that they took away from him the responsibility of care that was, and would remain, legally his. They leapt-in, and decided for themselves, in a 'we know best' approach, rather than allowing the doctor to make his own decisions in the changed set of circumstances. It shows the paradox of midwives practising from a committed belief of leap-ahead partnership with the woman, yet at the same time attempting to maintain a leap-in relationship with medical colleagues, making decisions without their involvement. One could argue that the woman's care remained safe throughout this political skirmish. The breakdown was rather one of inter-professional trust. It was the 'theys' of midwifery and obstetrics in philosophical opposition. Where is the woman in such a scenario? How does she come to understand the conflicting modes of practice being acted out on her? Is there a danger that the focus of care will move away from the woman to become one of winning the battle for professional and philosophical supremacy? Would the midwives argue that they were all the time facilitating the freedom of the woman? What matters most? Do the same things matter to the different people involved? Does the conflict of 'what matters?' lead to breakdown?

Breakdown in relationship with technology

The first story of this chapter was about the woman with the twin pregnancy whose membranes ruptured at 21 weeks. The outcome of that was that she went into labour, and had an emergency Caesarian birth at 27 weeks. One baby died within hours of birth.

This is the story of how technology gave the semblance that all was well:

I stayed in the antenatal ward for three and a half weeks, just waiting. I had scans every week, growth scans and to check the amount of fluid that was there. On the scans it showed that there were two sacs, that both had the same amount of fluid and they were both quite normal. They couldn't even tell which baby had the ruptured membrane at all. But they couldn't see the dividing membrane either, and they said "oh sometimes if there is no fluid there it is stuck to the baby" which was obviously what had actually happened.

They were seeing the fluid that was just around the baby that survived, and there was none around the one who died. But it still seems quite strange, when you saw her after the birth, how they could not have seen that there was no fluid around her. Like she had club feet because of the lack of fluid. Her feet were quite bent, you know you would think they would have seen it but it seems like they were not supposed to see it, so they didn't. When they did the Caesar the baby they took out first was the one who had no liquor. She was the one who died just a few hours later.

The doctor came afterwards. He was really helpful all the way through. He had tears in his eyes. It made me cry just seeing the tears in his eyes. He said "I am sorry we couldn't have warned you what was going to happen". I said "well don't worry because I wouldn't have wanted to have known, this is the best way that it could have happened"

The scans revealed that although this woman's membranes were ruptured, both babies had sufficient fluid around them to be safe. The woman and the doctors were reassured through the waiting time that all was as safe as it could be for both babies. The interpretation of the scan, however, was later found to be wrong. One baby had lost all its liquor, and was found at birth to be severely compromised. There was a breakdown of understanding. On reflection, this woman is glad that there was. She would not have wanted to have known that her baby was suffering, for in this situation there is little that could have been done that would not have put the other baby at significant risk. If it had to be that way, it was better not to know.

It was different for the doctor. He had been reassuring this woman week after week that according to the scan both babies were fine. Now he had to face the woman, to say he had been wrong all the time. This woman was gracious in her understanding. How will it feel for him next time he reads a scan report. Will he still trust the scan report to be as it appears to be? How can he not trust, when 'they' scan for the very purpose of trustworthy information? For him, it was a situation of semblance being false. He has experienced breakdown. He must now learn to live with the possibility of breakdown. At the same time, he carries with him the reminder that for the woman, breakdown was the best way it could have happened. Technology transformed the situation from its natural state into something that it was not. Smith (1996) would perhaps remind us to use this story of breakdown to help us understand the essence of technology, that it is not necessarily wiser than human understanding, that it therefore should not take priority as truth-as-unconcealing. It simply portrays one of the possible truths. It is by claiming such an openness to understanding that Heidegger would be likely to applaud us for freeing ourselves from technology. Young (1997) reminds us that Heidegger accepted that technology (such as the ultra sound scan) is indispensable to modern existence, and "that it would be 'foolish' and 'shortsighted' to condemn modern technology as the 'work of the devil'" (p.191). "We cannot, then, abolish the technological world. Yet, though it constantly threatens, we can avoid 'bondage' to it by, while using technological devices, leaving them outside our inner core" (Young, 1997, p.192). Maybe this experience of breakdown has shown the doctor in the story of the twins how technology threatens, and has helped him to understand the importance of avoiding the absolute bondage of reliance on 'the scan report'. Maybe through his tears, he has seen afresh. Through him we see that a practitioner has their own 'inner core' that speaks a different kind of understanding about 'being safe'.

Breakdown in the things that hardly seem to matter

It is clear that things, such as the safeness of the baby, 'matter'. Practitioners will do their very best to protect physical well being. Practitioners know the things that matter. The following stories are examples of breakdown that occurred probably because the practitioners involved did not consider that 'it mattered'. The first woman told the story

of her long labour, her long period of pushing, and her transfer to theatre for a forceps delivery. She told her story with enthusiasm. The delivery hadn't been as she had hoped but it had been alright. She asked me if she should go on, and tell me what happened next. It was then that the memories brought tears to her eyes:

The morning after the birth, I couldn't move. I had had an epidural. I knew there was some sort of pad under me, but apart from that I really didn't know what they had done down there or what was happening or if I was bleeding everywhere or if I'd had an accident or what had happened, and I was actually quite scared of that. A nurse came in, I am sure she wasn't a midwife. They changed shifts. I said "I need to go to the toilet", she said I could go and have a shower and did I need a wheel chair. I said "I don't know", so I sort of stood up and discovered that my legs worked vaguely and I said "oh I will walk down there to go to the loo".

I got down there, and I was really upset because I didn't know what I could do and what I couldn't do. I knew I had stitches and I didn't know if it would hurt when I went to the toilet. There are all those sorts of things that you don't know. And so in the end I called her on the buzzer and I said "what can I do and what can't I do? and I didn't pack soap and shampoo in my sponge bag, I don't know why". And she said "oh well I will get you some hospital soap", so she gave me some soap. It was a bit of a drama. I had forgotten my shampoo and so I said "look I'll just use soap". And I said "what do I use to wash myself" and she said "oh just wash yourself with water and you can use soap and all the rest of it".

I actually needed a bit more 'being with' than I got. She literally disappeared while I sort of struggled through a shower and by the time I finished that, I collapsed. I got half way back and they put me in a wheel chair and took me back to bed.

Looking back on that shower, I was petrified. I didn't feel particularly well, probably because I was hungry and that was probably the reason I didn't feel well rather than I was losing heaps of blood or anything. And the other thing was I was terrified of leaving blood on their towel and I was trying to avoid it. When I actually called, when I buzzed her to come back I burst into tears. I think then she realised how desperate I was and sort of did an about face and stopped treating me a bit like a number and started talking to me. That was a really vulnerable time.

For the staff, the drama of the birth was over. It was a new shift. Nobody knew this woman, they simply knew she needed a shower. It was a low priority task to be done. The nurse, who is likely to have been an untrained assistant, was delegated to complete the task. For the woman, it was, however, a time of crisis. She faced the morning after

her birth no longer knowing her body. It had been numbed by anaesthesia, traumatised by the birth, and was involved in the post-birth physiological processes, the most apparent of which was vaginal bleeding. This woman no longer knew how to accomplish the everyday tasks of getting up, going to the toilet, having a shower. Her body was no longer ready-to-hand. She was frightened by her lack of knowing. At the same time, it would have seemed silly to say 'I don't know what to do'. She was made to feel foolish for forgetting to bring her soap and shampoo. She was trying so hard to shower herself, and not get blood on the towel. It was a task that is done in everyday life without a second thought. On this day it seemed almost impossible. It was the one time through her entire labour experience that she was brought to tears, brought to a state of collapse. The thing that mattered least of all to the practitioners was, in the end, the thing that mattered more than anything else to this woman.

The next story is again from a woman who gave away her hopes one by one as her labour took on a chain of interventions, and came to end in a forceps delivery:

Because of the meconium in the water they had to call in a paediatrician, so I knew I couldn't hold the baby straight away. All the stitches, oh it seemed to take forever. Eventually it was done. The baby was brought over to me wrapped in a towel.

Now I hadn't said I wanted much, but one of the things that I had said was I wanted to feel the baby naked on my chest straight away. It wasn't possible with meconium, so after he had done his thing, I wanted the baby brought over and put to the breast straight away, and to feel him. I didn't feel that was a particularly big thing to ask. It wasn't the 'lets be all natural thing'. I think it was just a fair enough thing to want. And the baby was brought over all wrapped in a towel.

The staff had dealt with the things that mattered to them. They had got this baby delivered, and had sucked out the meconium liquor. It is normal to then wrap the baby in a towel. Without thinking, that is what they did. For the woman, this was the ultimate betrayal of her relationship with her midwife. She had reluctantly accepted all the other losses in her experience because she could understand them. Receiving and holding her baby naked on her chest was the one dream she could still hang on to. It was still a

possibility. It was taken from her, because it didn't matter enough to the midwife for this request of hers even to be remembered.

What is the Being of 'mattering'? Is it from self, or 'they'? I suggest that 'they' have a powerful and dominant voice in establishing what does matter and what does not matter. Routines and normal practices are based on what matters. Leaping-in determines what matters. Leaping-ahead leaves open the possibility of recognising what might matter to the woman, but recognition of what might matter to this woman must then be held onto as 'remembering' for when such a situation arises. It is, perhaps, worse to know what matters and then ignore it, than to never have known in the first place. Practitioners assume to know what matters about being safe. Both of these women carry stories with them that remind us that assumptions are not always to be relied upon. If the practitioner could come to know what matters to the woman, and if the woman could come to know what matters to the practitioner, and if they could together work out how both sets of 'mattering' could complement each other, and weave what matters together in 'concernful' care, then perhaps, some situations of breakdown could be avoided.

Breakdown in institutional care

When a woman places herself in the care of an institution, the assumed place of safe care, the possibilities for breakdown are numerous and diverse:

Post delivery, they sort of just did what they had to do with the clean up and were gone. They just left us there. It was busy, but like they were gone, they were gone. We all ended up having a sleep. We ended up having 2 to 3 hours in that room. I remember thinking "gosh, my mum and dad are going to come in" and things were still all pretty blood and guts" They came back, and said "oh look, sorry, we are just really busy at the moment". They finished the clean up. We didn't get up to the ward for about 5 hours.

The lady who was looking after me for the first eight hours, she gave me the impression that she was really busy, and that there was barely going to be time to look after me. I just was totally fazed. I felt quite dizzy going up to the ward. I remember ending up sitting with my head between my knees in the wheelchair and apparently I looked as white as a sheet.

I was told to ask for ice packs, and I did, and I did. I got one lot in delivery suite, and one lot on the ward, and that was it. They said they

didn't have any. I am sure not getting them is part of the reason why I ended up so sore with the forceps pull, and the haemorrhoids, and having the episiotomy. I was pretty disappointed about that because I felt I couldn't walk for weeks and weeks and weeks.

What didn't occur to me before I went in was that there would be one midwife that would be looking after me on each of the shifts. I was a bit confused about all that. Some of them did come in when the shift changed and introduced themselves, but some of them didn't. You would ask one, and you would get the wrong one, and you wouldn't get an answer at all. I wasn't sure who was looking after me. I remember one young girl coming in and introducing herself, and I was impressed because she made a real effort. Being two in a room you would think that the same one would be looking after both of you but that wasn't the case either, which was really weird.

Where does the breakdown lie in this story? It lies in the thrownness of busyness. Priority care in Delivery Unit goes to the women in labour. This woman was now low priority, she had to wait until there was time. She felt left and abandoned. Who is responsible, the midwife who left her because she had more urgent priorities, or the management who determine the staff numbers, or the funders who set limits on the possibilities of safe care? On the postnatal ward, this sense of staff barely having time to look after her continued. We are left with the same questions. Can a midwife who has too many women to care for in a safe manner be held accountable for minimal standards of care, or does the responsibility lie elsewhere?

The ice packs tell their own story. This woman asked again and again for icepacks. Did she not get them because in the busyness her request was forgotten? Did the busyness mean that no-one had put in a replacement order and the freezer was bare? Was it too much of a bureaucratic nightmare to order more? Was there no budget to order more? The responsibility for 'concernful' practice goes beyond the responsibility of the individual midwife. It is the institution itself which places limits and constraints on what the practitioner is able to achieve. This woman could not walk for weeks and weeks. Breakdown has long term consequences for the woman that seem to be of little interest or concern to the nameless, faceless, bricks and mortar institution through which she passes. Is this safe care?

The story of this woman's postnatal care uncovers the facelessness of institutional care. Certainly, there are faces rushing past and faces to ask questions of, but seldom is there a face that makes a real effort to be a person, to create a relationship. There is rather, a concern of indifference. Why would this be, when there is an assumption that the spirit of practice is one of 'concernful' care? Perhaps, it is that in times of busyness, staff develop habits of coping that then become the routines of practice. Perhaps, it is the routine of caring for mothers and new babies day after day that dulls the senses to the significance of the experience for each woman. Perhaps, it is that care takes commitment, it involves 'self'. If, from the busyness, the staff are tired and worn, offering 'self' may require from the staff too great an effort. Perhaps, it is that each staff member knows they are only one of many, that their face can merge into the faceless, institutional whole.

Breakdown in institutional care can be described as the being-of-the-self of the woman, being taken away by others, the others being the faceless, indefinite 'they' who prescribe the averageness of care. Routines, in their familiarity, become accepted as safe care. As routines, they can be answerable for everything, without the need for any one person to vouch for anything. When it is always someone else who did it, or should have done it, then the responsibility lies with no one person (Heidegger, 1927/1962 p.164-165). Institutional breakdown is therefore an insidious undermining of the 'being of safe'. It is found in commonness, in okayness, in low priority matters. It is no-one's fault and everyone's fault. It is so ingrained in the care of institutions that it is taken-for-granted and accepted as being how-it-is. It is only the person who walks away from such breakdown of care that can show us how it really was, for it has left its pain and its scars.

Breakdown in feeling safe

Heidegger tells us that Dasein [Being-in-the-world] always has its mood (1927/1962, p.173). It follows therefore that the moods of 'feeling safe' or of 'feeling unsafe' or the "pallid, evenly balanced lack of mood" (p.173) will always be part of the woman's

experience. The next story, a continuance of the previous story of postnatal care, captures the mood of feeling unsafe:

We left coming home too late in the day. We didn't end up leaving the hospital until about 4.30 pm which was crazy. My husband was late getting there and I wasn't organised when he did get there. Dressing a newborn baby into all her beautiful baby clothes was just a nightmare, like there were ribbons on everything. I couldn't bend her arms into the gown. I just felt like I really didn't know what I was doing. The hardest thing was we weren't confident about getting her into the car seat. In days gone by you wrapped them up beautifully in a nice shawl but you can't do that with a car seat. We ended up asking one of the midwives to check that we had done it all correctly, because I was concerned about that.

The baby was pretty upset by the time it was all done because I knew she was quite starving. It was quite cold when we came home. I remember being really concerned about how cold it was. We had a debate about where we were going to put the bassinette. I managed to last until we got to the front door and then I burst into tears and the feeling of 'what have we done, what on earth have we done and how on earth are we going to be able to do this'

When we got into the house it was just overwhelming. I remember quite a few tears over that, just sort of thinking "gosh, I have no idea about being a mother and here I am with full responsibility for a little mite. It was just so scary.

This woman felt unsafe. She felt overwhelmed by the responsibilities and decisions before her. She was aware of her own incompetence in what seemed such simple tasks. All the safeness of her childbirth experience dissipated as she crossed the threshold back into her own home. The security of her own home became the insecurity of the place where she was now in charge of her own baby. The possibilities of having a new baby changed from joy to fear. Heidegger suggests fearing about is "being-afraid-for-oneself" (1927/1962, p.181). Fear is present when "that which is detrimental draws close by, then it is threatening; it can reach us, and yet it may not" (p.180). The fear of this woman is for herself, in her new situation of being a mother, a situation which has now become closer to her than it has ever been before. Its threat is in its very closeness, in its possibilities of reaching a state of not coping, of not being competent, of not being a safe mother.

Breakdown in this situation is in the mood rather than in the physical wellbeing of mother or baby. All is well, there is no real problem, only a host of imagined ones. What is the role of the practitioner, and of the maternity services, in supporting women through the breakdown of their moods? A practitioner has the knowledge and skills to teach, to instil confidence, to suggest possible solutions to situations that may arise, to translate fear into strategies of management. How are funding agencies to be convinced that working with the woman about possibilities (leaping-ahead) is just as important, if not more important, than working with the actual situation? Breakdown of mood to fear and anxiety may well be the precursor of breakdown of physical/emotional safety. Breakdown of mood exposes the woman's experience, and enables the astute practitioner to offer an engaged relationship. First, however, the practitioner needs the opportunity to be there, and to be in relationship.

Breakdown leading to catastrophe

There could be a tendency in all of the stories that have been told, to shrug one's shoulders and say 'so what -what difference does it really make; 'being safe' and 'being unsafe' are part of everyday life, you just learn to live with them'. The last story reminds us of what being unsafe can lead to, and how hard that is to live with.

When I was pregnant with my first baby, I thought the decisions we made were good. Like I have beaten myself up about it since that I didn't investigate this doctor. I thought a hospital, a doctor with a diploma in obstetrics, and I assumed if you had a baby in a hospital there was this sort of mechanics that came into action, that there was this back up that would crank into gear. I didn't realise that a practitioner could work so independently.

The doctor was always very very busy and when I think about the meetings now, compared with the other ones, they were always very quick. The waiting room was always full of pregnant women waiting to be seen so I thought I had made the right choice 'this is obviously a good place to be'. I was sent for a second scan because of concern about the liquor, and I thought 'oh that is good the doctor is keeping a close eye on me'.

I wasn't nervous about being overdue. I got comments from people "oh baby will come when it wants to, baby will come when it is ready". I went in to that first birth thinking that a natural birth would be probably what I would do, not strive for, but that would be a positive thing.

When we went into delivery suite, my husband and I were left alone a long time. We got there, and the doctor turned up about half an hour later and told the midwives I wanted to go in a nice big deep bath. I think the staff had the feeling that 'she's one of those patients that want that sort of treatment'. I was put in this deep bath. The midwife hadn't been notified I was coming in, there had been no call about coming in, and something was going on amongst the staff.

I was left in that bath for over four hours and never taken out for a trace to be done [fetal monitoring], or to be examined. When the doctor finally came back, and dragged me out of the bath, I was fully dilated. I suspect now that I had been fully dilated for a while now I know what the transition stage is like.

I was alone with my husband. He didn't know what should have been happening and it is really hard for him too, like he feels like he should have done more, he should have got me out of there, he should've done something. His sister had said to him "it is a woman's thing and just leave her to it", and I thought 'oh well this is what you do, you get in a hot bath'. Really someone should have got me out of there and had a good listen.

When the doctor came back, the meconium was there. We went down to the delivery room, and it was really hard work. I mean there was no offer of any kind of pain relief. When we got down there, there seemed to be more emphasis on "take your nightie off" and things like that. When I think now I was birthing without my nightie on and my other births I kept my nightie on, I didn't have to sit there with nothing on. I remember the paediatrician came in and I was sort of meeting him with no clothes on, very undignified. It was awful when you think back and think 'God really there should have been somebody there who was for the baby and for me too' because there wasn't really. There was no real worry about what kind of discomfort I was in. It was just this picture of the natural birth with the squatting and doing all the right things, and naked. And we are not that sort of people really.

The sonicaid broke down and the doctor didn't go and find another one. It seems hard to believe now. I mean just having these other babies, and seeing a well managed birth. If I had had a baby before I would have known it was all wrong. And close attendance, ... it is pretty scary, especially for your first baby, to be left alone for a long time.

I don't remember feeling afraid, because I think I was so locked into just sort of coping with my pain. I actually felt a bit removed from what was happening, that there was going to be a baby at the end of this. It wasn't until I saw her. She was just so gorgeous when she came out.

I heard the doctor talking to the midwife and she said "we can't pick up the heart beat but that is ok, it is the position the baby is in". There was that sort of reassurance. There was meconium present "but that is ok that is because that is common when you are overdue". Now, if I heard meconium come up I would just expect there to be some pretty 'action sort of action', not just 'let things go on'.

The paediatrician came in because the meconium was present. The doctor had called him and said "you will need to come to the birth to suck it out" and so he popped in and out throughout that last stage. I found that reassuring too.

The midwife was really ... I don't know, she was treated really badly, "just do this, do that, do this". She commented twice to the doctor, I didn't hear the fetal heart, and she made a point of noting down in the birth notes, I guess so she wouldn't get into trouble, that she felt the baby was distressed. She was just dismissed and when she saw me sort of a few hours later, my baby by then was in intensive care, and I sort of didn't know what was going on, it hadn't dawned on me at all, she shrugged her shoulders and said "well of course, long second stage, low heart beat, meconium". She knew things were wrong but I think she was getting really bullied. She probably wasn't that confident, so maybe she just sort of knew it and stuff, but it didn't feel like an equal situation.

When they took my baby to the neonatal unit, I was so exhausted, I just kind of went 'boom'. I didn't really think about anything. They said they would take her up for a bit of observation. About 3 in the morning I walked up to the intensive care and the nurse said to me "she has just had a massive convulsion and we have given her paraldehyde". It was my first insight. I thought 'things are really bad here' and I had to ring up my husband. From then on every bit of news was bad ... we never got a bit of news that gave us hope.

She was unconscious or she didn't open her eyes for two weeks and then when she opened her eyes there was no focusing. I couldn't cope with the world, I just wanted to be hidden. My husband and I would just sort of huddle up. I got a faith during that time, because the only way I could get to sleep was to pray.

I had this idea if I could get her breast feeding everything would be alright. There was this sort of thought 'oh that she had a bit of epilepsy and that was terrible, terrible, oh my daughter is going to have epilepsy' and that was like 'oh she might be in a wheel chair', or 'she might even be a hemiplegic' and gradually it became like 'she might recognise me as her mother'. I had just been thinking all the time through my life I have been able to say 'oh it would be ok if this happened', there was always some

solution. In this case there was nothing. There was nothing I could... there was no anchor, I just felt like I was spinning the whole way. I remember one day having this feeling 'all you have to do is love her, that is all'. It would be not ok but that is all we can do and all the other stuff we just have to put to one side.

I guess for me her death was in a way easy for her. It sounds terrible, but that constant seeing her not being able to do anything, not making any changes. It is more straight forward to say 'I had a beautiful daughter I loved who died' than a daughter who I had to love and care for in a different way than I expected.

The ultimate breakdown is the unexpected, unexplained damage to the newborn child, leading to their death. This story raises many of the possibilities of breakdown that have already been discussed. There is first of all the thrownness of distress of the baby. Why was the baby born in a damaged condition? It may be that even if the care had been beyond reproach, still this baby would not have been a perfect baby. The answer to that question lies in the darkness. While it is acknowledged that a practitioner should not be held accountable for 'what is', they are rightfully held accountable for the spirit of practice that seeks to uncover 'what is'. Initially, the doctor seemed to do this uncovering in the ordering of the scan when the woman went post term. It is presumed that the scan gave the semblance that the baby was fine. Throughout labour, it seems that the assumption that the baby was fine was believed to be the truth. Minimal efforts were made to confirm that belief. The spirit of practice seemed to be one of concern, but was it 'concernful'? It was concern based on preconceived notions of how it would be. It was concern in which the doctor had leapt-ahead with an imaginary woman, the "they of natural birth", rather than this particular woman who now looks back in embarrassment at the assumptions that were made about what she would want. Even when there were announcings of distress, such as the meconium liquor and the fetal heart that was difficult to hear, the mesmerising assumption of normality took precedence in determining care. There was no opening-of-each-to-the-other in this relationship. The doctor decided for the woman, and the woman in her belief that doctors know best, passively trusted she was receiving safe care.

The breakdown of technology in this story is, ironically, a breakdown in disguise. It was assumed that the sonicaid wasn't picking up the fetal heart because sometimes it doesn't, depending on the position of the baby. That assumption was false. The technology was in fact revealing the fetal heart as genuinely announcing crisis. The announcement was not heard.

The gaps between practitioners show us that even if other practitioners are 'being' safe, and practising from attentive concern, the primary caregiver (the one who carries the responsibility for supervision of care) can over-ride, and disregard their concern. There is an underlying atmosphere of midwife-doctor political tension in this story. Barriers in inter-professional relationship were in place, making the sharing of concern so much more difficult to be heard. It uncovers questions of the meaning of responsibility. Can another practitioner stand by and observe the unsafe practice of the 'practitioner who is deemed to be responsible' without doing whatever it takes to preserve the well being of the baby, and say at the end of the day "I was not responsible"? Is responsibility a delegated professional function, or is it a moral concern of each person? If we accept the 'rule' that the person to whom responsibility is legally delegated, is the person who makes the final decision, Young (1997) suggests Heidegger's objection would be that rules "by controlling one's understanding of the world ... make one's responses to life rigid and robotic ... [and] unoriginal, not one's own" (p.88). Young further says that "they do this by dimming down situations ... so that only the barest outline of what is occurring is accounted to be morally relevant" (p.88). He offers us fresh possibilities of interpretation. We could say that the doctor was following the rules of being autonomous, and as the person responsible, believed they were making morally relevant decisions. We could say the midwife, while she believed the doctor's decisions to be unsafe, nevertheless was kept morally relevant in her submission to the decisions of the practitioner who was responsible. Yet, the uncovering of the compromised state of the baby at birth, reveals that both the doctor and the midwife had dimmed down the possibilities of the situation. If the moral voice had challenged either practitioner at the time to break the rules that were dictating their actions, to save the life of this baby, it is likely that they would have eagerly done so. Do the rules and routines of practice dim

down our recognition of what is happening? Do they stop us from taking moral action, because in the dimness we cannot see the deterioration and decay. Heidegger directs us to seek “the insight of the moment, a radicalism untrammelled by any pre-given moral principles” (Young, 1997, p.90). Yet, he recognises that we cannot but take with us our fore-having and our fore-sight. Within this, he reminds us of the notions we carry to “do the courageous thing”, or “do the polite (or politic) thing” (p.91-92). That is the tension of practice, knowing when the moral call to be courageous outweighs the less threatening call to obey the rules. A courageous practitioner is much more likely to call a halt to breakdown than a polite practitioner. Yet, when the dimness turns to light, which of us wouldn't have wished to have had the courage to save the life of the baby?

What mattered most of all to this woman was the birth of a healthy baby. As she reflects back on that day, she is left wondering if that is what mattered most to the practitioners. Could it be that the doctor assumed a natural birth mattered most? Could it be that for the midwives, their attitude of political indifference to the doctor mattered most? Did they all get confused in their priority of process over outcome? Did they all forget the possibility of being-towards-death? Did they forget that it is possible for a baby that has seemed to be unaffected by the labour, to quite quickly show signs of distress that might ultimately lead to death? Were they all trapped in dimness, and only seeing the barest outline of what was happening in their midst?

At the time, the woman felt safe because she assumed she was being kept safe. Her birth experiences since have given her an understanding that ‘being safe’ means close monitoring of the baby, and rapid response to potential problems. This woman and her family now live with loss and grief and carry always with them the love for their first born. She was a child of possibilities, few of which she was ever able to achieve. How were those possibilities taken away? Was it just how it was, or was it a situation where attentive concern could have transformed the unsafe to the safe? Could this story have had a different ending? These are questions that remain unanswered for this family. They are questions which deserve to be remembered, and dwelt with, again and again, in the everydayness of practice.

How does breakdown happen?

Breakdown may happen in itself, by itself. It simply happens. There may be nothing to predict, explain, or prevent its happening. It is the thrownness of Being, it is ever a possibility. On the other hand, breakdown may happen within the spirit of practice. Concern for the safety of mother or baby may be acted out in an indifferent or deficient manner. Semblances may be taken as truth. Appearances may be disregarded, discounted, or not looked for in the first place. Concern may leap-in with the practitioner thinking they know best, when all the time it is the woman who really knows best. Concern may think it is leaping-ahead, involving the woman in a spirit of partnership, while all the time it is actually the practitioner who is making their own assumptions about what the woman is thinking, or wanting, leaving her as a passive recipient of inappropriate care. Concern may think it knows what matters, and what does not matter. Breakdown occurs when no-one listens and heeds the woman, when no-one understands what matters to her.

Relationships are the interface between the offering of safe practice, and the receiving of safe practice. They are vulnerable to each closing off to the other, to barriers being established that disallow engaged conversation, to a semblance of communication which isn't how it is at all. Relationships among practitioners may be violated by politics, by a distorted sense of responsibility, by agendas above and beyond the safe care of a particular woman. Relationships are closely aligned to the 'concernful' spirit of practice. Each supports the other and, conversely, a deficiency in either breaks down the other.

For the most part these stories of breakdown have been used to highlight one aspect, but on closer inspection it becomes obvious that breakdown is a multi-faceted, cascading scenario. One breakdown will lead to another, which leads to another. Institutional care has ingrained in its very routines of care a multitude of inter-connected breakdowns which are so much a part of everyday practice that they go unnoticed by all but the woman.

For the woman, the mood of safety is vulnerable to things going wrong. If her trust or confidence are infringed upon, or broken, her mood is likely to become one of feeling vulnerable, feeling anxious, feeling unsafe. Her mood will in turn affect her 'being', and her 'doing'.

There are no safe harbours in the technology of birth. Breakdown can occur because technology is trusted, and because technology is not trusted.

Breakdown is an ever-present possibility of practice. Breaking-down can be happening in the midst of what is assumed to be safe care. Breaking-down can show itself to women and practitioners, and be disregarded or ignored. When the breakdown is allowed to take on its full potential, because no-one sees, or because no-one has the courage or the wisdom to act, the unsafeness of the consequences can be devastating.

'Concernful' practice is mindful of breakdown. It does not assume that breakdown is happening or that it is not happening. It tries hard not to assume anything, having the courage to move beyond the normal response, even to break the rules. It is alert to possibilities. It looks for both semblances and appearances, and then seeks to ascertain a situated knowing. It acknowledges the darkness, and the thrownness. It responds to the cues, moment by moment. When breakdown announces itself, 'concernful' practice steps in. 'Concernful' practice may make the difference between safe and unsafe, between life and death.

Breakdown

break, batter, burst, crack, crash
 what was whole,
 what was intact
 is beginning to disintegrate

are you watching?
 have you looked?
 what have you seen?
 what have you assumed you've seen?
 what might lie underneath the seeing?

what was that?
 did you notice it?
 did you **take** notice?
 did you respond?

do you know the woman?
 have you listened to what she knows?
 have you found out what matters, really matters?

are you responsible
 or are they?
 should you stick your neck out
 or do you passively do as you are told?
 if it goes wrong
 when it has gone wrong
 are you covered legally?
 are you at peace morally?
 is it okay
 because in the busyness
 that is the way it always is?

does the woman feel safe?
 is she safe?
 will she be safe in your care?
 can you guarantee it?

safe, secure, undamaged, unharmed, unhurt
 unscathed
 by the ravages
 of breakdown

is that too much to ask?

CHAPTER TEN: THE MEANING OF BEING SAFE

And the way up is the way down, the way forward is the way back.

T.S.Eliot, *The Dry Salvages*, Four Quartets.

The tensions of the hermeneutic circle come to meet us face to face. We have made our way up, and made our way forward. Now we come to see the need to go down, and the need to go back. The way is not a linear progression to 'truth'. It is rather a dynamic to-and-froing between knowing and not knowing, understanding and not understanding, between story and story, between chapter and chapter, all informing and being informed by the complex whole. What then is the meaning of 'being safe' in relation to childbirth? It finds its 'being' in the spirit of practice. It finds its relationships in the 'being-with-others'. It finds itself pressed down and hemmed in by 'being there' in the world of practice. All of this is within the horizon of time past, time present and time future. Being safe is open to many possibilities of influence, some within the control of women and practitioners, and some throwing a situation out of any person's control. None of these understandings of what it means to be safe stands alone. They are all part of the whole, all interdependent, all merging into a sense of one. The oneness may be of harmony or discord. There is always the possibility of 'being safe' keeping itself safe, or 'being safe' breaking down in a way that may or may not be showing itself. Complexity builds on itself, layer by layer. Let us in this chapter take the way down and the way back to consider again the notions that inform the whole, trying to put into words how the parts come together.

The spirit of practice

For the practitioner the concerned spirit of practice helps make 'being safe' possible while the unconcerned spirit simply lets the situation 'be'. All this happens within the horizon of time. King (1964) reminds us that care, as described by Heidegger, "is unity of time-future, past and present" (p.51). Let us then draw together the notion of the spirit of practice in relation to time.

*Time past and time future
 What might have been and what has been
 Point to one end, which is always present*

T.S. Eliot, *Burnt Norton*, Four Quartets

Time past

The spirit of safe practice builds on the foundation of all that has gone before. It has the rich alchemy of knowing that comes from the melting pot. In that pot there needs to be learning from being taught, learning from reading, learning from listening, learning from asking, learning from doing, learning from making mistakes, learning from reflecting and making sense, learning from risking, learning from ‘simply knowing’. Learning that has achieved the alchemy of wisdom melts down all the moments of understanding and blends them together to become something more, something deeper, something more open to new understandings. Hall (1996, p.5) says “Wisdom is security in time of trouble”. It is this alchemy of turning knowing into practice wisdom that makes ‘being safe’ possible. It therefore follows that without the necessary ingredients in the melting pot, without the alchemy, and without the commitment to draw from established understanding, the acts of ‘being safe’ may not achieve safe practice.

For example, the new graduate may not have the depth of experience to equip them to practice safely without a wise mentor alongside them. The person who brings with them all the knowledge of academia, without the experience of hands on practice, may have deficits in their practice wisdom. The supporter of natural birth, who never reads a scientific article, puts limits on the depth and breadth of their understanding of practice. So too does the person who reads nothing but scientific interpretations. What goes into the connecting, merging understandings of the melting pot matters. How that learning is examined, in terms of its own content, and in terms of one’s own prejudices, matters. How often one reflects on one’s own melting pot of understanding, matters. The fact that someone has been a practitioner for thirty years may have little bearing on the safe practice of that person if their melting pot of knowing has been on only a low simmer. Experience alone does not guarantee safe practice. The midwife in Chapter Six, who reflects on the experience of meconium liquor revealing itself just prior to the

anticipated birth, talks of the misgivings she had about herself afterwards, and the thoughts “*what did I do then? did I take an unnecessary risk? or did I take a measured risk, and it was okay? I don’t know*”(p.129). She has deliberately placed this experience into the melting pot and turned up the heat. She wants to expose the flaws in her response to that situation. She wants to consider again the possibilities that lay before her. Just because the baby was fine in this particular situation, does not fool her into thinking it couldn’t have been otherwise. She leaves the question of ‘being safe’ open and unanswered. That understanding from her time past, will be there already in every similar situation that comes her way. Reflective alchemy turns doubt and misgiving to ‘being wiser’ and ‘more ready’ when the next time comes.

Time present

And so to the moment of practice, the moment of acting, the still point of decision. ‘Being safe’ means to engage in the moment of practice and to recognise the meaning that is showing itself. The things that make ‘being safe’ possible are the alert watchfulness of the moment that lets nothing go unseen or unquestioned; the thoroughness that performs every relevant aspect of the assessment not merely to tick off the checklist, but to investigate all the possibilities; the blending of the knowing of the intellect with the knowing of the moment; the all-encompassing gaze that sees beyond that which grabs attention, that sees through the mask of normality. Attention to the moment prompts judging and deciding, acting and reacting. There is the tension between wanting to involve the woman, to enable her to feel and be in control, alongside the immediate need to leap-in and act when there seems to be no time to be given over to informing and asking. The still point of deciding is but a moment of the dance where there is “*neither arrest nor movement. And do not call it fixity*” (Eliot, Burnt Norton). A midwife in Chapter Seven captures such a moment: “*I don’t do anything arbitrarily. I just respond to what’s happening, because you never know the sort of hidden potential for the woman you are looking after, or even the hidden inadequacies. You just have to be alert to things*”(p.149). It is the alertness, the responsiveness, and the openness to possibilities that shows a presencing of ‘being safe’.

What is it that makes this sort of practice possible? Firstly, it is a deeply held understanding of the responsibility one takes on when one participates in the care of a person. As one midwife described it in this study, "*it's like a big lovely golden sandy beach with a grey lake*" (Chapter Seven, p.147). Keeping the woman and her baby out of the grey lake is an ever-present responsibility. Without the ethos of practice that has the bottom line value of there being 'a healthy mother and baby' and at the same time values a relationship of partnership with the woman, the safety of practice is under threat. In Chapter Eight we heard the distress of women whose stories told of midwives who did not ask, did not listen, did not seem to care. Those women felt unsafe. Gelven (1970, p.192) describes the indifferent and deficient present as merely "seeing the situations and actions as part of a natural kind of activity". Consider the practitioner who believes so strongly that birth is a normal life event that they are there to do no more than 'be present'. They are not looking for what is going wrong for they have not considered that it might go wrong. They are not investigating possibilities, for they are fixed on the one possibility of a normal birth. Their failure to recognise that there are possibilities that are not normal and that might bring harm to the mother and/or her baby means they do not see what is there to be seen, they do not act when action would bring safety, they are not ready when the crisis is upon them. Their practice is not safe. Equally, the practitioner who is fixed in their belief that birth is not normal, that there must be routine intervention, that technology must be employed to facilitate the process, is not safe. They too are not looking, are not thinking, are not acting in response to the uniqueness of a woman in her particular situation. Fixed, rigid beliefs and routine practices, even if validated by research findings, have little to do with making 'being safe' possible. They might make the practitioner feel safe in their strict adherence to a personal philosophy, or in their obedience to institutional policy, but that does not mean the practice will be safe. Safe practice needs the freedom to appreciate the situation for what it is, the openness to consider other possibilities, the willingness to be innovative in response to the way that might work.

Time future

The past and the present of 'care', of 'being safe' are always present, whether they are acknowledged or not. What of the future of 'being safe'? What matters is not only that 'they are' safe, but that they 'can be safe', that the possibilities are recognised of what can be done and what cannot be done, what might happen, and what might not happen. It is to be constantly ahead of 'what is' in a quest to find possible meanings of what is still to come. One midwife in Chapter Seven remarks "*I look for all possible angles that might happen, and also anticipate as much as I can what might happen ... in my mind I am turning them over, so that I can give her safe practice*" (p.140). Gelven (1970, p.192) states: "the future has meaning insofar as one is aware of and is capable of possible ways to be". What makes 'being safe' possible is the on-going search for the meanings of the future. Once the practitioner has gathered together all the understanding from the past, all that is to be understood in the here-and-now, they must move on to consider what that might mean for the future. Are there possible complications? Is there a need for referral? Should original plans be changed? Is there a need for extra vigilance, extra preparedness, extra precautions? Looking ahead leads to planning, to taking precautions and making changes in anticipation of what might happen, and thereby facilitates safe practice.

In contrast, the unsafe practitioner merely waits for whatever might happen, to happen. Their unconcern for the future means they are unlikely to take the time to anticipate, they will not be prepared or have initiated strategies that could have prevented or minimised the problem. The woman who tells her story in Chapter Nine shows us midwives who did not seem to be looking ahead to the consequences of the difficulty she was having with breast feeding, meaning that day by day her baby was not getting enough milk. They did not see until the declaration came "*my God, you have to get some food into this baby*" (p.196). They were simply there, doing what needed to be done in the 'now'. In the 'now' practitioners may seem to be safe, for how can the practice of the future be observed? Much of it lies hidden in the furrow of the frown, in the wakefulness in the middle of the night, in the quiet, deep attention to detail. Looking

forward is looking into the darkness. Decisions that encompass the possible future can only ever be based on supposition, on seeing patterns, on making a 'best guess'. The safe practitioner will have the courage and the confidence to make plans with the woman that have no sure foundation. They will discuss possibilities with the woman, even at the risk of upsetting her, for they will believe that the woman also has the need to be alert and vigilant, and the right to be prepared. It is not safe practice to exercise excessive caution at every turn with every woman, for that in itself will minimise the alertness and the vigilance. It is knowing when, and knowing how, that matters.

Being and practice

The spirit of safe practice rests in time past, time future and time present. Furthermore, it resides in the being of the person. If the practitioner is exhausted, unwell, highly stressed, distracted by emotion, or other personal circumstances, their ability to 'be safe' may be undermined. Recall the practitioner in Chapter Seven who described a run of night after night of insufficient sleep: *"I was just exhausted ... I'm a bit worried about that sort of situation, when I can't be bothered, I'm too tired"* (p.159). It takes engagement, concentration, and a full measure of energy and commitment to make 'being safe' possible in time present. What if practitioners are haunted by the crisis of yesterday? What if they are fearful of the consequences of tomorrow? Given the experience of 'being human' it is unlikely that all practitioners achieve 'being safe' all of the time. Do we expect too much? Is it too hard for practitioners to declare themselves unfit for safe practice at a moment's notice? Is one's reputation measured more by one's ability to 'cope' than in one's willingness to admit that one is unfit to cope for the present time? Do the 'they', the voices of our mind, dictate the possibilities of 'being safe' in the work ethic that demands practitioners meet their responsibilities, regardless of anything bar a major crisis in their life? It is time we (practitioners, employers, colleagues, clients) recognised the spirit of practice as being fundamental to 'being safe'. It is time to accept that no person can maintain a 'concernful' spirit of practice all of the time, and to put strategies in place to enable a less-than-safe practitioner to step back from their responsibilities with full support from those who stand alongside.

Relationships

Heidegger brings us the notion that we draw the possibilities of our being from what is prescribed and decided upon by others (King, 1964, p.113). What then makes 'being safe' possible if its being is prescribed and decided upon by others? From the perspective of the practitioner, it means that their understanding of what being safe means is an understanding of what others expect it to mean. Who are the others? They are the colleagues who stand alongside one's practice, the profession who sets standards and monitors practice, the employers or funders who decree the quality and quantity of practice, the media who offer public opinions on practice, the laws that regulate practice, and society itself, with its pervasive opinions on how practice should be. The practice is prescribed and decided upon long before the practitioner meets with a woman to provide her care.

What of the woman? She has emerged from the era of modernity, where she once had little choice but to hand over her right to be involved in decision making. With the rise of the feminist movement, she has demanded the right to receive detailed information from the practitioner, to make her own choices, to be in control of her own experience. Yet, the stories in this study confirm that in this enlightened era women still have their care prescribed by practitioners, and decisions are still made without their involvement. Remember the woman in Chapter Nine (p.197) who was so sure that she should not have an episiotomy, yet who had one without any explanation or request for permission, and then had to live with its devastating physical and emotional consequences. Remember too, the woman who so sadly told us "*Now I hadn't wanted much, but one of the things I had said was I wanted to feel the baby naked on my chest straight away ... I didn't think that was a particularly big thing to ask*" (Chapter Nine, p.211). Both these women had 'asked', both requests were either ignored, forgotten, or thought 'not to matter'. It simply happens that way in the everydayness of practice. It is taken for granted by the practitioners that their professional decisions will be the best decisions. Sometimes, they probably do not even recognise that there was a decision made within all that happened. They merely go about their everyday mode of practice, crammed full

of rituals, routines and habits, assuming their sense of 'being safe' to be congruent with the 'feelings of being-safe' of the women they are caring for.

Further to the power the woman loses to practitioners, for her there is also a sense of 'what is expected' from partners, family, friends, women's magazines, antenatal classes, maternity units, and practitioners. No choice is a free choice when others have feelings, beliefs and values about the choice that is made. The choice becomes much more than 'will I do this or that'. It is about 'will doing this bring other consequences with it, will it harm a relationship, will it offend, will it create barriers to on-going help?' Remember the enormous tension in the choice the woman had to make when she was told "*the baby did have genetic abnormalities, and, what did we want to do?*" (Chapter Eight, p.166), and the strong influence of relationships on the final decision. Decision making is much more complex than a choice of 'safe' against 'risk'. All those who are connected with and who influence a woman will bring their own understandings of the meaning of 'safe', and their own strategies for the avoidance of risk to their decision making. How does this matter to 'being safe'? Some might argue that it is what keeps 'safe' safe, for it discourages deviant behaviours, and encourages conformity to what is assumed to 'be safe'.

This study has shown that practitioners and women need to seek to understand beyond the words empty of meaning, beyond the knowing of 'the everyday' and come to understand 'self' and 'other' in what Heidegger would describe as an 'authentic' manner. What makes 'being safe' possible is genuine disclosure of what is really happening, what one is really feeling, the hopes, the fears, the wonderings, the uncertainties. Genuine disclosure is only likely to happen where there is mutual trust and respect, and the time and privacy to enable conversation. Remember the woman in Chapter Eight, who had a feeling that something was bothering one of her unborn twins, and who in the very back of her mind knew that the baby was not going to live. Remember how she recalled of the staff "*They don't always listen to you. They think*

mothers are silly or something, and they don't know" (p.178). Remember that this woman was shown not to be silly, that her knowing was later seen to be 'how it was'. In a relationship, 'being safe' can be wrongly assumed even though all seems to be safe. For example, a woman may visit her practitioner on a regular basis, have no specific complaints about her care, and have the well being of herself and her baby monitored. The practitioner may perform the role 'they' expect of them, by asking the appropriate questions, and making the routine assessments. The woman is likely to accept this prescription of care. Remember again the woman with the twin pregnancy who conscientiously went to her doctor at 21 weeks when she could feel 'a trickling'. Remember how she went back again, and still "*he thought that maybe there was pressure going on to my bladder...so he didn't do anything*" (Chapter Nine, p.193). Women comply and obey for they have been socialised into such behaviour over generations. The care, however, can not be what it seems, if there is not a genuine, respectful, open, believing relationship. The care may be safe if there is nothing to make it unsafe (just as the day is fine if it does not rain). The care will not be safe if either the woman or the practitioner has information or feelings that they do not disclose to the other, or if either does not take notice of what the other tells them.

There has been, perhaps, a tendency in the past to view relationships as a consequence of practice rather than as integral to the safety of practice. At the same time, there is a need to recognise that relationships are dependent on more than a willingness to relate. Sometimes they simply do not work. Sometimes they need to be brought to an end so a new relationship can take its place. A 'concernful' relationship, that lives in the play of seeing both near and far, and that opens itself to what the 'other' believes, lies at the heart of safe care. It is the responsibility of those who oversee institutional practice to ensure that every woman has the opportunity to engage in such a relationship.

Midwifery philosophy in New Zealand currently upholds 'partnership', the sharing of power between woman and practitioner, as fundamental to the ethic of practice. Heidegger, and the stories of this study, confirm for me the need to be open to the

movement of power in this relationship. While 'leaping ahead' to predict the possibilities of what might happen, and being able to inform the woman in such a way that she has time and information to arrive at the 'best choice' of what she wants to do, is an admirable aim, it is not necessarily always safe to practice in this way. There are times when in the best interests of everyone, the practitioner must 'leap in' and act with urgency and immediacy. The woman who was having a miscarriage (Chapter Six) just wanted to get rid of the pain, and to get the Dilation and Curettage over and done with. She became very frustrated with the practitioners who kept asking "*how do you feel about this?*" (p.124). In that situation, she just wanted them to get on with it, she just wanted them to leap-in and rescue her from the pain, and do what they had to do. It is time to stop the ideological pretence of power sharing in every situation. A genuine relationship would discuss the possibility of there being a time when the practitioner needs to 'take over'. Its foundation of 'concernful' commitment to 'being safe' would build the trust that is likely to ensure the woman would continue to feel safe in her handing-over of decision making. On the other hand, practitioners need to recognise the situations in which, without even knowing, they unthinkingly maintain power, and in doing so deprive the woman of the right to decide about the little things that 'matter'. It is perhaps the little things that the women feel most able to decide for themselves, and feel most betrayed when they are robbed of that opportunity. Remember the woman in this study (p.211) who still grieves over losing the first touch of her naked baby on her chest, for to her it 'mattered'.

When a relationship is stretched to its very limits, the fundamental beliefs about whose responsibility it is to protect 'being safe' are exposed. I believe it is morally untenable for a practitioner acting in the spirit of safe practice, to heed the woman/partner's decision to stand by and do nothing while the life of the woman and/or baby moves toward death. A practitioner who strives to protect life in everyday practice cannot simply abandon those values and beliefs. They supersede the protection of the relationship. The purpose of the relationship is to facilitate safe practice. If the relationship reaches a point where the practitioner is convinced that the decisions of the

woman/partner are dangerous, and if the relationship is no longer effective in promoting safe care, then the practitioner moves beyond the relationship to consider other strategies for attaining safe care. As the midwife who gave us the metaphor of keeping the women in her care out of the 'grey lake' of danger says to the women in her care "*maybe you could get to the other side, but I'm not prepared to take the risk*" (Chapter Seven, p.147). The relationship matters, but it does not matter as much as the need to preserve life.

Alongside this is the practitioner's own need to protect self from accusation of professional negligence. If the woman or baby suffers harm or death, even though the practitioner may have offered those warnings, the family may still say 'we did not understand, why did you not tell us?' If the family stand by their own decision, and do not blame the practitioner, the practitioner is still left knowing that if they had been more assertive, or sought outside advice, a death may not have occurred. They still stand accountable to their professional body, and to society. They still have to live with the sense of failing their own personal standards and values. It is asking too much to expect them to practice in a manner they honestly believe to be life-threateningly unsafe without involving the wise counsel of more experienced practitioners or managers. Partnership ceases to be operative when either party stops listening to or heeding the advice of the other, yet still the practitioner carries the responsibility of safe care.

The world of practice

The woman and the practitioner come together in the world of practice. It is not a world that exists outside, apart, distanced from them. Rather, they are within the world. It is by their being there that they understand what the world of practice is, and in turn shape it to how it is/will be for them. Everyone else is there ultimately for the sake of safe childbirth, yet, for each person the possibilities of how that world will be are "the possibilities of *my* being; the world is therefore always essentially *my* world" (King, 1964, p.88). This does not mean that the person is free to act in whatever manner they choose within that world. They are "pressed upon and hemmed in" (p.81) by 'them', by

all that is happening, by all the possibilities before them. The voices of the dominant view live in every piece of paperwork, in every policy, in every person who passes one by in the institutional corridor. The eyes of the dominant seem to watch over one's shoulder, their presence to breathe down one's neck, to wake one in the middle of the night to niggle in one's mind. Within this world are the demanding, faceless, nameless crowds, who create havoc, upset careful plans, block access to what one wants 'right now', provoking irritation and grumpiness at every corner. 'They' and 'them', whether they be the anonymous mass, or the named, known colleagues, take away any pretentious notions of being in control of time, or space, or method, or mood. Sometimes there are possibilities of a sense of control; other times there are not. Such is the pressing, hemming world of practice.

Technology presses upon both practitioners and women. It is within the world. It is already there as a possibility of care. It is expected to be made use of. It is said to be for the sake of being safe. Sometimes it makes 'being safe' possible, sometimes it takes away from the 'being of safe'. Recall the woman with the ovarian cyst that silently haunted her pregnancy (Chapter Six, p.126-7). The ultra-sound scan did not see the cyst in pregnancy. Hiding the cyst was unsafe, in that nobody was able to see this enormous hormone-producing cyst was there, but at the same time it brought the safeness of ignorance. It enabled the situation that was not normal to be treated as normal. The practitioner and the woman must decide about the safety that technology may bring, or take away, yet the decision is not theirs alone. The decision about the use of technology belongs to the funders who put limits on what is economically possible; it belongs to the professional body who determine what is 'best practice'; it belongs to the pressure groups who persuade and dissuade; it belongs to the thrownness of the world, the waiting time on a busy day.

The thrownness of the world of practice means births happen when births happen. It is very difficult in a world of tight resources to adequately plan ahead for safe levels of staffing, safe amounts of equipment, safe numbers of beds. If a woman needs an urgent

caesarian section, as does another woman, as does a third woman, and there is one set of resources available to respond immediately, a helplessness arises. When there is a desperate need 'to be safe' it may be impossible to be as safe as one would hope to be. Compromises are made. Risks are taken. Hope is hoped. Remember the baby who was born brain damaged because, even though those involved knew this baby was at risk, the labour took place on a day when delivery suite was very busy. "*By the time the person discovered she had this tracing, it was awful*" (Chapter Six, p.133). Hope was not enough to save this baby. The chaos of delivery suite perhaps robbed this baby of its chances of being safe.

What is the responsibility of management in the achievement of safe practice? When they are asleep in their beds at night, and the maternity unit is in chaos because of sickness of key staff, and woman after woman comes through the door with problem after problem, who is responsible when in the midst of it all, a baby dies? Is it the practitioner who was juggling multiple urgent cases, and was with another labouring woman when this baby announced its cry for help? Is it the person in charge who failed to access replacement staff (but where from, and how safe would they be, and was there funding to do so?). Is it the management, who should have thought of such a possibility, and should have organised contingency plans? Has it something to do with the high number of exhausted, demoralised staff who have recently resigned, and have not been able to be replaced? Is it the policies from on high which because of funding boundaries would prevent the common sense solution of transferring some of these women to the neighbouring maternity unit? Who really cares about the safety of care on an hour by hour basis around the clock? Who gets the blame, and who, on the other hand, deserves the blame, when the baby dies?

Do not forget the politics of practice. Remember the voices telling of political strife: the midwife who said of her medical colleagues: "*when I went out to a birth ... I was looking over my shoulder, you have this feeling of fear*" (p.182); the obstetrician who says of his midwifery and general practitioner colleagues: "*you feel really grumpy being*

called in, having no influence on the choosing of the time, and then having to deal with the possible poor outcomes” (Chapter Seven, p.158); the obstetrician who talks of money tensions “*I think even if you are a wonderful midwife, and you work very hard, and you take home double the salary of a senior consultant, then it’s very hard to justify*” (Chapter Eight, p.181); the general practitioner, who worries that the midwives in delivery suite changed his plans: “*that may be fine, but nobody rang me up to find that out...I’m still the one carrying the can*” (Chapter Nine, p.206); the woman who was advised by an obstetrician not to have a midwife because of “*the cost to the taxpayer*” (Chapter Eight, p.183); the woman who cries “*it feels sometimes in the whole drive for the political stuff that goes on, that if a few babies get damaged, and bumped off, it is worth it*” (Chapter Eight, p.184). Political skirmishes are a sure road to unsafe practice. The politics of practice get in the way of open, respectful communication. They erect barriers where none should be. They draw-in issues of power, status, and financial reward. They take away control, and provoke conflict. A mood is created where fear goes ahead to be-there in the next situation. The politics of practice can detract from the focus of ‘what matters’, and undermine the concernfulness of practice.

The funding of the maternity services underpins the rationing of practice, where in a government office it is decided how soon Mrs Average will be discharged from the maternity unit, and how many visits she will need from a midwife before ‘all is well’. Remember the devastation of the woman in Chapter Nine who had such a struggle to establish breast feeding who says: “*Nobody sat, I know it is pretty boring, but nobody sat and watched what I was doing for a feed*” (p.196). Sitting takes time, a midwife sitting costs money. Remember the woman who arrived home with her new baby “*and then I burst into tears, and the feeling of what have we done, what an earth have we done, and how on earth are we going to be able to do this...it was just overwhelming*” (p.215). The funders of the maternity services need to heed that cry for help. Safe care means considering the consequences of minimising the amount of funded care available to women, and making provision for responding to the ‘over-and-above’ needs that arise.

Thrownness

Besides all this, is the thrownness of the nature of childbirth itself. History shows us that death used to be a fairly common consequence before the era of professional practice, of technology, of drug therapy. Now practitioners can do something to halt the progress towards death. Sometimes, however, that 'something' is not enough, or it comes too late. Remember, that in this small study, one woman had a miscarriage (p.123), another had a twin daughter who died soon after birth (p.208), and yet another "*had a beautiful daughter I loved, who died*" (p.219). The devastation of thrownness is still within the everydayness of maternity practice. We saw in the stories that practitioners in these situations did not always provide practice that could be deemed as safe, nevertheless, we need to remember that the progress towards death does not begin (although in some instances it may) with the practitioner. Something has already 'gone wrong' before the practitioner gets there. The problem already exists when it is discovered. It is unlikely to be the practitioner's fault that the problem came into being. It simply did. It is there, without invitation, without understanding as to 'why'. It simply 'is'.

The problem may be discovered by the woman, or by the practitioner, or by the technology. Once it is made public there is a sense of ownership, a sense of 'who does this problem belong to?' In giving the problem over to a named person, perhaps we forget that this person has received a problem that is already there. This person has not created the problem in the first instance. This person can only be held responsible for what it is possible to do in the given situation. When a baby is already unsafe, it may have crossed the boundary to a place from where it is impossible to return to the territory of 'being safe'. If it is already beyond being saved, then the most skilful practitioner, of the wisest knowing, will make no difference. In childbirth, there are no guarantees of safety. No practitioner can promise safe outcomes. No woman can make plans for care that will guarantee her safe passage. No relationship is good enough to stop thrownness. The physiological process of childbirth often remains beyond the grasp of understanding, of intervention, or of rescue. Even amidst safe care, babies continue to

die before and after birth, and, occasionally, a woman will die. It is not what we expect. It is not what we talk about in anticipating childbirth. Yet it happens.

*Go, go, go, said the bird: human kind
cannot bear very much reality.*

T.S.Eliot, *Burnt Norton*, Four Quartets

What are the implications for practice?

*Do not let me hear
Of the wisdom of old men, but rather of their folly*

...

*The only wisdom we can hope to acquire
Is the wisdom of humility: humility is endless.*

T.S. Eliot, *East Coker*, Four Quartets

The implications for practice that arise from this study begin with a call to recognise the folly:

The folly of assuming that simply because a practitioner is registered, and has knowledge, and/or experience, their practice will be safe. The folly of limiting the vision of practice to what is happening right now, forgetting to think back on all that is known, neglecting to look forward to the dangers that might lie ahead. The folly of not recognising the freshness, the alertness, the undistractedness needed to engage in a 'concernful' spirit of practice. The folly of being satisfied with the interaction between woman and practitioner that is empty of meaning, that does not genuinely disclose what is going on. The folly of adhering to the ideology that assumes all women, at all times, will make safe decisions. The folly of proclaiming the ideology that assumes all practitioners, at all times, will make safe decisions. The folly of placing the blame on the person who was there, or supposed to be there, when at the time they were supposed to be doing more than was humanly possible. The folly of calling an institution safe when even with the best intentions, in thrownness, so much can stand in the way of 'being safe'. The folly of reaching out to technology as the mainstay of safety. The folly of establishing an economic formula to guide the equitable quantity of care, assuming it will be able to achieve safety. The folly of not understanding that the problem was already there, that even at the earliest moment, it was already too late.

We need to address these follies with humility. We need to stop accusing others of 'unsafe practice' without first looking to the unsafety in our own practice. We need to become alert to indifferent and neglectful practice and relationships that close-off to meaning, and endeavour to bring to light the things that stand in the way. We need to acknowledge the darkness of practice - that which is unknown, that which is beyond understanding. We need to accept that there is no guaranteed path to safety, yet still strive to find what seems to be the most safe path. I talk of 'we' yet only 'you' can know and decide what possibilities your engagement with this study can lead you to.

What are the implications for education?

For me, as a teacher of midwives, and of other health professionals, I have a much clearer vision of what it means to be safe. I know that it is not enough for the student to recite back the knowledge of practice. I know that it is not enough for them to demonstrate the skills of practice. I know that it is not enough to respond to the dramas of practice. They must achieve an alchemy of knowing that prompts them to act with the wisdom of hindsight, foresight and nowsight. They must come to understand the folly of their assumptions. It is a big ask. Some students may never achieve this complexity and depth of thinking. Without it, they cannot be safe. To be put forward as 'safe' to practice as a registered midwife, they need to be able to demonstrate that they have begun to achieve an alchemy of knowing that will stand them on their beginning feet. They need to show the wisdom of knowing what it is they do not know, the foresight of anticipating when they will need help, and the ability to act in the crisis situation of the 'now' in a manner that promotes safety. They need to demonstrate openness and concerned regard in their relationships with women and their families, and with other practitioners. They will need to be able to make sense of the world of practice, everyday much the same, and always very different. Within all of this, they will need to be ready for thrownness, and equipped to deal with situations to the best of their ability, knowing they can hope to do no more. They need to understand that some babies will die, no matter how safe the care.

What are the implications for judging ‘safe practice’?

Judging practice as ‘safe’ or ‘unsafe’ is integral to the establishment, maintenance and protection of safe practice. The wise practitioner judges their own practice, both in the midst of practising, and in the reflection that follows. It is through such scrutiny, always keeping open the possibilities of ‘being unsafe’, that their practice will be made safer. Judging the practice of others is the mandate given by society to employers and disciplinary bodies to ensure that practitioners are ‘being safe’ in the care they offer to women, with the expectation that they will examine episodes of ‘unsafe’ practice. The practice of the person being judged is seen in retrospect through the stories of those involved, and the trail of evidence that is left behind. To judge if the practice was ‘safe’ or ‘unsafe’ it is not enough to simply look and listen. I believe there are important questions from this study that need to be asked. In crafting these questions, I am reminded of Heidegger’s caution that ‘Questions are not found ready-made like shoes and clothes and books’ (1935/1987, p.19). Questions need to have life breathed into them. In their very questioning they need to unwrap and free the meaning that they carry with them. Questions need to be asked over and over again, in many different ways. I offer you the questions that follow as a possible way to begin to uncover ‘being safe’ in its concerned, indifferent, or neglectful mode.

These questions are offered in the present tense, as questions that can be asked by the practitioner about their own practice in the midst of the unfolding of a situation. They can equally be asked in the past tense, in personal reflection, or in judging the practice of another. The comments that follow each question are to explain my meaning more clearly, especially in relation to retrospectively judging the practice of another.

What is showing itself as safe, or unsafe?

(Perhaps there is something that immediately grabs your attention as being safe or unsafe. It may or may not be the thing that matters most.)

Is the showing a facade, a pretence, a ritualised myth?

(Remember that what 'seems to be', may not be 'what is'. A false sense of security may have arisen. It is important to probe beneath 'taken-for-granted' understandings, to find out what is/was really happening.)

Is the spirit of practice engaged and present in the dynamic, ever changing nature of 'being safe'?

(It is difficult to re-capture the moment when a decision was made, but it is important to reveal in present, absent or indifferent mode, the practitioner's alert watchfulness, their on-going anticipation of what might happen next, and their responsive actions.)

Is there anything weighing down the spirit?

(We tend to assume that a practitioner will always be 'at their best'. If the practitioner is tired or unwell or distracted, there are more questions that need to be asked.)

Does the practitioner bring a wisdom of practice?

(A wise practitioner is likely to show their wisdom by 'being different'. Through their insightful understanding they have the courage to go against normal procedures and protocols if they believe that in a particular situation 'normal care' is not 'best care'. 'Being different' therefore does not necessarily mean 'being unsafe'.)

Are there questions to discern what lies in the darkness?

(In any situation there are unknown factors which may be revealed 'later'. Sometimes it is possible to anticipate what might lie in the darkness. The safe practitioner will always acknowledge the tension in their practice between what is 'known', what is assumed, and what is 'not yet known'.)

Are the relationships with others free from the distortions of what the 'dictatorship of they' think?

(Sometimes practice is guided more by false perceptions of 'what should be done' than by genuine assessment in partnership with the woman. Best practice in a particular situation may not be 'what others expect to be done', but will enable the woman and the practitioner to bring their own informed expectations to decision making.)

Do the words that are shared hold a meaning that is genuine?

(Practice will only be safe if all those involved understand the meaning of what is being said, and the implications that lie behind the meaning.)

Is there trust?

(Where there is no trust, there is likely to be barriers to communication, and reluctance or even fear of engagement with each other. Such relationships can lead to breakdown and loss of safety.)

Is there a sense of care?

(A practitioner can go through the rituals of care, and offer evidence of 'being safe', but if the woman does not experience a sense of 'care' it is unlikely that the relationship will grow into one that facilitates safe practice.)

Does the practitioner know when to leap-ahead, and when to leap-in and take over?

(Through recent decades the pendulum has swung from the philosophy of practitioners always 'knowing best' to one where 'all decisions must be in partnership with the woman'. There is, however, a time for the practitioner to accept their professional responsibility, and in the best interests of the woman and baby, to act on their understanding. Questions need to be asked to reveal if the practitioner has an appropriate sense of when to work in partnership, and when to leap-in and act.)

Does the woman feel safe?

(Practitioners assume women feel safe when sometimes, perhaps in the things that hardly seem to matter to practitioners, women feel unsafe. Questions need to be asked about how sensitive the practitioner is/was to the feelings and hopes of the woman and her family.)

How is the world of practice impacting on what is happening, and might happen?

(A practitioner is always hemmed in and pressed upon by the context of the practice situation. Questions must be asked about 'how possible was it for the practitioner to offer safe care?')

What are the barriers, where is the breakdown?

(When there is a story of breakdown, questions need to be asked about 'what got in the way of 'being safe'?'. The barriers need to be identified and examined.)

How can the situation be influenced, altered, improved?

(Questions reveal possibilities for change. Were questions asked at the time that could have initiated improvements to the situation? Are there questions that need to be addressed now to ensure the same unsafe situation is unlikely to happen again?)

Who gets to carry the burden of responsibility? When? How? Is this just?

(The burden of responsibility may go far beyond the practitioner. It is important to recognise, and bring to account, those responsible for influencing the situation that led to unsafe practice.)

How did the unsafety begin? Is there an answer to this question?

(There is a tendency to believe that unsafe situations begin through the fault of a practitioner. That may or may not be so.)

Was the unsafe situation already there? Was it already too late? Was it beyond responding to safe care?

(There is a growing trend to invest practitioners with the power to guarantee safe outcomes. There are no guarantees. Sometimes the practitioner is unable to do anything that will change the developing situation.)

Do we need simply to say 'it happened, and it would have happened no matter what?'

(We can only say 'it simply happened' when we have addressed all the other questions. Nevertheless, 'was it a situation of thrownness?' must be a question always asked at the same time as the other questions that challenge practice. In judging one's own practice, or the practice of another, it is important that the minor misdemeanours do not come to take the blame of a situation that was 'going to happen no matter what'.)

The questions highlight the need for more research

Each of these questions addresses a small part of the big question of 'being safe'. No one question stands alone. As each part is examined in detail, I am struck afresh by the enormity of the responsibility that is encompassed in 'being safe'. On any given day of practice, could every practitioner confidently declare themselves 'safe' in response to each challenge the questions bring? I believe there is a call for more research to uncover the 'safeness' or 'unsafeness' of everyday practice, so we are not blinded by unrealistic expectations. It could be that many practitioners 'get away with' indifferent and neglectful practice because the woman and her baby are safe in their own being. At the same time, I believe there is a need for more research to help us understand how 'safe' practice may be more effectively achieved. It is not good enough to accept that there may be unrealistic expectations of 'being safe' every day, in all situations, without actively addressing the possible undermining influences on those expectations. It is easy

to raise the research questions for they are never ending and will never be fully answered. It is not so easy to decide on method that will maintain ethical integrity in a research study which would seek to show the 'everydayness of deficient and neglectful practice'.

Limitations of this study and opportunities for further research

There are no limitations, and there is every limitation. There are no limitations because this study never presumed to be anything more than it is. There is every limitation because of all it did not do.

*What might have been is an abstraction
Remaining a perpetual possibility*

...

*Footfalls echo in the memory
Down the passage we did not take
Towards the door we never opened
Into the rose-garden.*

T.S. Eliot, Burnt Norton, Four Quartets

What are the possibilities left undisturbed, the passages not trodden, the doors left unopened? There are the stories from every midwife and every doctor and every woman that were not asked, and were not heard. There are voices who did not get an opportunity to speak: women from other cultures, women disadvantaged economically, educationally, and socially. There are the 'others': the managers, the paediatricians, the students, the husbands and partners. They too will have their meanings of being safe. All these meanings are important, they deserve to be heard. Every book, every journal article, every research study, every media article, every text related to childbirth carries in it meanings about 'being safe'. Many of them sat patiently by me waiting for their moment of inclusion, which never came. Many more of them remain behind the doors I never opened. This journey of research is not finished. It has merely made a beginning.

Interpretive phenomenology brings itself to inform the meaning. Its own voice has dominated the discussions. I could start my quest for a clearer understanding of 'safety' all over again and engage in a closer analysis of power through critical social theory (eg.

Habermas, 1978; Fay, 1987), through critical/feminist analysis (eg. Oakley, 1980, 1984; Katz Rothman, 1982/1991, 1989), and through discourse analysis (eg. Foucault, 1980; Sawicki, 1991; Weedon, 1992). I could uncover the false consciousness, the hegemony, the vested interests, the gender issues, the dominant discourses, and make more explicit the social construction of the meaning of 'safe'. All of this lies behind a door we merely peeped through from time to time. I could ask the question 'what is going on in relation to safety?' I could ask that question of all the players, and observe what goes on in the name of safety, until there were no new answers. I could analyse those answers to find the shared understandings, the common core variables, until finally I could put before you a theoretical analysis of the concept of safety. All of these would open up fresh understandings of safety. That being so, it is again clear that any one methodology has its own limitations on what it is possible to achieve. I stand with Darbyshire when he says "I am a phenomenologist. I can't help it ...I keep flying the phenomenological flag because I believe there are still countless questions to be asked" (1997, p.1). That is the direction of future research, to continue questioning, to continue to uncover.

Then there are these letters joined together in words, linked together into sentences, lined up one after the other into a from-start-to-finish whole.

*Words strain,
Crack and sometimes break, under the burden,
Under the tension, slip, slide, perish
Decay with imprecision, will not stay in place,
Will not stay still.*

T.S.Eliot, Burnt Norton, Four Quartets

How hard it is to say what I mean. Sometimes I do not know what I mean until I have said it, and then, is it what I mean? How hard it is to decide the order of things, to know what should come first, and what come after, and to recognise that what comes between separates part from part. How hard it is to leave so much unsaid.

What is the meaning of ‘being safe’?

Being safe is extraordinarily complex, and very simple. All it needs is genuine concern, genuine caring, and an active mind. It is not surprising that the human race has survived so many generations of procreation in eras preceding the capabilities of today. The physiological processes of birth are designed to happen whether they are understood or not. Pregnancy happens. Labour and birth happen. Breast feeding happens. Nurturing happens. Caring happens. Concern happens. Solutions are found in the context of what is possible. If all goes well, all goes well. If it doesn't, the woman and/or the baby may die. That is where the extraordinary complexity arises. Why do they die? How can we predict that might happen? How can we prevent it from happening? How can we rescue the woman and the baby who are heading towards death? There are no simple answers to any of these questions. Sometimes it is possible to understand, to see ahead, to predict wisely, and to save lives. Sometimes it is not. Such is the constitutive nature of the experience of birthing.

A woman near the beginning of her childbirth experience, engages a practitioner in the understanding that she is ‘being safe’ and will be ‘kept safe’. It is therefore the responsibility of practitioners’ to come to their own understanding of what this means. This study has uncovered the complexity of the spirit of safe practice. It has recognised the importance of a concerned, connecting relationship. In other words, there are many things that a practitioner can do, and can rightly be held accountable for, in the quest for ‘being safe’. There are, however, situations beyond the control or influence of either the woman or the practitioner. There are times when, with the best will in the world, it is not enough. There is sometimes breakdown of safety. In looking back, we can understand what went wrong, but if we were to turn the clock back, and put ourselves in the shoes of the practitioner, would we, could we, have made any difference?

To call a practitioner ‘unsafe’ is a judgement that calls for wisdom, perceptive insight, and a willingness to look beyond the ‘facts of the matter’. There are many questions that need to be first uncovered so they can then be asked. In the answers will be more

questions. The practitioner does not stand alone. They will have been enmeshed 'with others' in the world of practice. Complexity builds on complexity.

In a nutshell

The meaning of being safe in the maternity services would be of no consequence if it were not for the thrownness of childbirth itself, and the world in which it takes place. Things go wrong. Death is always a possibility. Thrownness simply happens. It is beyond our knowing until it happens. It may be beyond our understanding and our skills. If that is the case, the safest of care will make no difference. 'Being' safe does not guarantee safe outcomes. Thrownness must always be considered when sitting in judgement on the safety of practice.

The spirit of safe practice is known by 'concernful' behaviours that are alert and engaged in time present, that draw from the alchemy of wise knowing from time past, and that are already thinking and acting in relation to time future. Such practice may be able to respond to the thrownness in a way that makes the situation safe. It may leap-ahead to prepare the way, or it may leap-in to rescue. Tiredness, frustration, politics, worry and a host of other factors are likely to dull the spirit of practice. It may become indifferent or deficient. The care may not always be safe.

Relationships matter. The very nature of practice draws individuals into relationship. The sharing of knowing, understanding and decisions creates a safe bridge across which care can be given and received. Relationships between practitioners need to be unbound from the political barriers of misunderstanding and mistrust to achieve safe care. There is a humanness in people that extends across territorial and philosophical boundaries, that has an inherent knowing of the meaning of 'being safe'. If this knowing is violated, the quality of the relationship is likely to be sacrificed. Decisions will be made from a vantage point that has the view partially obscured, that no longer has access to all the available understanding of what is happening.

All practice happens within the complex world of practice. It is a pressing, hemming world that may take away the spirit of practice, take away the possibility of knowing and connecting relationships, take away what could have made a difference, what could have made it safe. It is a world determined by economic rationalism, by the power of evidence, by tradition, and by the predominant worldview. It is the faceless, nameless 'body in hiding' when the question is asked 'who is to blame?'

Being safe is all of this and more.

*Words, after speech, reach
Into the silence.*

T.S. Eliot, *Burnt Norton*, Four Quartets

The silence is mine, and is yours
Silence of the spirit
thinking, remembering, pondering, wondering,
thinking ahead, anticipating, guessing
knowing
or not knowing.

Silence of relationship
where we look at each other
as though for the first time
searching for meaning of me
and meaning of you

Silence of the world of practice
infusing the very soul of practice
stealthily
surely
claiming its own rights
directing us in its own ways

Silence of the silent voice
that is only ever heard
later,
maybe when it is too late.

It all reaches into silence.
We will only hear the silence
if we listen beyond the noise
if we go by the way of ignorance
into the endlessness
of humility.

CHAPTER ELEVEN: THE COMMON GROUND OF MEANING

*In my beginning is my end. Now the light falls
Across the open field*

T.S. Eliot, East Coker, Four Quartets.

What is the meaning of ‘being safe’ in childbirth? On the open field of practice, in the everyday situatedness, there are multiple, and at times, conflicting meanings of ‘being safe’. This chapter engages the findings of this thesis in conversation with what could initially be seen as opposing worldviews. These worldviews that have been implicit throughout this study, but are now explicitly brought to your attention. There is a sense that I am beginning a new discussion, bringing in new philosophical paradigms, when it is too late to do so. My response is that unless the findings of this thesis can be seen to engage with the multiple realities of the philosophical and pragmatic world of practice, then they are no more than empty words. Therefore, in my end is a new beginning, as I seek to situate the hermeneutic, phenomenological meaning of ‘being safe in childbirth’ within the ‘open field’ of the wider discourses of both practice and scholarship.

As I stand on the ‘open field’, I bring with me the understanding that the approach to meaning in this study looks to the ‘phenomenon’, a meaning that lies close to the experience itself. I have come to see how the very nature of a phenomenon brings openness to all possible meanings. It is with optimistic anticipation that I suggest that hermeneutic phenomenology creates a place where diverse meanings come together, where understanding can be shared.

What is the difference between a worldview and a phenomenon?

Other voices on the open field are likely to talk of more abstract ideas, concepts and theories. They offer a ‘worldview’. “Heidegger scornfully calls a ‘worldview’: something, like astrology, Jungian psychoanalysis or ‘feminist ontology’, which one picks and chooses (and hence only half believes in) because one finds it vaguely comforting or politically useful” (Young, 1997, p.95). The uncovering and showing of a phenomenon is an attempt to look at the way things are in their situatedness of ‘how it is most days’. A phenomenon cannot be plucked from its world and examined in the

laboratory, for it is only itself in its world. It does not exist without the people who are involved in the experience. It shows itself when the person does something (or does not do something), for the sake of (or in the forgetfulness of) the phenomenon. The phenomenon of 'being safe' is therefore about you and me, and what we do or do not do. There is no escaping the phenomenon. A person can decide not to follow a theory, or not to adopt a certain worldview, but they cannot free themselves from the phenomenon of 'being safe'. Every action, or non-action, of their day that is 'for the sake of being safe' shows their understanding of what that means, in that situation, to them. There will always be a showing of 'being safe' in some form or other.

What do we bring to the common ground?

Young (1997) offers the analogy that our lives are like a book, in which we, the authors, build the characters by leading them through a series of actions and reactions. It is, however, never a book that we have begun. "It is more like being asked to continue and complete a book begun by someone else" (p.59). Because we are 'in the world', it is likely that each one of us has a worldview already setting the scene of our story. We already come with ways of interpreting and ways of understanding. A mystery thriller, a romance, a science fiction and a biography are all quite different ways of telling stories, yet each show what it is to be human. The worldviews that tell the stories in the maternity services are similarly quite different, yet I argue they all encompass the same phenomenon of 'being safe'. Let me show you. Anderson (1996, p.106), under the intriguing title *Four different ways to be absolutely right*, suggests that "contemporary Western societies have at least four distinguishable worldviews". He names these as the scientific-rational, the social-traditional, the neo-romantic, and the postmodern-ironist. Let us take these one by one and examine how they bring a distinctive style of meaning to 'being safe', being aware that style may bring its own silences, its own blind spots. The question I ask is: does 'what matters about being safe' still matter in this worldview?

The scientific-rational meaning of being safe

Anderson describes the scientific-rational worldview as one in which "truth is 'found' through methodical, disciplined inquiry" (p.107). This assumes that there is truth that

will be found through scientific research that will determine what is and what is not safe. The rise of evidence based practice signals that this worldview holds favour in the Western world of health care. The meaning of 'being safe' is that decisions of care, interventions, and models of practice are based on the evidence of randomised controlled trials, substantiated by meta-analysis. The assumption is that once the best practice has been identified, then the standard of safety is defined by that practice. Within this discourse, there is recognition that the complex nature of health care may not be served by evidence alone and that there is danger in the creation of an orthodox practice that discounts the judgements of the practitioner (Murphy, 1997; Page, 1996a).

A current initiative of the scientific-rational worldview is best practice guidelines. These range from specific protocols to those which describe "boundaries within which practice should occur in usual circumstances" (National Advisory Committee on Health and Disability Fifth Annual Report, 1996). We see the formation of the New Zealand Centre for Evidence Based Nursing, a joint venture between Auckland Healthcare and Auckland Institute of Technology (Kai Tiaki, 1997). There is a sense of society taking on a new sense of responsibility in articulating 'how to be safe' and in defining 'how safety will be measured'. Halligan, Taylor, Naftalin, Homa & Crump (1997) describe how clinical practice guidelines are now being used to inform audit tools which measure both quality and outcomes. While they too acknowledge the need to defer to the practitioners' complex judgement, it seems that such a worldview places the practitioner in the role of needing to defend their practice against what is deemed by a rational, scientific process to be acceptable. My perception is that the scientific-rational worldview is currently upheld by the funders and providers of health care as determining 'what is safe care'. Benner, Tanner & Chesla (1996) agree that major societal forces support "continued reliance on rational models for both ethical and clinical decision making" (p.13). Practitioners are 'kept safe' by adhering to pre-determined guidelines of practice. One could argue that the client is also kept safe by receiving what is believed to be the safest care. There is, nevertheless, the possibility that the practitioner will put their own need to be safe ahead of other possibilities that may be suggested by the client. Obeying the rules may take precedence over 'good ideas'. Notions of complexity, uniqueness, and individual judgement, while

acknowledged within this worldview, are vulnerable. The standard or the evidence is the 'truth' until proven otherwise.

Now imagine yourself as a practitioner working from this worldview. In the spirit of 'concernful' practice (discussed in Chapter Seven) you will eagerly read and critique the research, and find the information to help you make the safe judgement. You will be familiar with and respectful of the practice guidelines set before you. You will question habits of practice that have no scientific underpinning. You will uncover assumptions of practice, and plan research in the search for truth. A committed scientific-rationalist will always be a questioning person, striving to give the best known practice. None of this is a problem sitting in the lecture theatre thinking ahead, or sitting in the tearoom discussing the unsafe practice of another. The evidence, the standards, the guidelines distinguish right from wrong. It is in 'time present', in the moment of the experience, in the still point of the dance, that 'being safe' takes on its own meaning. In the thrownness, the evidence suddenly becomes irrelevant; in the disruption and distraction, the guidelines do not show the way; and in the uniqueness of the 'now' the standards become meaningless. We all know that, because we have all had those moments. We share the understanding that our own intentions of 'being safe' in a particular situation would not always stand up to public scrutiny from the scientific-rational worldview.

Remember the midwife and the doctor in Chapter Six (p.129) who suddenly found that there was meconium in the liquor of a baby who was about to be born at home. They were thrown into a situation where they were now 'breaking the rules'. They were now in an experience where 'being safe' meant working from a spirit of concernfulness. 'What mattered' was to anticipate the 'what if's?' and to decide on 'the most likely to be safest' plan. No research, no guidelines, no statistical prediction could make that decision for them. It was their engagement in that situation, with that woman and her labour, their discernment, their gut feeling, that in an unspoken conversation, they agreed on the decision to proceed with the birth at home. The midwife reflected later on the risk they took. In a court of law would those in judgement be able to put themselves back to the moment of the experience of 'needing to decide'? Would they appreciate that the experience overwhelms the scientific, rational solution, for there are so many unknowns within the equation? Safe practice undoubtedly takes much of its 20th

century advancement from the scientific-rational worldview, but 'at the still point of the turning world' the experience of 'being there', of seeing, feeling, worrying, trusting, matters more. You cannot say 'this baby will not come to harm' because pre-determined understanding tells me so. You cannot predict with perfect accuracy when the baby will be born. You would be foolish to judge with reference only to what could be proven, for in that moment there are very few 'facts', and those there are, are likely to change. The worldview of the scientific-rational offers valuable pre-understandings, and is a useful guide in planning ahead, but in the moment of practice, the phenomenon of 'being safe' takes precedence. Such understanding is embodied. For example, at the homebirth, after the doctor asked the midwife 'what are you going to do?', rather than proceeding with a discussion, he moved on to prepare the resuscitation equipment. He knew what mattered most. He knew about 'being safe'. It did not need a discussion. It simply needed two concerned practitioners to go about their business. Their implicit agreement was in the support they gave each other in creating a safe place of birth. It is the unspokenness of the shared agreement that hides and reveals the connecting conversation, the common ground.

The social-traditional meaning of 'being safe'

The second worldview is described by Anderson (1996) as the social-traditional worldview, one "in which truth is found in the heritage of American and Western Civilisation" (p.107). It is, therefore, the worldview which sees 'being safe' as lying within the social behaviours and traditions that have been established over the decades and generations of our society. Within childbirth, the social-traditional worldview would uphold the doctor as the safe provider, the hospital as the safe place of birth, and science as acted out through the medical model of care as the safe underpinnings of practice (Wagner, 1994; De Vore, 1995). It is a heritage of patriarchy, where male dominated structures define truth and enact power based on such truth (Oakley, 1980, 1984; Katz Rothman, 1989; Fleming, 1995). It is a society that holds a view on morality, and which has looked to the church for standards of ethical decision making. There are 'right' ways of doing things that are inherent within the culture and customs of practice. There is a sense of security in known ways, routine practices, and shared expectations and values. 'Being safe' may be made explicit in policies and protocols,

but its behaviours are affirmed even more potently in the social fabric of society itself. Disbelief, scorn, criticism, and warning are heaped upon the individual who would dare to go against the 'tried and true'.

The hospital as the institution of safe care is the hallmark of the social-traditional view of 'being safe'. Take the 'length of stay' as an example of 'being safe'. When the cry comes to save money, the social-traditional values of the hospital being the 'safest place' to recover are called to question. Dowswell, Piercy, Hirst, Hewison, & Lilford (1997) draw attention to the tension arising between administrative efficiency and clinical efficiency. One seeks to maximise efficient bed use, while the other puts the clients needs first. Dowswell et al. concluded that a postnatal bed stay of 2.6 days, with an occupancy rate of around 70% is "about right" (p.135). A new tradition of maintaining high turn-over and bed occupancy rates is being established and affirmed. It is fuelled by the need to save money. The traditions are changing, yet they carry with them the tension of undermined clinical standards and values.

Lawler (1997) sees the social-traditional meanings of health care being overtaken by gradual, progressive invasion of economic rationalism as the priority discourse in the social order of the Western world. She suggests that in the health sector, financial and resource management of clinical services have become the major issue. The economic discourse becomes the imposed discourse from which practice must take its meaning. It silences such therapeutic practices as "pass[ing] the time" (p.42) with the client. It leaves "little space for the individual and individual experience...[and does] not benefit from the humbling and sobering realities that people in clinical practice understand" (p.42). The discourse of safety regulation in documents such as the *Regulation of Safety in Health and Disability Services* (Ministry of Health, 1997) is strongly rooted in economic rationalism. It is protecting the self interest of the provider, that they shall be released from the economic burden of 'doing harm'. 'Being safe' means more than that. It needs to be remembered that the process of preventing harm can often cause harm in itself. Murphy (1994) reminds us that risk identification and intervention can lead to "unnecessary hospitalisation, caesarian sections, false diagnosis of disease, unmeasured psychological impact" (p.25). 'Being safe' is more complex than any risk management

system is ever likely to be able to accommodate. Madjar tells us: “We juggle the perspectives of anatomical-physiological understandings with the realities of working with individual persons who laugh, cry, hurt, worry; feel anxious, depressed, contented, happy, frustrated, angry, exhilarated or despondent; and have needs which we, as nurses [or midwives, or doctors], often cannot meet or resolve” (1997, p.54).

What has happened, and is happening to the meaning of ‘being safe’? It is a meaning that has its roots deeply entrenched back in time. It is a meaning that is influenced by economics, politics, and management ethos. It is meaning that makes its own transitions with the sureness of the incoming tide. It carries practitioners and clients along with it relentlessly. They must somehow learn new ways of ‘being safe’ in the swirling currents of these tides of change. This thesis has revealed the undermining of safety by the social-traditional tensions within the maternity services, as funders, managers, practitioners and consumers struggle against the vested interests of each other. Some cling to the social-traditional stability of the era of modernity, while others, with new understandings, seek to gain new access to power. All are dictated to by ever decreasing resources. Safety becomes a ball in play, a political weapon, a disciplinary stick, and a hallmark of power. This worldview does little to uncover ‘how to be safe’, but shows us much about the constraints to the experience of ‘trying to be safe’.

The social-traditional view is likely to differ across professional groups. In Chapter Seven, there is an example. A midwife says “*definitely the home feels safe to me*” (p.158) and a general practitioner offers the opposite view: “*I do have some safety concerns at home*” (p.159). They both back their statements with valid argument. On closer examination, one sees that what they are each saying is “I don’t feel safe because I am not familiar with the setting, I don’t feel equipped to cope”. They both demonstrate the same ‘concernfulness’ to be able to practice in an embodied manner, to be able to respond to any emergency by drawing on known and familiar strategies. The phenomenon of ‘being safe’ is common to both, even though a superficial listening would argue that they are in disagreement. Different, opposing, conflicting opinions of ways of practising find their tension at the meeting of the discourses of worldviews. One tradition cannot agree to be another tradition, without giving away its ethos. The traditions can only ever agree to disagree. However, within the traditions, are humans

being human, sharing a common understanding of what it is to be human, what it is that 'matters'. I have come to understand that the humanness of sharing in birth brings people to a place of common ground. There may be masks of indifference, or rituals of political gameplaying, that hide, or disrupt the human experience. Nevertheless, I argue that within nearly every tradition there is concern for the life of the woman and her baby; there is celebration when all goes well and deep sadness in the face of tragedy or loss. Embodied within us is the understanding about 'what matters' that enables the conflicting worldviews to find a place of common ground, that brings a 'togetherness of practice' as the moment of the dance is shared together. To offer safe practice we need the wisdom to see beyond the tension, the courage to take off the mask of our worldview, and the willingness to hold out our hand to the other in our mutual sharing of shaping, and being shaped by, the experience.

The neo-romantic meaning of being safe

The neo-romantic worldview is one "in which truth is found either through attaining harmony with nature and/or spiritual exploration of the inner self" (Anderson, 1996, p.107). The focus is strongly upon 'self'. Childbirth is seen as an experiential process where the focus is just as likely to be on planning the experience as on determining strategies for safe outcomes. The scientific-rational view and the social-traditional view tend to be calmly ignored, unless a crisis arises which demands the assistance of the knowledge and experience that arises from these more technically-advanced worldviews. Harmony with nature calls for a new search, or for what has been called a (re)search, within the western world into complementary therapies (acupuncture, homoeopathy, herbal remedies) (Saks, 1994). The diagnoses by these practitioners are likely to be based on different worldviews of body functioning. 'Being safe' enters a new realm of understanding and enacting.

The scientific-rational and social-traditional worlds look on in bemusement. If it is an additional strategy of care, it is tolerated on the understanding that it is likely to make no difference (do neither harm nor good). If it is, however, chosen as a replacement for expected care, then it is likely to be declared 'unsafe'. Some practitioners have chosen to straddle these three worldviews, incorporating complementary therapy into their

normal professional practice. A nursing perspective (van der Reit, 1997) suggests that the (re)emergence of complementary therapies in nursing rejects the technological approach of the medical model, and moves towards the “embodied and experiential elements of human life” (p.104). The tension arises when measures of efficacy of such treatment are demanded “using the established benchmarks of scientific rigour” (p.106). The scientific rigour brings double jeopardy, for even if efficacy is demonstrated through experimental design, the fundamental question of the scientific basis of the therapy itself still remains open to scepticism and attack.

This thesis uncovers the need to take heed of the ‘inner self’ of the client. Remember the tears and the hurt in the stories told by the women? It was in not being listened to, not being respected, not being told what to expect, not feeling ‘cared for or cared about’ that mattered. The experience of ‘being there’ stays in the memory of the women. They remember what people said, or did not say. They remember receiving care based on wrong assumptions. Throughout the twentieth century, with the hospitalisation of birth, and the increase of technology, there has emerged an era where the scientific-rational worldview has become dominant in the ‘shoulds’ and ‘oughts’ of maternity care. Let us not pretend any worldview, even the scientific-rational, necessarily permeates the experience to bring safe care. The experience is always there, no matter what. It is always vulnerable to indifference and abuse.

It is important, however, not to romanticise the experience. When we read the letters of New Zealand women of the Nineteenth century (p.27-29), we are reminded of the women and babies who died at the hand of nature. This thesis uncovers the spirit of safe practice, with its alertness to the possibilities that ‘things could be going wrong’ even when there is no showing of signs. It is not blinded by the romance, yet it shows that childbirth is an experience that goes beyond the control or understanding of mere human practitioners. The woman in Chapter Nine, whose baby lay unconscious for two weeks in the neonatal unit, says “*I got faith during that time, because the only way I could go to sleep was to pray ... there was no anchor. I just felt I was spinning the whole way*” (p.218). It brings us back again to the humanness of the experience of childbirth, and the deep spiritual and emotional needs that are far beyond the scope of

the scientific-rational worldview. That does not mean they are beyond the understanding or experience of the practitioner. Remember the doctor of the woman whose twin daughter died soon after birth (p.208), who came to seek her with tears in his eyes? Engaging in a 'concernful', caring, considerate manner matters in human relationships, and matters in being safe. Such a relationship is the safe path through the conflict of worldviews.

Remember the woman in Chapter Nine (p.199-200) who did not want an episiotomy? She got one anyway. The scientific-rational dictated over the neo-romantic. When the '*absolutely huge*' perineal haematoma developed, the woman's cries for attention were disregarded. Perhaps she was seen as 'making a fuss', perhaps as being a hypochondriac. It seems, however, that this woman had an intuitive understanding of her body that was much more insightful than any understanding held by the practitioners. If they had listened, if they had been respectful, if they had been willing to try, if they had maintained a relationship that responded to cues, then, it could have been said: they were 'being safe'. Those who discount, ridicule, or ignore what they perceive as an opinion from the neo-romantic worldview close off possible insights that may be the light for the path to safe care. Openness to whatever is 'other' or 'different', and the willingness to engage in new experiences and learn from them, is what being safe is all about. It is in the exploration, in the openness, in the dialogue that the holders of different worldviews will gain the insights that are only accessible on the common ground.

The common ground

Heidegger (1959) shows us the common ground in his writing *A Discourse on Thinking*. He has written this paper as a dialogue between a scholar, a teacher and a scientist; in other words, a dialogue between three worldviews. Listen to the words as the dialogue moves from one worldview to another: "*Assuredly...*" "*If this were so, then ...*" "*This ... could hardly be anything other than ...*" "*So*"... "*All the same I can no longer hold back the confession that ...*" "*You mean to say...*" "*But...*" ... "*Then perhaps we can express our experience during this conversation by saying...*" (1959, p.85-86). Heidegger shows us that when people from different worldviews are open to each other,

are willing to listen to what the other is saying, and learn from it, then they engage in an experience of understanding that no one of them could achieve on their own. In the common ground one does not give away beliefs and values, rather one opens them to fresh scrutiny somewhat in the manner of spring-cleaning. Some may be thrown away in the recognition that they are now out-dated and irrelevant, but others are polished, held gently, and put back with a re-awakened understanding of their preciousness. We, therefore, need not be afraid or hesitant of the common ground. We need only come prepared with the commitment to expose the untidiness of our thinking, the clutter of our ideas, the depth of the dust that has gathered in the time of un-thinking. Dialogue on the open field, with 'different minded people' is more than a spring-cleaning of your own thinking. It offers new ideas, challenges assumptions, looks at situations from other standpoints and shows what one might never have seen before. It advances thinking and understanding. It connects conversations in the common understandings of experience. It begins to breakdown the barriers that stand in the way of 'being safe'. Having brought you to dwell with notions of 'commonness' and 'shared understanding', let me now both disrupt and confirm those understandings as we explore the fourth worldview of postmodern-ironism.

Postmodern-ironist meanings of being safe

Anderson (1996, p.10) offers an overview of what has come to be called 'postmodern'. The first notion is about 'self-concept'. Rather than being who or what we are because it 'simply is' and that is how we are 'found', the postmodernist understands people in terms of the identity they have 'made', constructed and re-structured for themselves many times out of many sources. That means a safe practitioner is a self-made practitioner who takes control of their own understandings, accepts and rejects worldviews, changes ways of practice, and is open to new ideas. It is a new breed. Anderson (1996) draws attention to the term commonly used by Roman Catholics: "Cafeteria Catholics". He explains it as "someone who behaves within the faith as one might behave in one of those restaurants where the customer takes a tray, goes down along a counter, and selects dishes that appeal to him or her at the moment - chooses what to eat and what not to eat" (p.176). It is an era where the individual feels released

from needing to accept, believe and practice everything in the total package, and with confidence and assurance picks and chooses what suits them.

This study has revealed the cafeteria practitioners, who no longer believe they have to be bound by the scientific medical model, nor conform to all the dictates of the social traditions of practice, who enthusiastically add some neo-romantic notions to their practice. They are practitioners who are not locked into any one worldview, but who pick and choose according to personal preference. The 'ought not's' and 'should not's' of worldviews are simply 'voices' which may or may not be listened to. A constructed understanding of 'being safe' is likely to have different flavours between different practitioners. If all practitioners were 'postmodern' each would simply recognise the other as 'different', not as less safe or more safe than themselves. Stapleton asks the question "if notions of choice and risk essentially translate into people management, then how does any 'civilised' society impose and evaluate regulatory mechanisms on personal behaviour?" (1997, p.66). It is a question that lies on the table, perplexing those who seek to control, who find their guidelines and dictates calmly 'not chosen' to be obeyed.

Anderson's (1996) second postmodern dimension is the 'moral and ethical discourse' where there has been a "move from 'found' morality of a single cultural and/or religious heritage to a 'made' morality forged out of dialogue and choice" (p.10). The ground of what is right or wrong, safe or unsafe, is ever shifting. There is no single source of moral guidelines from which a profession can build its standards. For example, there are those who uphold the sanctity of all life, at any stage of its development, above all else. There are others who would put the rights and wishes of the woman above those of her unborn, not yet viable, child. There are some who despair at the quality of life of the congenitally or genetically deformed child, who would seek to close off that child's life at the earliest possible opportunity. There is no longer a 'truth'. There are multiple opposing truths. How can safety be enacted when one would seek to save lives in all situations, and the other, in some situations, to prevent a baby from living? What is safe to one is unsafe to the other. It is a world of moral and ethical paradox. At the same

time, it is a world where, Rorty suggests, anything can be made to look good or bad by being redescribed (O'Hara & Anderson, 1996).

There is the story of Beverly torn between her two worlds. In one, she is a radical feminist university student. In the other she returns to her home town as a "nice, sweet, square, conservative girl" (O'Hara & Anderson, p.167). When asked by her therapist when she feels most like herself her answer is "When I'm on the airplane" (p.167). Is it the same for the practitioner who celebrates the non-intervention of the homebirth, and with the very next client engages every technological intervention available. Are they only ever themselves when they are between clients? Lifton (1996) talks of the different number of masks we wear, and raises the question "Should there be one face which should be authentic?" (p.127). He goes on to suggest that just as we change our masks, "so idea systems and ideologies [can] be embraced, modified, let go of and re-embraced, all with a new ease that stands in sharp contrast to the inner struggles we have in the past associated with these shifts" (p.128).

This study suggests that there are many masks portraying the moral and ethical discourse of the safety of maternity care, yet if we took all those masks away, the naked value underlying each would be that the life of the woman and her viable baby matters more than anything else. The sanctity of the life of the woman is a shared value, as is the life of the baby once it falls within the legal parameters of having the right to life. 'Being safe' means striving to keep a life intact and free from harm. That is within our heritage of 'being human'. Confusion and tension comes to the fore when we move beyond what is possible through nature, to what is now possible through technology. We are regularly faced with new possibilities that are beyond our experience of 'being human'. For example, it is technology that enables us to diagnose physical defects and deformities in the fetus, before it reaches a time when it could fight for its own life if it were born. It opens the possibility of removing the fetus from the mother, thereby leading it to death. As humans, we are still grappling with these possibilities. We do not share an embodied understanding because only some have lived the experience, and tell us the decision of abortion is one of ambivalence and tension. When we read of 'baby-making' technologies, when we consider the possibility of the cloned replica of one

human being into a new, identical model, we gasp. No experience has prepared us to know how to understand.

Anderson's (1996) third dimension of the postmodern approach is that of art and culture. "No style dominates. Instead, we have endless improvisations and variations on themes; parodies and playfulness" (Anderson, 1996, p.10). Jenks has called it a time of "incessant choosing" with the possibility of a "striking synthesis of traditions"(1996, p.27). Seedhouse (1991) describes the uncertainty that "runs deep within medicine" (p.19). He points to the degree of arbitrariness between the decision of what is normal and what is not normal. He suggests that "normality changes as a river changes dependent upon the terrain over which it flows" (p.27). Stapleton (1997) offers caution that there now exists a "shopping list mentality in the name of choice ... where midwives are expected to accommodate every wish and whim, no matter how unrealistic it may be" (p.66). Do you hear the chorus of voices from philosophy, from medicine and from midwifery who all cry out to warn of the quicksands over which the practitioner must now tread a wary path. There is danger, yet there is the sense of adventure as each person decides for themselves which way to go. O'Hara and Anderson (1996) capture the paradox: the bad news of all this is "the serious despair, emptiness and social disintegration that sometimes follows the disappearance of all certainties" while the good news is "the freedom it offers, the great wealth of opportunities to explore and create" (p.172).

Choice and uncertainty are the paradoxes that hold loosely to the notion of 'being safe'. Neither the practitioner nor the client may know what is safe. They can only know the choices before them, the opportunities and the possibilities. They may not even know for certain that the normal has become problematic, that a choice needs to be made to be safe. The security of the all-knowing practitioner has gone. The power of the client who demands to make her own choices has stepped in. It is a new relationship in new times, that encompasses new possibilities of what may be safe. This thesis suggests that it is not the choices, nor the uncertainty, that makes practice unsafe, rather a lack of awareness that there is always uncertainty, and always choice. Danger lies in a deficient spirit of concern, a wrongly judged 'leap in' approach to practice that does not leap-

ahead (with the woman) in anticipation and preparation, or a wrongly timed 'leap ahead' approach that misjudges the moment when there is no time to talk through the decision, there is only time for action. Danger also lies in indifferent or 'unconcernful' relationships that do not hear what is said, nor invite the trust to prompt the saying of the private concern of the other. Choices and uncertainty deserve focused attention in regard to each person and each situation. That is 'being safe'.

The postmodern-ironist worldview is about choice and freedom. On the other hand, there is recognition that no choice is free from consequence. There is awareness of scrutiny and surveillance from local, national, and international, professional and consumer bodies. There are those who take the power to declare the choice of a practitioner to be 'unsafe'. Foucault says "I don't believe that this question of 'who exercises power?' can be resolved unless that other question 'how does it happen?' is resolved at the same time" (1996, p.38). The 'how' of power in today's world is in the strategies of surveillance. The consumer in New Zealand has the right to make a complaint to the institution providing care, to the professional disciplinary body, to the Accident Compensation Corporation, to the Health and Disability Commissioner, or to bring a civil case in a Court of Law. The practitioner is open to further surveillance by those who fund care, provide care, or monitor the professional standards of care. Practitioners live constantly in the paradox of being free to practice in whatever manner they choose, while knowing that they could be called to account at any time for any of those decisions. Remember the satirical advice given by Lewis (1945) about the two fatal errors: to show no initiative, or to make the slightest approach to unauthorised action. He describes the space between as being 'perfectly safe'. The problem is, there is no space between. Any initiative is by nature unauthorised, and any obedience to authority is without initiative. The practitioners in this study talked about the risks they take in their everyday practice. Risking goes hand in hand with uncertainty, and uncertainty is always present in the moment of now.

*We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time ...*

*Not known, because not looked for
But heard, half-heard, in the stillness
Between two waves of the sea*

T.S. Eliot, *Little Gidding*, Four Quartets

Hearing in the stillness

It is time to stop talking, on and on. It is time to listen for the stillness of the half heard understanding. We have taken the interpretive phenomenological understanding of 'being safe in childbirth' that has arisen from this study, and have joined it to the conversations of four worldviews. The intriguing insight is that while each of these worldviews is very different, our conversation with each of them made sense. There was engagement, there was understanding, there was agreement. How can that be? That is the gift of the hermeneutic approach to understanding. It does not pigeon-hole ideas into categories that can or cannot be accepted. It "gives itself without hurry to the task of understanding, is open to conviction, afraid of obstinacy, and would rather learn than take the lead" (Joubert, 1898 /1994, p.203). It is the same approach that lies at the heart of 'being safe'. It is the openness, the willingness, and the commitment to become engaged which make 'being safe' more certain. In other words, one must become more uncertain to achieve more certainty. It is not about theories or concepts or standards of practice, all of which can be held at arms length. It is about self. Hear these words:

There are some conversations in which neither the soul nor the body takes part. I mean those conversations in which no one speaks from the depths of his heart, nor even with the true temper of his mind; in which there is neither freedom, nor gaiety, nor flow, nor play; in which we find neither movement nor repose, neither distraction nor relief, neither concentration nor diversion; in fact, where nothing has been given and nothing received, where therefore there has been no true exchange (Joubert, 1898/1994, p.203).

A hermeneutic understanding expects that the soul and the body are engaged in the experience. It invites the speaking that comes from the depths of the heart, or the stirring of the temper. It celebrates the movement, the play, the distraction of other ideas. It seeks a true exchange, between the reader and the text, between the two people in dialogue, between the practitioner and the woman. The answer to the question 'what is the meaning of being safe?' is found both in the experiences of the participants in this study, and in our shared experience of the hermeneutic approach. The embodied

mode to 'being safe' or 'being a hermeneutic scholar' are the same. It is a connecting conversation which arrives at a shared understanding.

'Being safe' is about more than following a prescribed set of behaviours. It is about more than adopting any or all of the worldviews. It is about more than knowing, and more than doing. 'Being safe' is about 'being ourselves'. Perhaps, we cannot be safe until we know who we are. Perhaps, we cannot be safe until we are willing to let go of who we think we are, trusting that the things that 'matter' will not be lost. T.S. Eliot shows us three conditions of who we might be:

*There are three conditions which often look alike
Yet differ completely, flourish in the same hedgerow;
Attachment to self and to things and to persons, detachment
From self and from things and from persons; and growing
between them, indifference.*

Little Gidding, Four Quartets.

Eliot talks of attachment to self and to things and to persons. Consider then that to be safe a practitioner needs to be attached to their own knowing, feelings and abilities; they need to be attached to the things of the practice environment that will facilitate safe care; and they need to be attached to the woman in their care, and the other people involved in the situation. Without the attachment, without the concernfulness, without the commitment towards safety, there is no 'being safe'. What nurtures the bond of attachment? What sustains the faithfulness of commitment? What makes attachment 'matter'? Those are the questions the worldviews struggle to answer. Some would argue it is a decision of self, others that it is a humanistic philosophy, and others that it comes from a spiritual call to 'love one another'. Perhaps it is all three. Nevertheless, attachment matters, yet attachment has its costs. Remember the midwife in Chapter Nine who confessed "*so much is asked of me, and sometimes I don't want to do it*" (p.203). Detachment and indifference are survival tactics of the tired, over-worked, stressed-out, burnt-out practitioner. We saw it in the midwife who paid scant attention to the woman who was having such struggles to breast feed her baby: "*she deserted me ... I felt rejected*" (Chapter Nine, p.196). We saw it in the faceless, nameless midwives on the postnatal ward. The woman said "*you would ask one, and you would get the wrong one, and you wouldn't get an answer at all*" (Chapter Nine, p.213). We saw it in the visits to the obstetrician "*He was a nice guy, but it is the usual thing of being in*

there for two seconds, and never asking anything because you know he has a room full of people, and you had to wait three quarters of an hour past your appointment time. The visits didn't seem important things to do" (Chapter Nine, p.205). Eliot's poetry reminds us that these three conditions of attachment, detachment and indifference, often look alike, and flourish in the same hedgerow. That is the challenge this thesis offers: do we know the difference between attachment, detachment or indifference in our own practice, do we see the three different modes in the practice of others, and can we do anything about it?

'Being safe' can never be dissected and withdrawn from the world of everyday practice. It is like drawing a diagram of the anatomy of a dissected frog, and saying 'that it is a frog'. A frog is only ever a frog as it croaks itself to our notice in the warm night air. 'Being safe' is only 'being safe' in the midst of the experience. We can only see it if we are there. We can only hear about it through the stories of what happened. We can only understand it when we understand the nature of 'being there' in the moment of time, at the still point of the dance. Once we accept that it is on the level 'as-close-to-the-experience-as-possible' that understanding shows itself, then we will see the value and importance in sharing our stories, then we will come to understand what we have not known, because we have not looked. The scientific-rational approach of the medical model, and the neo-romantic tendencies of the midwifery model do not trap those two professional groups into opposing camps. Rather, if we listen with openness we will hear different words telling the same stories, different strategies being employed to the same ends, different arguments leading to the same place. It will only be when together we go to the open field with a commitment to talk and to listen, to hear and to learn, to hold on to and to give up, to disagree and then to agree, to break down the rigid claims of the worldviews that dictate our thinking, to believe that we share a common concern, it is only then that 'being safe' will cast aside the political impediments that stand in its way.

*... to make an end is to make a beginning
The end is where we start from*

T.S. Eliot, Little Gidding, Four Quartets

The end is where we start from

If to make an end is to make a beginning, if the end is where we start from, then we must go back to the beginning. We must offer all that has been said to question again. We must hold nothing as truth, and no understanding as complete. We must take our own understanding to meet with the understandings of others. We must be willing to let go, and declare that what we thought was a warranted interpretation is not how it is at all. With our heads full of understanding, we must ask again ‘what is the meaning of being safe in childbirth?’ We must never stop asking. If we keep asking, if we keep doubting, if we are always willing to listen when someone says “no, that is not my experience”, if we accept that having got to the end we have only got to the beginning, then maybe we begin to embody the understanding of ‘being safe’. To hear the stillness between the waves is a lifetime’s struggle. Remember the obstetrician who said “*I think we are always in a quagmire between doing too much and too little. And we never hit it quite right ... We all strive to hit it right. And I think it’s a whole life’s struggle to get it right, to get as close to right*” (Chapter Seven, p.140). Understanding the meaning of ‘being safe’ is to no longer pretend there is a defined, pre-determined, agreed upon ‘right’ way of being safe. Coming to understand is to talk together about the quagmire, to tell each other of the ways of striving, the good times and the bad times. It is to share the stories of the struggles, and come closer to understanding what makes the struggle so hard. It is to keep reminding ourselves that coming to know the meaning of being safe will be the struggle of the whole of our lives, and of the generations that follow.

being safe
 is not something you can hold at arms length
 it is not something that you can grab hold of
 in learned books
 it refuses to be categorised, conceptualised, theorised or locked away in a glass cage

being safe
 does not belong to the scientists, or the traditionalists, or the romantics
 nor can it be scorned upon and cast aside as irrelevant constraint

being safe
 will never be agreed upon by all the different factions
 yet they will mostly be saying the same thing,
 perhaps without ever knowing it

being safe
 will always be safe
 because it lives and hides
 where it can always be found
 but is seldom seen

being safe will always be understood
 by those who have lived the experience
 for it cannot be escaped or ignored
 even though at times we turn away
 because it seems too hard

being safe will always find the language that is common
 on the open field, in the open mind

it dwells in uncertainty and possibilities
 to 'know' is to be open to 'not knowing'
 to 'understand' is to recognise that 'you do not understand'
 to 'decide' is to realise that 'you could be making the wrong decision'
 to 'act', is to accept that 'it might be better not to act'
 it is the restless to and fro

being safe
 is a whole life's struggle

not being safe
 is always waiting to tempt us into its detachment and indifference
 a much more peaceful road
 until the danger comes and claims us

Appendix A

**(This is the Information Sheet and Consent form used when
this study began in 1994 as a Masters Thesis)**

Information for potential participants of a research study

Title of study

**“The lived experience of being safe as a practitioner within the Maternity services”
- a phenomenological research study for a MA Thesis (Department of Nursing and
Midwifery, Massey University)
- Researcher: Liz Smythe, Midwife Teacher, Auckland Institute of Technology**

The purpose of this study is to gather the descriptions of both midwives and doctors about their feelings and experiences of ‘being safe’ in the context of the childbirth process.

The study recognises that there are different opinions about what being safe means. It seems that safe outcomes are demanded by everyone, but the ‘safe’ way of reaching these outcomes varies. The concept of ‘being safe’ raises many thought about practices, attitudes, expectations and values. This study does not wish to separate out the doctors view from the midwives view, rather to identify the shared themes.

Participating means you would be interviewed by me for the purpose of describing your experience of being safe. To achieve rigour in the research process, the conversation would be audiotaped, and later transcribed. You participate under a chosen name to protect your anonymity. The tapes remain confidential to me, to the typist, and the Thesis Supervisor.

The interview would take place in an environment that is private, convenient, and agreed on by us both. It is likely to last approximately an hour. You would later be given a copy of the transcript of the interview, with my comments about the meanings that seem to have emerged. You are invited to respond to these comments, or to add further comments that have arisen since the interview. You are also free to delete any parts of the transcript that you do not wish to be part of the research study. It may be decided by us both that a second interview is needed. Again, participants will be invited to respond to the analysis of the data to ensure that the report will accurately reflect the lived reality of ‘being safe’. Communication between us will remain open throughout the data collecting and refining process, until it is agreed that the meaning has been described to our mutual satisfaction, or until you wish to discontinue the process. Thus the data that finally appears in the research report will reflect the partnership of describing the meaning.

The research report will contain direct quotations from the transcripts. This is to validate the interpretations that are made as coming out of the research study. An example you give to describe a particular point may be used in full. It is from such

stories that the reader is able to relate their own experience of 'being safe' and perhaps reach a new understanding of meaning.

It is important to remember that the purpose of this study is to find meaning, not to judge individual practice or situations. The only judgement that may result from the study is from you yourself as you reflect back on issues of being safe. My role is not to agree, or disagree. I am there only to hear the descriptions, and to work with you in teasing out the meaning.

If you would like to discuss this further, or if you are willing to participate, I can be contacted at AIT: ph.307 9999 ext 7196.

Thankyou for your consideration

(Appendix A continued)

The lived experience of being safe as a practitioner in the Maternity Services

Consent Form

I have read the information sheet for this study and have had the opportunity to seek further information. I understand I may ask questions at any time.

I also understand that I am free to withdraw from this study at any time, or decline to answer any particular questions in the study. I agree to provide information to the researcher on the understanding that it is completely confidential.

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

Signed:

Name:

Date:

Appendix B

(This is the information and consent form in their revised form. The proposal was resubmitted to the Massey Human Ethics Committee in May 1995 when the study was transferred to become a doctoral thesis, and permission was sought to include women who had been clients of the maternity services as participants.)

The Lived Experience of 'being safe' as a practitioner, or as a client, within the maternity services

Information Sheet for women who have been clients

Who is the researcher:

I am a midwife who teaches at the Auckland Institute of Technology.
I am enrolled as a PhD student at Massey University.

How can I be contacted:

My contact phone number is 307 9999 ext.7196
My postal address is School of nursing & Midwifery, A.I.T., Private Bag 92006, Auckland.

What is this study about:

In 1994 I began a research study in which I talked to midwives and doctors about what 'being safe' meant to them in their everyday practice.

It now seems important to also talk with women who have been clients of the maternity services about what 'being safe' meant to them when they were pregnant, during labour, and in the postnatal period.

I believe we all have a sense of what being safe means, but that we don't often describe it in words. This study hopes to come to a description of what 'being safe' means to both the women and the people who work in the Maternity Services. It is for a PhD thesis.

What would you have to do :

If you agreed to participate we would decide on a time and place to meet each other. I would then ask you to tell me what 'being safe' meant to you in relation to your childbirth experience/s. With your permission, I would tape record our conversation. At any time during our conversation you have the right to ask me to turn the tape off, or to delete something you have said. You also have the right to refuse to answer any particular questions.

The tape would then be transcribed, either by me or by a typist who would be required to sign a confidentiality clause.

I would then give you a copy of this written record of our conversation, plus a summary of what I think are the important points you have made about 'being safe'. You are free to cross anything out that you do not wish to be part of the study, or to correct the meaning I have taken from what you said.

We will then decide together whether there is a need to meet again for another conversation.

How much time will be involved :

The initial conversation is likely to take an hour, during which time the study and your involvement would be more fully explained.

If you take part in this study, you have the right to :

- * refuse to answer any particular question, and to withdraw from the study at any time
- * ask any further questions about the study that occur to you during your participation
- * provide information on the understanding that it is completely confidential to me. All information is collected anonymously, and it will not be possible to identify you in any reports that are prepared from the study
- * be given access to a summary of the findings from the study when it is concluded

Thank you for your consideration

(Appendix B continued)

The lived experience of being safe as a practitioner, or as a client, in the Maternity Services

Consent Form

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

I also understand that I am free to withdraw from the study at any time, or decline to answer any particular questions in the study. I agree to provide information to the researchers on the understanding that it is completely confidential.

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

Signed : _____

Name: _____

Date : _____

Appendix C

Letter to practitioner participants, informing them of the transfer from a masters thesis to a PhD thesis, and seeking permission to include their data.

20th March, 1995

Dear

Last year you kindly participated in a research study for my MA thesis related to the concept of 'being safe' as a practitioner of the maternity services.

During the year I interviewed two hospital midwives, two independent midwives, one domiciliary midwife, two hospital obstetricians, one private obstetrician, and one general practitioner.

In October I spent time exploring the common themes. The picture that emerged was :

- there are generic behaviours related to 'being safe'
- people had a sense of 'knowing' about 'being safe' that had developed over time under a variety of different influences
- practitioners who provided continuity of care saw the relationship with the woman as an important component in 'being safe'
- practitioners who did not provide continuity of care recognised the objectivity they brought to their practice as similarly being an important component of 'being safe'.
- the interface between practitioners where referral or consultation is sought is a place where 'being safe' sometimes becomes vulnerable
- practitioners recognised technology as both enhancing safety, and being a threat to quality care
- the reality of the practice situation means that the best intentions are sometimes not enough to attain a sense of 'being safe'.

The combined data you all so generously provided was very rich in meaning and stories.

The opportunity has now arisen for me to take this research project further, that my thesis become a PhD thesis rather than a MA thesis. I have been awarded a Post-graduate Diploma in Social Science for the papers I previously completed at Masters level, and have been granted permission from the PhD Committee at Massey University to transfer to PhD.

I would like to talk with women who have been clients within the maternity services about their experience of 'being safe'. Several of you mentioned the enormous sense of trust women seem to invest in the practitioner. I would like to explore their perception of who carries the responsibility for 'being safe', and what it is that engenders a perception being in safe hands.

My request to you is that the data you offered on the understanding of it being part of a Masters Thesis may now be included in my PhD thesis. I would ask that you return the enclosed form to confirm this.

I would once again like to thank you for the contribution you have made. I have become very attached to every participant's input. When I did the 'cut and paste' there was hardly anything that seemed unimportant. And amidst the sometimes stormy political climate it is reassuring to find a strong sense of shared belief and understanding amongst such a wide variety of practitioners.

If you have had further thoughts since the time of our interview, or if you would like to talk with me about the picture that is emerging from the data, I would be very willing to meet with you again.

Yours sincerely,

Liz Smythe

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