MIDWIFERY PRACTICE:

AUTHENTICATING THE EXPERIENCE OF CHILDBIRTH

A thesis presented in partial fulfilment of the requirements for the degree of Master of Arts in Nursing at Massey University

Joan L. Bassett-Smith

1988

TABLE OF CONTENTS

PART TWO: THE DATA

APPENDICES

ABSTRACT

The purpose of this grounded theory study was to identify, describe and provide a conceptual explanation of the process of care offered by midwives and the effects of that care on women's experiences of childbirth in hospital. Ten couple participants and their attendant midwives provided the major source of data. The primary data collection methods used in this study were participant observation during each couple's experience of labour and birthing, antenatal, hospital and postnatal interviews with couples along with formal and informal interviews with midwives.

Constant comparative analysis of data eventuated in the identification of a core category termed 'authenticating'. Authenticating, in the context of this study denotes a process that is engaged in by both midwives and birthing women in order to establish practice, and the experience of giving birth, as being individually genuine and valid. Authenticating is multifaceted and is seen to include the intertwined and simultaneously occurring phases of 'making sense', 'reframing', 'balancing' and 'mutually engaging'.

The process of authenticating is proposed as a possible conceptual framework for midwifery practice. It identifies the unique contribution the midwife can make to a couple's experience of childbirth and serves in a conceptual way to unite the technical and interpersonal expertness of the midwife. The conceptual framework of authenticating legitimizes 'being with' women in childbirth and facilitates a woman-centred approach to care with consequent implications for practice, education and research.

ACKNOWLEDGEMENTS

This research endeavour is the culmination of two years of study at Massey University. A very sincere thank you is extended to the faculty of the Department of Nursing Studies for providing a supportive and yet challenging and stimulating environment.

This researcher was privileged to share in the labour and birthing experience with ten women and their partners. Without their willing and enthusiastic participation, this study would not have been possible. My thanks to all of you.

Sincere appreciation is also extended to the midwives who welcomed me into their workplace and participated in the study.

Being a thesis supervisor is a challenging responsibility. I have appreciated the experienced wisdom and sheer hard work that Irena Madjar has contributed to this thesis and a special thank you is extended to you Irena.

Norma Chick and Julie Boddy have contributed to the completion of this thesis in many ways. Your encouragement and support has been greatly appreciated.

Much of the pleasure of living in New Zealand has been due to the new people I've met. In addition to being a special friend, Pat Hickson has contributed her time and computer expertise in assisting with the completion of this thesis. With Jo Walton, Joan White, Bronwyn Paterson, Wilma Young and Pat I have shared happy and special times that will not be forgotten. I thank you and know that 'miles' will not detract from the feeings of friendship and colleagiality.

Appreciation is extended to the Nursing Education and Research Foundation for a grant that has assisted with expenses.

I feel very privileged to have a supportive and caring family. My love and appreciation are extended to my mother and father who regularly sent messages of their love and encouragement, to friends and colleagues in Canada, and to a very special New Zealand family who have made our stay here so wonderful.

Most importantly, my love and heartfelt thanks go to John, Christopher, Michael, and Derek who have consistently encouraged and sustained me, done without me when necessary, and together provided a loving and fun time for our family.

PART ONE

INTRODUCTION

CHAPTER ONE

INTRODUCTION AND OVERVIEW

This study seeks to examine the characteristic pattern of midwifery care in a hospital setting, and how that practice affects the experience of childbirth for women.

PURPOSE AND CONTEXT OF THE STUDY

The experience of childbirth is supremely important to most women. It is not seen as merely an event in their life, but as a cultural experience that has far reaching ramifications for a woman's feelings about herself and, as well, for her transition to motherhood. The investigator has a long standing professional background relating to aspects of pregnancy, birthing and the puerperium. While reflecting on the care offered to women and their partners, the vast amount and variety of literature available, and personal experiences of childbirth, it became apparent that there is no one way of giving birth that is suitable for all women.

The movement of childbirth care from home to hospital and from midwifery to physician care has been an established fact for many years. Since the 1950's, however, women have expressed increasing dissatisfaction with the way childbirth care is offered. This 'consumer movement' has been responsible for surfacing many aspects of a medical birth as being for the convenience of caregivers and not necessarily for the benefit of women giving birth. As a result of this consumer involvement, changes have occurred with regard to hospital procedures and policies. Midwives, for the most part, work in a hospital setting, and their practice is therefore constrained by the organisational and ideological factors that are part of any bureaucratic organisation.

Although there is considerable research about midwifery care, this research frequently decontextualises midwifery practice from the environment in which it occurs. As well, in much of the research done to date a theoretical framework, ideological perspective or representative interest group has

provided the impetus for the study, the direction taken, methodology used, and therefore, the kind of findings reported. This study seeks to avoid an 'a priori' perspective by using grounded theory methodology in order to generate data deemed pertinent by both midwives and women experiencing birth in a hospital setting.

AIM OF THE STUDY

The purpose of this study is to identify, describe and generate a conceptual explanation of the process of care provided by midwives and the effects of that care on a woman's experience of labour and birthing in a hospital setting.

SIGNIFICANCE OF THE STUDY

Research has affirmed the importance of the birth event with regard to a couple's marital relationship, parenting abilities and a woman's sense of self esteem and personhood (Klaus & Kennell, 1976; Newton, 1977; Mercer, 1985). Arizmendi & Affonso (1987), in a study designed to rate a woman's experience of antenatal and postnatal stressors, found that the study participants expressed continued and highly stressful thoughts about their labour and delivery still predominating late in the postnatal period. This study confirms the importance of labour and birthing in the whole of the pregnancy experience and raises questions as to the reason for the predominance of this particular stressor.

Most of the research conducted to date has focused on a narrow aspect of midwifery, making it difficult to see how specific practices relate to overall patterns and contexts of care. In addition, almost without exception, midwifery research has been conducted by either North American or United Kingdom researchers in their respective countries. The generalizability of findings to New Zealand is therefore limited. The present study has a broad focus, utilizes a New Zealand setting and population and is particularly timely as the education of midwives is under review. The study provides findings and information not available from other sources.

The theoretical orientation chosen for this study, that of grounded theory and symbolic interactionism yields a further significance to this research endeavour. A basic premise of symbolic interactionism is that for behaviour to be understood it must be examined in interaction and within it's natural setting so that shared meanings held by the participants can be illustrated (Chenitz & Swanson, 1986: 6). This study explores the beliefs, thoughts and feelings of women experiencing childbirth along with those of the midwives caring for them. In effect, ten case studies of couples and their attendant midwives provide the major source of data. Data come from the participants and include their interpretation of events as they occurred. Linking of the midwife's perspective with the woman's view of her care is also something that has not been attempted in previous studies.

STUDY QUESTIONS

Initially the study was guided by the following questions:

(1) What are the reasons, sources, and explanations given by midwives, for the type of care they provide to birthing women?
(2) What is the nature of the relationship between midwife and woman?
(3) Is there a particular psychosocial process operating in the woman - midwife interaction during the period of labour and birthing?
(4) What is the world of a birthing woman like and how does the setting and events occurring within that world impact on the woman's perception of care given and received?
(5) What influences a woman's view of her labour and birth experience?
(6) What influence does the birthing experience have on a woman's perception of pregnancy and parenthood?

Consistent with grounded theory methodology, study questions were altered and new questions generated as data collection and analysis progressed, thus the direction of the study was further refined in process.

STRUCTURE OF THE THESIS

The account of this research study and it's theoretical outcome is divided into three parts. **Part One** (chapters 1-3) provides a general introduction to the study. Following on from the overview presented in **Chapter One**, **Chapter Two** discusses and critiques relevant literature in the areas of midwifery practice and the experience of childbirth. **Chapter Three** begins with a discussion of the relevance of grounded theory methodology in addressing the research questions posed, and then describes the use of grounded theory in this particular study by outlining the procedures followed. The chapter concludes by illustrating the constant comparative method of analysis, using study data, and then summarizes the ways in which credibility issues of the research were addressed.

Part Two of the thesis (chapters 4-9) presents the theoretical outcome of the research. **Chapter Four** describes the environment and background for childbirth in which data collection took place, thus providing a context within which to view the findings. **Chapter Five** presents a descriptive account of one couple's labour and birthing experience. This chapter provides the reader with a picture of the continuity between past and present birthing experiences. Chapters 6 through 9 present the phases of the identified conceptual framework. Each chapter describes one phase of the process and includes a definition of the key concept, and excerpts from the data to describe both the phase and the process. Conditions that facilitate and hamper successful passage through the phase are identified and discussed. *Making Sense* is covered in **Chapter Six,** *Reframing* , in **Chapter Seven**, *Balancing* , in **Chapter Eight**, and the last phase of the authenticating process, *Mutually Engaging* , in **Chapter Nine**.

Part Three (chapters 10-11) concludes the thesis. **Chapter Ten** provides an integration of the conceptual framework, i.e. the process of authenticating, along with a discussion of the contextual factors that both increase the need for authenticating and hamper successful passage through it's phases. In **Chapter Eleven**, implications for practice and education are discussed. Limitations of the present study, and directions for further research are identified.

CHAPTER TWO

REVIEW OF THE RELEVANT LITERATURE

This chapter reviews literature related to the practice of midwifery, the context in which childbirth occurs and selected aspects of the birthing experience that are seen to influence the woman's perception of and feelings about the event. The discussion begins with a consideration of midwifery practice, including views of midwifery held by midwives and the general public. Two paradigms of care of parturient women are presented and contrasted. The review concludes with a discussion of couple satisfaction with care, the experience of control in childbirth, management of pain, and the provision of support to birthing women.

MIDWIFERY PRACTICE

How Midwives See Their Practice

> To be a midwife is to be with women, (the meaning of the Anglo Saxon word) sharing their travail and their suffering, their joy and their delights. To be a midwife is to engage in a close and intimate relationship which often lasts only as long as the pregnancy, birth and puerperium but the effect of which travels down through the centuries in the image women have of themselves and their abilities and worth.
>
> (Flint, 1986: 14).

As exemplified by the above statement, within their own group, midwives have a strong sense of professional identity and believe in the importance of their role in childbirth. In the broad context of health care delivery in New Zealand, however, the role of midwifery, viz a viz others involved in the care of pregnant and parturient women, is less clear and less certain.

The ascendancy of medicine and it's involvement in childbirth has changed midwifery practice in New Zealand from autonomous work to delegated practice determined by doctors. The movement of childbirth into hospitals has affected both women giving birth and midwives. Not the least of these

effects has been the disenfranchisment of midwives from their historical role in childbirth.

Hospital practice is seen by many midwives as unsatisfying personally, as well as professionally, and as not meeting the needs of birthing women. Working in a hospital and under the direction of a doctor, has made it increasingly difficult to practice midwifery in a way that would recognize that 'given support and patience, 85% of women can give birth normally and naturally without the routine interventions that have become commonplace in hospitals today' (Donley, 1986: 15).

Midwives who attempt to retain their traditional beliefs and autonomy via independent practice do so at considerable personal cost. Moreover, the location of their practice is determined by the availability of a supportive doctor who is willing to be present at a home birth. The number of registered domiciliary midwives in New Zealand fluctuates between twenty and twenty five (Donley, 1986). This naturally limits a home birth with midwifery care to only a few women, and to certain areas of the country. Although only a small group actually practice as domiciliary midwives, the number of midwives supportive of autonomous practice is much larger and they have become a strong voice in the community for the return of midwives' right to independent practice.

It is evident from the literature that midwives do not present as a unified body of professionals. The first area of discord relates to the view held by some midwives that practice in a hospital is incompatible with the ideals of midwifery. Midwives who practice in hospitals have been accused of giving up their midwifery identity for that of obstetrical nurses whose primary loyalty is to standards as determined by the medical profession (Walker, 1976; Broom, 1984; Sutherland, 1984). One New Zealand midwife argues that it is impossible for midwifery to be practiced in a hospital setting because the attempt to do so results in misplaced loyalty to doctors and systems rather than to women and their babies (Donley, 1986).

The second area of discord relates to the belief among some midwives that they do not need to be nurses at all, indeed that nursing and midwifery are two distinctly different vocations. These midwives see nursing education as irrelevant for a midwife who cares for a woman going through the normal process of pregnancy. They go further, however, when they state the belief

that nurses, by virtue of their education and socialization are not as able to practice from a midwifery perspective and are more likely to impose a medical model of care on their practice. This belief has led to a movement for direct entry midwifery programmes. (Donley, 1986; Strid, 1987)

Since the passing of the 1983 Nurses Amendment Act, midwives in New Zealand can be registered to practice only if they had been previously educated as nurses. The New Zealand Nurses Association supports this position and has a policy which expresses its commitment to midwifery remaining a specialised and advanced clinical diploma in nursing (NZNA, 1984). The Save the Midwife Direct Entry Task Force, on the other hand, has expressed it's commitment to establishing a three year direct entry midwifery programme that would meet international requirements (Strid, 1987).

What one can conclude is that midwives in New Zealand are themselves divided as to whether or not nursing education should be a requirement for practicing midwifery. Nevertheless, there is general agreement about the need for greater autonomy. Midwives see themselves as being educated for and capable of independent practice, but as being constrained by social structures from practising in an independent fashion. A consequence of this is some degree of job dissatisfaction and chronic shortages of practicing midwives in some parts of New Zealand over recent years.

Whatever one's position on direct entry for midwifery education may be, there is clear agreement that the midwifery programmes currently offered in New Zealand show areas of deficiency.

Currently, midwifery education is offered as a component of an Advanced Diploma in Nursing, attained via a one year course at a Polytechnic Institution. A Government directed evaluation of the Advanced Diploma in Nursing courses supported the need for changes in the midwifery component, some of which are being implemented for the 1989 term (cited in Andrews, 1987). Concern remains, however, that clinical experience gained during the programme is neither long nor broad enough.

The World Health Organisation definition of the midwife (Donley, 1986) states that the midwife is a person who is qualified to care for women during pregnancy, labour and the postnatal period, to conduct deliveries on her

own responsibility and to care for the neonate. New Zealand midwives have adopted this definition and voice commitment to the views the definition represents. In New Zealand, as in other parts of the world, however, the issues of how a midwife should be educated and where she should practice remain debatable.

Public Perceptions of Midwifery Practice

Systematic and comprehensive research about how midwives are perceived by the general public is rare. A recent study (NZNA, 1988) conducted by a New Zealand Nurses Association committee, set up to rewrite the 1981 Maternal and Infant Nursing Policy, carried out a survey of groups involved in maternal child care. One of the purposes was to determine how these groups felt about midwifery services. While the respondents were a preselected group of people that could be assumed to have knowledge about midwifery, the findings have some relevance with regard to the public's view of midwifery. Overall, midwives were perceived positively, mostly for personal characteristics such as their warmth, caring and supportive manner, but also for their non interventionist approach to birth. In addition, the process of labour and birth was highlighted as a crucial time where midwifery care was needed. There was also, a strong plea both for knowing the attendant midwife before labour and for continuity of care. Awareness of the difficult working conditions and troubled relationships with physicians was evident as well. The survey clearly pointed out the differences between a hospital and home birth. Domiciliary midwifery services were considered excellent with consumer satisfaction very high. Satisfaction was related especially to continuity of care and the non interventionist approach to childbirth that characterize a home birth. Increased availability of home births and a return to autonomous midwifery were also identified as important issues for those participating in the survey.

The Home Birth Association in New Zealand has maintained a high community profile. In addition to such activities as a National Home Birth week, there are frequent personal accounts of birth at home that appear in both local newspapers and professional journals (Hasslacher, 1988). One could speculate that public knowledge about a domiciliary midwife's expertise and role in childbirth would be considerable. This has not, however, been researched.

The public's knowledge about a hospital midwife's expertise and role, seems less clear. North American research has shown a general lack of knowledge among the general public with regard to the education and skill of the midwife, although a favourable attitude toward midwifery exists (Davis & Katz, 1979; Kalisch, Kalisch & Clinton, 1980).

A Canadian study done by Field (1987) looked at how parents see maternity nurses. She identified an emphasis on interpersonal skills, similar to the findings of the NZNA (1988). The research showed that women desired personalized care that conveyed a feeling of respect for them as an individual, along with positive encouragement during labour and delivery. In addition, advocacy, especially in relation to doctors and intervention techniques was considered important by these women. Continuity of care, again emerged as significant to women.

The importance of womens' groups in changing the public's perceptions of birth and its management is stressed by Benner & Wrubel (1989). They suggest that it was women, nurses and childbirth educators who through dialogue provided society with some what of a cultural victory over a completely technological self understanding of childbirth.

It is important to remember that it was the impetus from childbearing women that kept the momentum for change going. What the public knows about midwifery, and how they value her contribution to their birthing experience, is critical to the existence of the midwifery profession. This is an area that requires further research.

Studies of Midwifery Practice

Much of the writing relevant to the actual practice of midwifery is to be found in the popular literature and is of two main types. The first consists of personal descriptions of midwifery practice using case studies as illustrations of various types of births and midwifery care provided.
Such material is frequently written by lay, and not nurse, midwives (Gaskin, 1980; Wellish & Root, 1987). The second type focuses on an author's personal beliefs about how midwifery should be practiced and is a kind of learning text for midwives (Flint, 1987; Kitzinger, 1987). The two types of literature are similar in their advocacy of independent practice for midwives and their condemnation of unnecessary medicalised births. In addition, in

New Zealand particularly, personal accounts of the value of a midwife's care during a home birth appear in both popular and professional literature (Hasslacher, 1988; Perry, 1988). Such literature is supportive of traditional midwifery care, but is anecdotal and not research based.

One area that has received considerable attention is the comparative safety of midwifery care and technocratic care, which is discussed in the next section. A second kind of research addresses midwifery practice in a hospital setting. Such research is beginning to indicate that skilled midwives can provide safe and appropriate care to selected women, as well as reduce the rate of invasive procedures seen as detrimental by Kitzinger (1987), Flint (1987), and other critics of high technology birthing. A recent study conducted in Australia (Griffith, 1988) is described in some detail here, not only because of its greater relevance to New Zealand, but also because the study investigated the effects of lower technology use on mothers and babies.

The study set out to test the hypothesis that sympathetic, flexible and innovative midwife attitudes and practices could help reduce the incidence of invasive procedures such as epidural analgesia, forceps delivery, vacuum extraction and cesarean section. A statistical analysis of 4565 individual birth records of one hospital was completed for an eleven year period. This time span was divided into subunits that coincided with changes in midwifery practice with regard to labour management policy in the area.

Among the changes introduced were the reduced frequency of administration of analgesic drugs and increased use of heat, massage and relaxation techniques, along with provision of regular one to one supportive care for the labouring woman. Rules determining the number of support people allowed were also made more flexible. Women in labour were encouraged to be active, upright and mobile, and to try various positions for second stage.

An innovative method of providing support for the squatting woman was introduced and at the same time parameters for second stage were reassessed in terms of the progress of labour and condition of the mother and foetus, rather than previously adhered to arbitrary time limits. Over this period, childbirth education classes were introduced and taught completely by the midwives involved in caring for childbearing women.

The results of the study demonstrated a decrease in the use of technological interventions from 24.6% in 1977, to 15.8% in 1986. At the same time the study showed that a return to traditional midwifery care for birthing women could not only decrease the use of invasive procedures but could do so with no deleterious effect on safety for either the woman or the baby. In addition, this study demonstrated that the neonates of those women, who in previous periods would have had operative interference in the course of their labour, showed no negative effects from a more traditional midwifery approach. APGAR scores, a commonly used assessment tool for describing the condition of the baby at birth, did not alter over the two periods.

This is an important study because it addresses midwifery practice in a hospital setting and because it validates specific aspects of practice. Due to it's retrospective nature, however, neither the midwives' nor the women's views with regard to these changes in practice could be identified.

With the exception of Griffith's (1988) study, there is a general lack of research that examines specific aspects of midwifery practice, leading to the danger that some of the rules and practices associated with childbirth may be based more on tradition or habit than scientific evidence of their validity. For example, research is required regarding alternative styles of pushing, positioning for second stage, and length of time considered normal to allow this stage to continue without intervention (Thompson, 1988). In addition, validating the usefulness of alternative forms of pain relief, and determining what women define as supportive care are valuable areas for research that have not been addressed either in New Zealand or overseas. What is clear is that actual studies of midwifery practice are scarce, particularly so in New Zealand. Just as absent from the literature are studies of women's subjective views of midwifery practice, based on direct experience of midwife care in institutional contexts. Such research needs to be an essential part of any movement trying to reinstate midwives as the primary caregivers in normal childbirth.

PARADIGMS FOR CARE OF BIRTHING WOMEN

There are two distinct paradigms, or professional views, evident in childbirth care. The technocratic and the midwifery paradigms are guided by quite different philosophies and they have different and significant effects on the recipients of care. Much of the conflict evident in the delivery of care to women during labour in New Zealand hospitals is related to the fact that the two paradigms exist side by side. Although some midwives do work in domiciliary practice, most work in a hospital setting, and thus, to a lesser or greater extent, within the technocratic paradigm. Not surprisingly, therefore, much of New Zealand literature is reflective of the tension existing between the two paradigms (Donley, 1986, Strid, 1987).

The technocratic paradigm, usually represented as the medical model of childbirth, is legally sanctioned and is currently in existence as the primary model within which childbirth occurs in New Zealand. Scientific medicine, maturing during the nineteenth century and until approximately World War II, gradually took over care of childbearing women. Within this paradigm, childbirth is seen as a physiological process delimited in time. Primary concern is with the mechanics of birth, or the 'passenger' the 'passageway' and the 'powers' (Arney & Neill, 1982).

It has been argued that the paradigm shift from midwifery care to technocratic care could be attributed to the ability of medicine to control the pain of childbirth (Arney & Neill, 1982). More usually, the move has been justified on the basis of advances made in obstetric technology which could decrease mortality rates (Richards, 1982; Mein-Smith, 1986). In a study of the factors which produced changes in New Zealand childbirth practices between 1920 and 1939, Mein-Smith (1986) successfully challenges the assumption that increased medical involvement in childbirth was responsible for declining perinatal, neonatal and maternal mortality rates. Feminist analysis with regard to the decline of midwifery care and the rise of obstetricians in the care of childbearing women, identifies motives of patriarchal domination and a transformation of power from women to men, as the primary reason for the paradigm shift (Oakley, 1986; Jordan, 1987).

Katz-Rothman (1982) presents one of the first systematic feminist analyses of how childbirth is 'managed' in North America. In contrasting childbirth care provided by physicians in hospital settings (technocratic model), with

traditional views of birth, Katz-Rothman coined the term 'midwifery model' to describe the essential differences between the two. She describes the essence of the midwifery model as care which is focused and centred on women in an holistic sense, and as encompassing a view of childbirth as a normal and natural process.

Historically, midwifery was practiced autonomously and childbirth was seen as a normal life process for a woman. Babies were born at home with the attendance of a midwife. The decline of midwifery care and the ascendancy of medical care has been well documented in New Zealand (Mein Smith, 1986; Donley, 1986; Donley, 1987), and in the United Kingdom and North America as well (Litoff, 1982). In New Zealand, regionalization of maternity services resulted in the closure of thirty three of the rural maternity units between 1970 and 1984 (Rosenblatt, Reinken & Shoemark, 1985). These Level One maternity hospitals provide care for women expecting normal births. Women admitted to these hospitals are attended by their own family physician and midwives. Care is characterized by low use of technology and a less formal atmosphere than would be found in larger obstetrical units. In addition, Level One hospitals exist in the woman's own community and are thus familiar and convenient to the women and their families.

Although the safety of these units for low risk women has been confirmed (Rosenblatt, et al. 1985), small maternity units continue to be closed and more New Zealand women are required to travel to a regional centre or base hospital for their maternity care. This trend away from midwifery care to increasingly technologized childbirth has been continuing in New Zealand, thus further limiting the opportunities for midwives to practice within the midwifery paradigm.

Effects of the Technocratic Model

Inherent in this model of care are beliefs that birth is a medical event, normal only in retrospect, and that advances in obstetrical technology are responsible for saving lives and should, therefore, be available for all births.

It has been suggested that after World War II, value was accorded to advances in technology and concern was primarily for the foetus and the hazardous journey of birth. Medical births were socially acceptable (Crouch & Manderson, 1987). Since the late 1950's, however, this model of childbirth has been challenged.

The dominance of the technocratic model over the midwifery model of care has led consumers, dissatisfied with their childbirth experience, to question the need for technology and to demand more participation in decisions affecting them. It was consumer dissatisfaction that eventually led to attempts to make the birthing environment more home like and family centred, to decrease, or at least to disguise, the medicalisation of the event, and to promote the notion of choice and availability of options in childbirth. The International Childbirth Education Association, a group of lay and professional people interested in childbirth, is an example of an organized movement developed in response to this perceived need for a change from technologized birthing. Chapters of ICEA exist in New Zealand.

The International Journal of Childbirth Education continues to publish literature on all aspects of pregnancy, birthing and infant care, and has been instrumental in conducting and reporting on research relevant to the 'normalizing' of childbirth. It has played a significant role in educating consumers about what was previously held as medical and therefore private knowledge. At the same time, some practices associated with a medical birth have been exposed as being for the caregivers convenience and not necessarily for reasons of safety or improved health outcomes (Haire, 1972). ICEA continues to be involved in education with regard to tools and techniques for women's use during birthing to decrease their reliance on medical intervention (Peterson, 1981; Simkin, Whalley & Keppler, 1982; Kitzinger, 1987).

At the same time as the development of obstetrical technology increased, women experiencing hospital births were given the message, at least implicitly, that the use of technology was desirable. Closure of rural maternity units reinforced the message that childbirth in a technologically sophisticated hospital was safer.

There is in the 1980's an increased awareness that childbirth within a technocratic model has significant effects on the experience of giving birth. One of the main effects of this model of care is that it limits choices for women in labour.

Some writers argue very convincingly that most obstetrical technology has been designed for the convenience of the caregiver and not for the physical or psychological comfort of women giving birth (Richards, 1982). In addition, it has been shown that the use of one intervention almost always necessitates the use of others (Klein & Westreich, 1983). The application of electronic foetal monitoring illustrates this point. Because of it's design, even external monitoring equipment requires that the woman labour in bed. On the other hand, research substantiates the value of ambulation with regard to shorter labours and an increase in spontaneous deliveries, as well as higher APGAR scores for infants born to women who had been ambulant during labour (Hodnett, 1982). Similarly, internal monitoring requires the artificial rupturing of the amniotic sac with the consequent danger of increased infection and cord prolapse. Therefore, women monitored internally, are immobilized in bed and will be given a specific period of time in which to give birth before additional interventions are employed (Olds, London & Ladewig, 1988).

Even apart from these obvious physical effects, birthing within a technocratic paradigm devalues a woman's participation in the process of birth and her knowledge about what is happening to her. The use of interventions frequently has the effect of rendering a woman a passive recipient of medical care, rather than as a person who has worked hard and successfully in giving birth. With the use of technology, caregivers take over, rather than assisting and enabling the woman to meet the challenge of birth. Jordan (1987) suggests that high technology tends to produce a hierarchical distribution of decision making power and to transform relationships to yield a dichotomy of powerful and powerless. Sandelowski (1988) describes technology as a conceptual system that emphasises fragmentation and

distance in contrast to a nursing view that values holism and connection. She argues that reproductive technology translates a woman's 'personal and felt knowledge' into visual and objective knowledge, displayed on charts and machines. Objective knowledge is taken over as part of medical diagnosis, with the consequence that women-generated knowledge becomes inferior to machine generated knowledge. Sandelowski argues that the experience of childbearing is being reinvented within a conceptual system that emphasizes separation and distance between the woman and the events of labour and birth.

The logic of Sandelowski's reasoning, strengthens the need for qualitative research of women's experiences of childbirth and the impact of technology on that experience. The research by Young (1984) goes some way toward addressing this issue. In a phenomenological reflection on the encounters the pregnant woman has with the institutions and practices of medicine, Young concludes that women find the encounter alienating in at least two ways. Firstly, because medical caregivers are associated with illness, their interventions encourage a view of pregnancy as a condition that deviates from normal health. And secondly, the manner in which the doctor retains control of knowledge related to the birth process through the use of technology is seen as devaluing the privileged position the woman has with the foetus and her own body.

Seen in this way, technology is not neutral at all, but acts in powerful ways to alter the childbirth experience for women. Midwifery practice within this model of care becomes constrained and both the midwives' and women's participation devalued.

Comparison of Midwifery and Technocratic Paradigms of Care

Midwives and women desiring a return to less interventionist birthing are in the position of having to prove that midwifery care, provided either in the home or low technology maternity units, is as safe as that guided by a technocratic paradigm.

There are a number of North American studies that have compared selected outcomes within the two paradigms of care. One such study compared the experiences of 438 women randomly assigned to either a midwife or house surgeon group for a hospital birth (Slome, Wetherbee, Daly, Christenson,

Meglen & Thiede, 1976). There were no differences in prenatal indices measured by oedema, weight gain, hypertension, urinary tract infection, or diabetes; nor were there differences in foetal outcomes measured by APGAR scores and gestational age.

Differences that were found related to an increased number of prenatal visits in the midwifery group and a greater percentage of this group experiencing spontaneous deliveries (82.6% versus 62.1%). The forceps rate was three times higher in the house surgeon group and this was true even among women who did not evidence either of the two conditions usually indicating the need for forceps, ie prolonged second stage and low birth weight.

A second study compared two matched groups of women cared for by certified nurse midwives and physicians (Beal, 1984). The midwife-managed group showed major differences from the group managed by physicians, with less frequent use of electronic foetal monitoring, intravenous fluids, and pain medication. As well, the midwife managed group had an increased incidence of spontaneous deliveries with local or no anaesthetic, and a decreased incidence of forceps, epidural analgesia and lacerations.

These studies are examples of research that has successfully challenged a major premise of the technocratic model and has demonstrated that midwifery care, characterized by little or no intervention in the birth process, can attain at least equal but usually better outcomes, when measured by the standard parameters of maternal or perinatal complications. With the evidence increasing that midwifery care is safe, midwifery clinics have been started in areas that traditionally offered only hospital or home birth care.

Data from North America suggest that midwifery clinics provide safe and less expensive care for women experiencing normal childbirth (Sharp & Lewis, 1984; Nichols, 1985; Rice, 1988). Such clinics, or alternative birthing centres, are also opening in New Zealand (Clark, 1987; Smythe, 1988).

In contrast to previously discussed research which looked at the care provided by nurse midwives, a study by Mehl, Ramiel, Leininger, Hoff, Kronenthal & Peterson, (1980) compares outcomes for a physician group and a non-nurse or lay-midwife group. In light of the current New Zealand interest in direct entry midwifery education, this study was intriguing.

A starting point for this research was the observation that data from California birth certificates demonstrated the out of hospital neonatal mortality rate as being less than that for in hospital born infants. It was suggested that interventions commonly associated with a hospital birth even in a low risk population, could account for these differences. A matching procedure was carried out to control the two populations for major medical risk factors. The first part of the study compared the midwife attended group (including all those transferred to hospital) with the physician attended group. The midwife attended sample showed fewer cases of foetal distress, postnatal haemorrhage, birth injuries, infants requiring resuscitation and finally, higher mean APGAR scores. The second part of the study compared the midwife attended group with the least interventionist of the physicians and found the only significant difference to be an increased incidence of foetal distress and problems with the placenta in the physician attended group. This study again demonstrated the safety of midwifery care and the deleterious effects of using technology on a low risk population.

Inherent in the two paradigms of care are different beliefs with regard to how one helps a woman in childbirth. The midwifery model is based on a belief in the midwife as assistant and facilitator to the woman giving birth, while in the technocratic paradigm, the expert, ie the doctor, delivers the baby.

As research evidence continues to challenge the belief that medical care for all pregnancies is necessary and desirable, it is providing a beginning impetus for a paradigm shift toward greater use of midwives as primary caregivers. The present study, undertaken in a system where the two models of care exist side by side, is an attempt to further explicate the dynamics of midwifery practice and demonstrate midwives' contribution to the wellbeing of women and their partners, even if it is likely that the two paradigms will coexist for some time to come.

SATISFACTION WITH CARE

The care paradigm within which childbirth occurs has been shown to influence the experience in many and diverse ways. Although the woman's feelings of satisfaction or dissatisfaction with her childbirth experience have not been directly related to the model of care provided, research has clearly identified some of the factors that influence her perceptions of the event.

Preparation For Childbirth

Preparation for childbirth has developed in response to a need for women to regain some control over and satisfaction with their experience of birthing. Research, attempting to identify the positive benefits of such preparation has produced conflicting results. This is not surprising when one realizes how many different types of courses are offered, as well as other factors such as the variability in the knowledge and skill of the teacher. Cogan (1980), in an extensive review of North American studies that address these issues, concluded that childbirth preparation was related to a reduced use of medication during parturition and a slightly decreased perception of pain in labour. In addition, prepared women experienced a lowered incidence of forceps delivery and a more positive attitude to the experience of childbirth. The finding that prepared women required less analgesia was confirmed in another study and linked to the fact that unmedicated women were more likely to remain aware and in control during the childbirth experience (Doering, Entwisle & Quinlan, 1980).

Discrepancy Between A woman's Expectations and Experience of Birthing

The problem of discrepancy between the woman's expectations and her actual experience of childbirth has been studied in North America and has relevance to feelings of satisfaction or dissatisfaction. In one study involving 332 women, the woman's perception of having participated in decision making emerged as the most important factor with regard to her satisfaction with the present birth, and her choices for future births (Nelson, 1982). Observations were made by the researcher regarding the rarity of a totally intervention-free birth and apparent physician control in decision making. Birch (1982) examined the congruency between participation in decision making desired and actually encountered by women during labour and birthing. In addition, the relationship between congruency and satisfaction with the birthing experience was examined. Findings revealed that for primiparous women satisfaction scores decreased as their incrongruency scores increased, but this relationship did not hold true for multiparous women. Both studies demonstrated that incrongruency between the woman's prior expectations and the actual event were common and negatively related to satisfaction.

There is some evidence to suggest that even knowledgeable women can be effectively managed by physicians and nurses in a way that reduces them to passive recipients of care, because women have been socialized to trust professionals and will ultimately yield to professional expertise and authority (McClain, 1981). Anxiety about their unborn baby, unfamiliar location and caregivers and the use of safety as a rationale for many decisions affecting childbirth contributes to this passivity.

Recent evidence indicates that some of the incongruency between expectations and experience relates to the use of interventions, and thus to dissatisfaction with the childbirth experience (Jacoby, 1987). In this study, women who reported that their labours were managed as they liked also experienced fewer interventions. Women who reported a higher number of interventions in their labour reported feeling dissatisfied with their experience. In addition, women who acknowledged feelings of depression since the birth of their baby had experienced a higher number of interventions than other women. This is an important study because it obtained women's views regarding procedures that are in frequent use and because it related the use of these interventions to women's feelings about the birth event.

While it is impossible to generalize these findings to New Zealand it is clear that giving birth in a technocratic paradigm of care increases the possibility of an interventionist birth, which for many women detracts from feelings of satisfaction with the event.

SUBJECTIVE NEEDS OF LABOURING WOMEN

Past research has pointed to the importance of the childbirth experience in a woman's life, and to the relationship between her perception of and feelings about the birthing experience, as well as her feelings about herself (Flint, 1988). Research that examines the subjective needs of labouring women has not, until the present study, been undertaken in New Zealand, and it is rare in North America. The studies that have been done identify supportive care as an important need of labouring women. One significant element of supportive care has been identified as the nurses' ability to be a sustaining presence and as well, be able to meet the woman's changing need for that presence (Shields, 1978). Supportive care has also been linked to the woman feeling safe and valued as a person (Field, 1985).

The studies that have been done validate the midwifery philosophy of one to one interaction with the birthing couple as being one of the more important aspects of care provided. They have also yielded preliminary evidence that the use of interventionist techniques, not only detracts from feelings of satisfaction, but may cause negative feelings about the birth.

Experiencing control in childbirth

The findings from a number of studies indicate that women hold a strong desire for a birthing experience in which they remain in control of the situation. Although the exact meaning of control may vary, it is frequently associated with self-mastery or retaining command over emotions and actions, ie., behaving appropriately and with dignity. Control may also be associated with the sense of continuing as an active participant in labour and being able to have some influence over events.

There are a variety of factors that influence a woman's sense of being in control. The physiological process of labour and the intensity of pain usually associated with giving birth act in significant ways to threaten self control. In addition, the doctor and midwife caring for a birthing woman exert a great deal of influence over how much control they either keep, or alternatively, cede to the woman. The amount and kind of information given, flexibility of rules, and provision of one to one care influence a woman's ability to feel in control of events. The use of interventions in the process of birth almost always interferes with a woman's sense of retaining control. (Littlefield & Adams, 1987)

North American research demonstrates that separation from partner, non participative decision making and intrusive procedures do have a negative effect on a woman's sense of control (Highley & Mercer, 1978). Researchers interested in the notion of control have developed a 'mastery model' of childbirth. In the mastery model, fear, loss of ability to participate and loss of dignity are important stressors, along with pain.

Humenick (1981) contrasts the mastery model with a pain relief model in which the relief of pain is seen as the most important aspect of care. She concludes that pain relief may seem to work for the short term, but evidence suggests that the long term benefit to women is greatest when they are able

to meet the psychological task they set for themselves and actually participate to the extent they desire. Support for the concepts embodied within the mastery model is emerging and warrants continued research (Humenick & Bugen, 1981). The increased availability and safety of pharmacological methods of pain relief has meant an increase in their use, at a time when research is beginning to identify the perception of being in control of events as more important than pain relief.

Most childbirth in New Zealand takes place in a hospital setting, often a technologically sophisticated one. The effect of the hospital environment on birthing women has not, until recently been examined. There is preliminary evidence that the multiple and unfamiliar stimuli that are a natural part of a hospital environment, negatively affect a woman's sense of control and, as well, physiological outcomes of labour (Hodnett, 1987; Hodnett & Simmons-Tropea, 1987).

PAIN IN CHILDBIRTH

Pain is a natural component of the experience of childbirth for most women. It is accepted as one of the more intense pain experiences recorded (Melzack, 1984). How pain has been regarded and treated reflects significant stages in the history of childbirth (Arney & Neill, 1982). Prior to the emergence of modern obstetrics, pain was regarded as a normal part of the momentous experience of birth and how a woman managed her pain was believed to reveal something about her character. Relief of pain in labour became part of the rationale for the rise of modern obstetrics and obliteration of pain became the norm during this phase. One of the consequences of the use of anaesthesia was the development of obstetric forceps and the necessity for episiotomies. The obstetrician replaced the midwife as primary birth attendant and women, through the use of anaesthesia and operative deliveries, were increasingly divorced from the experience of birthing. In the late 1950's the childbirth education movement, redefined pain from something to be obliterated to something to be understood and worked with. (Arney & Neill, 1982)

The obstetric view of pain as something to be obliterated and the childbirth education view that pain should be worked with, presents women with a serious dilemma as the two positions reflect very different views as to how pain should be managed.

Factors Relating To Pain in Labour

The physiological reasons for the pain associated with labour and birthing are fairly well understood, however, other factors influencing the pain experience are less well understood. Research does support the idea that primiparous women generally experience more intense pain than do multiparous women (Gaston-Johansson, Fridh, Turner-Norvell, 1988; Lowe, 1987). As well, an increased perception of pain is associated with a history of severe menstrual pain, unstable emotional feelings and unrealistic expectations about pain (Fridh, Kopare, Gaston-Johansson, Turner-Norvell, 1988). One study has shown that receiving sensory information about labour pain does result in a perception by women of experiencing less pain (Geden, Beck, Anderson, Kennish, Mueller-Heinze, 1986).

The belief that anxiety and stress result in an increased perception of pain originated with Dick-Read's work (1956) and has been substantiated in several recent North American studies (Klusman, 1975; Simkin, 1986; Hodnett & Abel, 1986; Lynn, 1987). The identification of this link between stress and pain has resulted in research that examines and confirms the positive value of providing social support to labouring women (Korr, Block, Charles, Mayering, & Meyers, 1977; Beck, Siegel, Davidson, Kormeier, Brifenstein & Hall, 1980).

Pharmacological Methods of Pain Relief

Provision of analgesic medication for labouring women is increasingly common as childbirth within a technocratic paradigm has become the norm. Birthing in an unfamiliar hospital environment, frequent use of electronic foetal monitoring, inductions and other procedures, as well as a lack of previous association with the caregiver, are factors that may be associated with the increased probability that medication will be given. Massage, immersion in a warm bath or shower and freedom to ambulate and choose various positions of comfort have not been relied upon in hospital, as primary methods for managing the pain of labour. In addition, research that examines the usefulness of these methods is rare. What one finds are personal accounts of individual caregivers' successful use of non-pharmacological techniques (Odent, 1984; Simkin, 1987; Cronk, 1987; Barnett, 1987; Duchene, 1988).

Although pharmacological pain relief methods have been used since the transfer of birthing from the home to the hospital, systematic studies of their effectiveness are rare, and one could presume that effectiveness has been taken as given.

Epidural analgesia for vaginal delivery, readily available and used in New Zealand, is arguably the most invasive, and technologically advanced form of pain relief in childbirth. It has been hailed as a great advance in modern obstetrics (Bonica, 1969). And yet, while the benefits of epidural analgesia seem to be taken as given, the overall impact of such technology is not always recognized. There is evidence, for example, that women given epidural analgesia may experience more effective pain relief than women given other forms of analgesic medication, but they also have more complications in the postnatal period. These include dizziness, backache, painful perineum and difficulty passing urine. Moreover, these women experience an increased incidence of interventions during labour (Williams, Hepburn, & McIlwaine, 1985; Crawford, 1985). The implications of these complications to the women themselves, were not addressed in these studies. Similarly, the issue of informed consent was not addressed, ie would women choose this form of pain relief if they knew of the likely sequelae.

While it is acknowledged that epidural analgesia makes a woman more dependent on her care givers and less able to work effectively with the process of birth, systematic study of the consequences and the meanings women attach to these consequences has not been undertaken, either in New Zealand or overseas. Similarly, minimal attention has been paid to the relative effectiveness of other kinds of medication, such as pethidine, and non-pharmacological pain relief methods.

The Midwife's Role in Managing Pain

Reliance by a midwife on her interpersonal skills, ability to provide supportive, one-to-one care and use of a variety of nonpharmacological techniques for the management of labour pain, was the norm when childbirth took place in the woman's home.

The transfer of childbirth to a hospital has meant that often the midwife is no longer able to provide one-to-one care, or to promote and assist with the use of massage or baths as a means of pain control. While midwives may have a good knowledge about a variety of pain relief measures, many feel constrained in their use and feel that medication is overused (Fagerhaugh & Strauss, 1977; Waldenström, 1988).

Because midwives play a crucial role in helping women cope with labour and to a certain extent can influence whether, or what type of pain relief is given, their knowledge and attitudes are important in determining women's experience of pain in labour. Research in these areas is, however, rare. The giving of information by a midwife about various alternatives with regard to the management of pain affects a woman's ability to make informed decisions with regard to her care. One overseas study shows that the nature and amount of information varies in accordance with educational and socioeconomic factors. Women who are perceived by their midwife as being less well educated and of a lower social class are given less information (Trandel-Korenchuk, 1987). Further research is clearly indicated with regard to midwives' attitudes to and knowledge about, pain management. In addition, research that looks at factors within the practice environment that affect the midwife's ability to manage pain is also necessary.

Women's Experience of Pain

The complexity of women's coping and the impact of pain relief is demonstrated in a study on women's decisions during childbirth (Christensen-Szalanski, 1984). This study shows that a woman's preferences related to pain relief vary with the passage of time, and that during certain periods a patient's expressed wishes may not be representative of her long term preferences. One month before birth the majority of women in the study indicated a preference for avoiding analgesia during childbirth, as they did again in early labour. In late labour, however, preference shifted to avoiding pain, but reverted to avoiding analgesia again at one month postnatally. Hence women's preferences one month before childbirth were the best predictors of their postnatal preferences. The researcher concluded that a decision to have pain relief during the active phase of labour may be based more on a response to the immediacy of the pain experience and not necessarily be in line with the woman's persisting values.

There is increasing support for the notion that a pain free labour and birth are not the most important factor in providing a satisfying experience for a woman (Davenport-Slack & Boylan, 1974; Humenick, 1981) and that the consequences that frequently accompany pharmacological pain relief methods may be detrimental. Rubin (1984) describes women who are given high dosages of central nervous system depressants to minimize the awareness of pain as having difficulty ascertaining the beginning or end of pain. The pain is not relieved, rather the woman's awareness of it is blurred. In addition women experience an increased and pervasive sense of anxiety because they feel less in control of themselves. Time and a woman's relationship to her body and it's position in space become distorted. (Rubin, 1984)

Pharmacological analgesia has frequently been given to labouring women on the basis that the stress associated with pain is detrimental to the foetus. Recent research is refuting that belief. Simkin (1986) puts forward the idea that the degree of stress present during a normal labour is usually harmless to the woman and beneficial to an uncompromized foetus. She argues that stress in labour exists not only because of pain but is also due to the imposition of thoughtless routines, unfamiliar personnel and technological interventions. She concludes that the use of analgesia to relieve stress may, in fact, do the opposite, particularly if interventions are the likely sequelae of such pain relief.

Women's experience of both pharmacological and non-pharmacological pain management techniques requires further research. In the past, emphasis has been on the relative safety and efficiency of a variety of pharmacological products and not on how women perceive their use. In particular, how women would balance pain relief options if they had complete information about the methods and their effects, requires investigation.

SUPPORT IN CHILDBIRTH

The childbirth education movement initiated the notion that a woman's partner could and should provide support to his labouring wife. The inclusion of partners in the process of labour and birthing occurred slowly and has been accepted in New Zealand since the early 1970's. The positive

benefits of a couple experiencing childbirth together are relatively unquestioned. Recent evidence suggests, however, that the addition of a third person available to support both partners can be helpful.

Two controlled studies that evaluated emotional support of labouring women in Guatemala found that those receiving the support of a doula (supportive lay woman) had shorter labours and fewer complications (Sosa, Kennels, Klaus, Robertson & Urrutia, 1980). A Canadian study lends further credence to the idea that the presence of a special person, known to the birthing couple, provides an additional buffer against stress (Hodnett & Osborn, 1988).

Preliminary evidence is confirming the positive benefits of support postnatally with regard to a reduction in anxiety and depression (Mercer & Ferketich, 1988). This is an important finding that has relevance to New Zealand, as postnatal depression is a significant problem (Breen, 1987).

While the value of support for birthing women is acknowledged, systematic investigation of what constitutes supportive care is missing. The use of touch has been considered a supportive tool for use with birthing women, however, research is sparse to substantiate it's value. One study confirmed the value of touch in relieving pain and stimulating uterine contractions (Hedstrom & Newton, 1986). Certainly the hospital environment and the use of technology detract from a woman's sensation of being physically connected to a warm and caring human being (Older, 1982).

CONCLUSION

Research evidence is mounting that birthing within a technocratic model of care has implications with regard to the woman's feelings of satisfaction, perception of control and sense of participation. In contrast, research is linking midwifery care with less interventionist birthing and comparable safety outcomes for low risk women. Research with regard to pain management has focused mainly on the effectiveness of pharmacological methods and not alternative ways of managing the pain associated with labour. A link between the use of analgesia and interventions in the process of birth is being made, and as well, between decreased satisfaction with the experience of childbirth and the use of interventions.

Evidence substantiates the importance of support for the labouring woman, however, gaps still exist with regard to what constitutes support and how the midwife best fulfils this role. Limitations evident in the available research include an almost exclusive reliance on the empirico-analytic approaches, the scarcity of research addressing midwifery practice in New Zealand, and the fact that minimal attention has been paid to the woman's subjective experience of her care. In addition, past research has not taken into account the place where most childbirth occurs and the factors operative in a hospital situation.

The present study addresses some of the gaps by discovering what both midwives and women see as important in their care during labour and birthing. The result is a description of midwifery practice and the experience of giving birth that integrates the experience of birthing women and midwives in a common process.

CHAPTER THREE

RESEARCH DESIGN, METHODOLOGY AND ANALYSIS

This chapter sets the context and background for the present study by providing a rationale for the chosen research design, detailing specific methodology and describing the process of data analysis.

Section one discusses the relevance of grounded theory for this study and then provides a conceptual explanation by describing the underlying conceptual framework and some of the ways in which grounded theory differs from other research designs.

Section two addresses the methodology of grounded theory as used in this study and includes a description of the setting, strategies undertaken to gain access to the field, process of participant selection and manner in which ethical considerations were addressed. Discussion of data collection methods and a profile of the study participants concludes this section.

Section three considers the analysis of data and provides an explanation of the constant comparative method using study data to illustrate the processes of coding, categorizing, memoing, reducing and the emergence of a core category. The chapter concludes by considering issues related to the credibility of grounded theory and the manner in which these were addressed in this study.

SECTION ONE: RESEARCH DESIGN

The selection of a research design is not merely a technical choice but one that reflects the researcher's view of the world of nursing practice and the relationship between client and nurse (Moccia, 1988). The qualitative paradigm is consistent with an open system view in which people exist in mutual interaction with their environment and with the belief that the subjective experience of the participants contributes to scientific knowledge.

Much of the previous research has been of a quantitative and hypothesis testing nature. It is not entirely surprising therefore, that among the gaps identified in the literature are those related to explication of the manner in which midwives care for and support women during labour and birthing, and to the actual influence of midwifery practice on their experience.

Grounded theory, has it's roots in symbolic interaction theory. It was developed by Glaser & Strauss (1967), as a rigorous and orderly research approach for the collection and analysis of qualitative data. The grounded theory method is a process by which a conceptual framework, designed to describe and explain a social process is discovered from data, systematically obtained and analysed.

> The qualitative holistic approach of grounded theory serves as a valuable heuristic tool in understanding and explaining human experience as it is lived, especially those subjective phenomena that can only be interpreted through the eyes of the beholder and those in which the whole is more than the sum of it's parts
>
> (Stern & Pyles, 1985: 3).

Grounded theory is also seen as appropriate for this study because of it's commitment to leaving open the definition of the problem and understanding the perspective of the people involved, as well as it's propensity to take a 'moving picture of processes as they vary under different conditions and interact with other variables' (Mullen & Reynolds, 1978: 281). Perhaps the most useful feature of grounded theory however, is the fact that it studies what is, that it works to explain variations in behaviour and that it predicts what can occur when conditions change (Wilson, 1985).

Symbolic interactionism, from which grounded theory is derived, is a social theory about human behaviour which focuses on the meaning of events to people in everyday life and which makes the assumption that it is in social interaction that the individual achieves a sense of self. Chenitz & Swanson (1986), describe George Mead's contribution to symbolic interactionism as that of postulating a social process whereby a biological organism develops a mind and a self and becomes through social interaction, a rational being.

It is through social interaction then, that an individual achieves a sense of self. Herbert Blummer (1969: 2) in elaborating on Mead's work depicts symbolic interactionism as resting on three premises:

* Human beings act toward things on the basis of the meanings that the things have for them.
* These meanings are derived from or arise out of interaction that one has with one's fellows.
* These meanings are handled in and modified through, an interpretive process used by the person in dealing with the things that the person encounters.

Within this framework a human being is seen as an acting organism not merely a responding one and it is the human beings ability to ' hold a concept of self... and for self interaction that is the basis for the formulation of meaning and experience in the world ' (Chenitz & Swanson, 1986: 5).

There are several implications for the conduct of research that arise out of the use of grounded theory and the underlying values of symbolic interactionism. First, for human behaviour to be understood it must be examined in interaction. Thus the setting is explored for social rules and events that illustrate shared meanings held by the people involved in the interaction. Second, that the researcher must act as participant in the world to be studied, as well as an observer of it. It is necessary for the researcher to understand behaviour as the participants understand it, to learn about their world, their interpretation of self in the interaction and to share their definitions. Finally, it is the researcher's job to translate the meanings derived from participant observation into the language of science (Chenitz & Swanson, 1986).

Stern (1980), identifies several important ways in which grounded theory differs from other research methodologies. With grounded theory, the conceptual framework is generated from the data rather than from previous studies; the researcher attempts to discover one or more dominant processes in the social scene rather than describing the unit under study; every piece of data is compared with every other piece, rather than comparing totals of indices; and finally, data collection is modified in light of

developing theory. In line with the above criteria, the present study was designed as a fieldwork study which used several different methods in order to describe and explain the experience of midwives and the women they care for during childbirth. A more detailed description of the conduct of the study and the specific methods used follows.

SECTION TWO: METHODOLOGY

The Setting for the Study

The setting chosen for this study was a base hospital in a New Zealand city where approximately 1900 births occur per year. The labour and delivery suite is staffed entirely by qualified midwives, although comprehensive nursing students do rotate through the unit at various times. There is a charge nurse present on both the morning and afternoon shifts and during the latter part of the study, a charge nurse was appointed for the night shift. There is a mix of private patients who are attended by their own doctor and public patients, attended by the house surgeon on duty at the time of delivery.

Women labour in a private room and are usually moved to a delivery theatre for the birth. The doctor is called at this time. In this hospital then, the midwife's role is primarily one of assessment and care during labour, assisting with a woman's delivery and continued assessment and care following delivery.

Access To The Field

To ensure, as far as possible, that this study was well understood and the researcher accepted into the setting, a number of steps were undertaken prior to actual initiation of data collection.

A proposal was submitted to the hospital Research and Ethics Committee and their approval received. A meeting was then held with the Head of the Department of Obstetrics and Gynaecology for the purpose of clarifying the aims and intent of the study. Meetings were also held with the Assistant Principal Nurse and the Senior Nursing Supervisor. Following these preliminary and introductory meetings, the investigator met with the two

charge nurses of the labour and delivery suite and the midwives who were available on that day. A copy of the proposal was left in the area and the charge nurses took on the responsibility of communicating with those midwives not present at the meeting.

Participant Selection

In accordance with the requirements stipulated by the Hospital's Ethics Committee, a member of the nursing staff searched the antenatal records for possible participants using the following criteria:

* women who were booked into the maternity unit with an expected date of delivery mid May to the end of July
* women who were expected to have a normal delivery
* women who had a male partner, who was expected to be present during labour and delivery
* women with a good command of the English language

Of the original thirty names selected, twelve were eliminated because their expected date of delivery conflicted with investigator's commitments out of the city. Each physician of the remaining eighteen possible participants was approached by telephone for permission to discuss the study with his or her clients. One physician refused permission to approach one client, however in all other cases, permission was granted.

The initial approach to potential participants was by telephone for the purpose of explaining the study and requirements of participation (Appendix 1). Eleven couples were visited by the investigator in order to provide further explanation of the study and to obtain informed consent. It was felt by the investigator that one of these eleven women would be caused increased stress, due to her already difficult circumstances, if included in the study. The final group thus consisted of ten couples who agreed to participate. No attempt was made to control for parity, age or any other factor, however, all were private and not public patients. Once consents were signed the involved physicians were notified by letter of their client's involvement in the study. A copy of the study proposal approved by the Hospital's Research and Ethics Committee was also included.

General approval for the study was obtained from the staff of the labour and delivery suites during the initial meeting held with them. At that time it was explained that the midwives attending during the participating couple's labour and birthing experience would also be asked to take part in an interview. The focus during this semi structured interview was to be on discussing the care the midwives provided to birthing couples, their educational and experiential background and their beliefs about midwifery practice. It was also explained that informed consent (Appendix 2) would be obtained from individual midwives at that time, and it was made clear that no one was under any obligation to participate.

Ethical Considerations

Potential Risks Associated With The Study

During all interactions with people involved in this study it was made clear that it was the investigator's intention to observe the care provided by the midwives and not to alter or interfere with events in any way. In this sense, the study carried no risks for any of the participants. However, it was recognized that the investigator's presence could result in increased stress on the part of either midwives or couples. Attempts to minimize this consisted of familarization contact prior to initiation of data collection, supportive discussions following contact and expressed willingness to postpone or terminate participation at any time should such a request be made. The investigator acknowledged that the willing participation of both midwives and couples was crucial to the success of this research project.

Women who expressed an interest in meeting the researcher and discussing the study further were visited in their homes, at a time convenient for both members of the couple. At this time informed consent forms were completed (Appendix 3). Assurances of the following safeguards were also given:

* All data would be collected and analysed by the investigator.
* Data would be secured in a safe location.
* Identifying names would be removed prior to transcription and pseudonyms used.

* Neither identifying details or participants' names would be used in any publications or reports.
* Recorded interviews would be erased following the analysis of data.

Data Collection Methods

In line with accepted views within grounded theory (Conner, 1988), every attempt was made to develop a relationship, with both midwife and couple participants, that was characterized by mutual respect and concern for the participants wellbeing. Related to this was the concern for shared power in the research process and the avoidance of imposing one's own views on the participants. And finally, the research was guided by a view of knowledge as both useful and empowering for both the researcher and the participants.

The investigator became engaged in the research process as a whole person, thus experiences as a nurse, childbirth educator and mother were shared with the participants and their questions about the investigator's experiences answered. A 'context of reciprocity' was created with free sharing of information.

Participants were asked to take part in at least three interviews following the one for consent. The first, conducted antenatally was for the purpose of gathering demographic data and exploring the couple's knowledge, thoughts, beliefs, and attitudes about labour, and the midwives role in caring for them. If either of the partners had experienced childbirth before, this was also explored. Subsequent interviews were conducted postnatally for the purpose of discussing the labour and birth event, the care provided by the midwife and the couple's experience of that care.

The primary aim was to capture information in the participant's own words. For this reason, a semi structured interview format was used. Couples themselves chose the nature and direction of the discussion for the most part, thus each couple provided information in an individual way. Unscheduled and unstructured interviews also took place with all women

participants while they were in hospital. These unscheduled interviews were not recorded on tape, but served the purpose of maintaining open communication and continued participants' involvement in the research process.

The six midwives who consented to being interviewed, participated in taped interviews lasting one and one half to two hours. The focus of these interviews was on their description of the care provided to both birthing women and support persons, their educational and experiential background, and their beliefs about midwifery practice. As with the couples, the aim was to follow their lead and encourage discussion of whatever was most important to them. All interviews were transcribed in full and formed the major part of textual data for concurrent analysis.

The cooperation of the participating couples in notifying the researcher of their pending admission to the labour and delivery suite facilitated participant observation by the investigator. All ten couples had agreed to the researcher's presence during their labour and delivery but her actual role during the experience was negotiated individually.

In reality, this role varied from a high level of physical and psychological support to the woman in labour, to only providing intermittent support to the woman's support person(s). Some information and clarification of events was provided in all cases. Such participation is in line with the grounded theory research design. It is important to state, however,that neither the researcher nor the couples felt that this resulted in any taking over of care that would normally have been provided by midwives. In fact, this was also validated with the midwives as the study progressed.

The investigator was present for nine births, missing only one couple who had their baby two weeks early, and while the researcher was out of the city. It was possible to visit this woman in hospital immediately after the birth of her baby, and her data were retained as part of the study. One of these nine couples experienced a cesarean birth, under an epidural anaesthetic. At their request, the investigator attended the cesarean birth, thus all ten couples continued participation through to the completion of the study. The result was approximately fifty hours of participant observation where the primary focus was on the actual care provided by the midwife, the context of

the situation at the time, and the woman's experience of that care. Field notes were recorded immediately after leaving the labour and delivery suite. The original intention of writing fieldnotes throughout the period of observation was abandoned as both impractical and interfering with the spontaneity of interaction between the researcher and the study participants.

Field notes were made available during the postnatal interviews if clients desired this, and were primarily used to validate the sequence of events, care provided and context of the labour and delivery area at the time. During the participant observation phase of the research, many informal discussions occurred with the midwives on duty. These talks related both to the care being provided the participants in this study and to general issues pertinent to their practice, environmental realities and professional concerns.

Women's hospital records, labour and delivery suite protocols, and informal dialogue with practicing midwives in the study setting provided additional sources of data. During the time of the study informal discussions with midwives, students of midwifery and women experiencing labour and birth were also held and provided contextual and validating information. Many of these discussions occurred in other parts of New Zealand, away from the formal study site. In addition, the researcher's personal experiences with childbirth, maternity nursing and childbirth education were considered important in sensitizing the researcher to issues existing in the realm of labour and birthing. Strauss (1986: 11), confirms the usefulness of previous experience in a variety of contexts when he states that, rather than ignoring personal experience as potentially biasing the research endeavour, it should be mined. He adds that 'the carefully managed triad of data collection, coding and memoing... serves as a genuinely explicit control over the researcher's biases'.

Profile Of Study Participants

Clients

Of the ten participating couples, three were primiparous, six were expecting their second baby and one, their fourth. Two couples were recent immigrants to New Zealand from South Africa, and had experiences of childbirth in their country of origin. One couple were of Maori background

and nine were Caucasian. Ages ranged from early 20's to mid 30's. Educational backgrounds were equally varied. All the women had completed some level of secondary education while four had attained professional qualifications. All except two couples had participated in some type of childbirth preparation classes.

Midwives

Selection of participating midwives occurred on the basis of their caring for one or more of the participating couples. In addition, any midwife working in the labour and delivery suite was invited to participate. Of the nine midwives who were involved in direct care of study participants, one left on an extended vacation and two midwives failed to respond to an invitation to be interviewed. Six midwives, therefore, participated in taped interviews lasting one and one half to two hours. Interestingly, while some of these six midwives were born in New Zealand, none had received their midwifery education in this country. One was educated in Australia and the remaining five in Britain. Ages ranged from early twenties to early fifties and years of experience in midwifery, from one year to more than twenty. Four of the participants had worked as midwives in New Zealand for longer than three years, while two, although relatively new to New Zealand midwifery had had experience overseas.

SECTION THREE: DATA ANALYSIS

The final section of this chapter examines the constant comparative method of data analysis as it was applied in this study. While data analysis is presented in linear fashion, it must be noted that the researcher worked within a matrix in which several processes were in operation at the same time.

Collection and analysis occurred simultaneously with the researcher continually checking incoming data against that which was emerging.

Because of the volume of data generated in the study, and for the purpose of clarity, antenatal, postnatal and midwifery data were at first analyzed in their separate groupings. Phases of analysis included:

* individual coding of antenatal interview transcripts for the first six couples. This served the purpose of creating initial codes and familarizing the researcher with coding methods.
* line by line analysis and coding of antenatal interview data for all ten couples.
* returning to previously coded transcripts every time a new code emerged.
* categorizing the antenatal data.
* coding of field notes as they were generated.
* coding and categorizing of data from the first six postnatal interviews.
* coding and categorizing data from all midwife interviews.
* collapsing of all couple data, ie antenatal, postnatal and field notes for six couples into conceptual categories.
* collapsing of midwifery data into conceptual categories.
* selective analysis of remaining four postnatal interviews.
* selective sampling of the literature and data.
* concept development and integration of data.
* search for a core category.

Postnatal interviews took place in conjunction with much of this analysis and were partially used to validate emerging codes and categories with participants. These were scheduled anywhere from three weeks to two months after the birth of the baby, and were organized to fit in with participant availability and energy level, as well as to allow the investigator time to work with the data. Midwife interviews were held following completion of the participant observation phase of data collection and were ongoing simultaneously with postnatal interviews involving couples, and data analysis. Opportunity was also taken at these interviews to discuss emerging themes and categories.

Memoing

Memos are the theorizing write-up of ideas about codes and their relationships and lead naturally to abstraction. (Glaser, 1978). Memoing begins as soon as data is obtained and continues throughout all phases of data collection, analysis and writing of the final report. Memos become the working documents for the research and are the primary method of recording and preserving thoughts, intuitive hunches, questions and perceptions of emerging relationships. They are thus written in a variety of locations, and range from lengthy and elaborate to brief and sketchy. As the study progresses, memos become increasingly more conceptual and analytical, a necessary step to moving beyond merely the descriptive.

Schatzman & Strauss (1973), identify three types of memos, all of which were produced in this study. Methodological memos served the purpose of reminding the investigator about issues related to methods employed in the study. For example, one related to interview timing was written early in the study. It reminded the researcher to schedule some of the postnatal and midwifery interviews early enough so they could be used to check out emerging themes and categories.

Observational memos were generated mainly from the review of field notes. Care was taken not to interpret events but to record observations about the context, or the who, what, why and where of the situation. These proved especially useful in capturing the atmosphere in the labour and delivery suite during the time that the study participants were there.

Theoretical memos, the third type identified by Schatzman & Strauss, were the ones used most predominantly in this study and served the purpose of recording the process of attempting to derive meaning from the data. Others have characterized this type of memo as a place to 'interpret, infer, hypothesize, conjecture, develop new concepts and links and to relate observations to one another' (Catanzaro, 1988: 445)

It was through an intense involvement with the data, regular memoing as thoughts occurred, and the frequent re reading of memos and data that a core category was identified.

Coding

Coding may be defined as a 'general term for conceptualizing data and includes raising questions and giving provisional answers about categories and their relations. It is a term for any product of analysis, whether a category or a relation among two or more categories' (Strauss 1986: 20). Use of the coding paradigm is recommended as being central to the procedure, in that it functions as a reminder to note conditions, interactions, strategies and consequences throughout interaction with the data.

The initial analysis involved line by line examination of the data and application of a conceptual label or code that symbolized an event or process within that slice of data. Codes were thus grounded in the data and furthermore, named or described the data from which they were derived (Stern & Pyles, 1985). In this study, open coding of couple data resulted in over forty codes; for example, 'accommodating', 'passively participating', 'taking on', 'confirming' and 'relinquishing control'. Midwife data yielded approximately thirty five codes, for example, 'relating', 'pacing', 'getting it right', and 'balancing'. Data bits pertinent to each code were transcribed onto sort sheets for easy retrievability.

Categorizing

As analysis proceeded, codes seemed to cluster together naturally into more encompassing categories. For example, one category, 'making sense', incorporated the codes of 'reflecting back', 'seeking information', 'rationalizing professional decisions' and 'confirming'. Category development served to move the analysis a further analytical step which Glaser & Strauss (1978) referred to when they commented that categories and their characteristics or properties are conceptual codes that serve as a midpoint between data and theory development.

As categories emerged, the data were re examined for the purpose of fully describing the category and it's properties and in particular to search for instances of variation within the category. It was within this orientation that category was compared with category, participant with participant, and each participant with each category, in order to search out linkages between and

among them. This process resulted in categories for couple and midwife data and served to identify important themes in both data sets.

Once these separate categories were identified it became necessary to link them together in order to characterize the concerns faced by women giving birth in hospital and the process by which midwives care for them. This was a time in the analysis process of intense reflection and the trying on of a variety of configurations to explain the data. At the same time, each category was being subjected to scrutiny for the meaningfulness of each category for each woman and midwife, and for definition and delineation of the sequences, processes and variations that comprised each category (Swanson-Kauffman, 1986).

Finally, categories were judged according to the following two criteria proposed by Catanzaro (1988), ie. the extent to which the data placed in the category fit together in a meaningful way, and the extent to which differences among the categories are clear.

Although data reduction occurred throughout the analysis, this process resulted in a more coherent picture of the most cogent categories and served as a final method of eliminating data that were intriguing and meaningful but only marginally related to the emerging theory.

Category Development

Substantive codes were grouped together to form categories and categories were analyzed from within, and for relationships between and among them. During this process it became apparent that several categories could be grouped together, or reduced to yield a concept. Selective sampling of the literature and a return to the data was necessary at this point to compare and contrast emerging concepts with previously researched concepts. It was in this way that centrality of these concepts was either confirmed or disconfirmed.

Throughout the analysis the objective was to discover the core category, the term used by Glaser & Strauss (1978) to refer to the category which accounts for most of the variation in the pattern of behaviour and which helps to integrate other categories.

Emergence Of The Core Category

Glaser & Strauss (1978), suggest that a judgement be made as to the identity of the core category based on the following criteria:

* The category must be central, that is related to as many other categories and their properties as possible.
* It must reoccur frequently in the data.
* It relates meaningfully and easily with other categories.
* It accounts for a large portion of variation in the pattern of behaviour.
* It is completely variable because of it's many and diverse relationships to other categories. Conditions vary it easily and it is readily modifiable.
* A core category is also a dimension of the problem and can be any kind of a theoretical code.
* A Basic social process (BSP) is one type of core category and is distinguished by it's identity as a process. A BSP has clear emergent stages or phases, changes and moves over time. The phases differentiate and account for variations in the problematic pattern of behaviour.
* A BSP is stable and durable over time but can also account for change over time.

As data collection continued, a lengthy process of intense reflection, close interaction with the data, conceptual mapping (Artenian, 1982), and continuing attempts to explicate main themes that described what was going on in the data, eventually resulted in the emergence of two core categories for this study. At the time of putting couple and midwife data sets together it became apparent that these core categories were a process and that generation of a conceptual framework about midwifery practice revolved around this process.

Trustworthiness Of The Study

Measures taken to ensure what Lincoln & Guba (1985) refer to as the 'trustworthiness of the study' will be outlined using the criteria of credibility, transferability, dependability and fittingness (Catanzaro, 1988; Sandelowski, 1986).

Credibility is achieved when the participants recognize the description or findings as being applicable to themselves, or when another researcher recognizes the description or interpretations as being faithful to the data. Credibility is enhanced by the investigator spending enough time in the field to be able to place the 'analysis and interpretation of data in context' and by persistent observation which increases the depth of data collected and decreases the possibility of participants 'putting on a front' (Catanzaro, 1988: 453).

In this study, measures taken to ensure that the criteria of credibility were met included:

* lengthy period of observation in the field and the presence of the investigator throughout each labour and delivery.
* the use of multiple sources of data. Midwives and couples were asked for similar kinds of information and all interview data were transcribed verbatim.
* triangulation of data collection methods. The use of interviews for both couples and midwives, participant observation, and written field notes all enhanced the precision of the research process.
* returning to the study participants at intervals throughout the process of data collection and analysis to clarify the meaning and importance of emerging codes and categories.
* the addition of followup interviews with a selection of couples and midwives following the completion of data analysis.
* investigator's previous experience with birthing couples.

Transferability, a term used to describe the likelihood of another researcher following the research design and arriving at similar conclusions, was attempted by describing the processes followed for data collection and analysis in some detail.

The criterion of dependability, met through an inquiry audit, was addressed throughout the entire research process. As this study was undertaken in partial fulfilment of a university degree the investigator met regularly with a supervisor, who in effect, audited the research process from the beginning to it's completion.

The criterion of fittingness was met partly by the methodology chosen, in that the processes followed in grounded theory ensure that the findings derive from the data. Elite bias of the study sample was avoided by having a group of participants who represented a variety of educational and occupational backgrounds (Sandelowski, 1986).

CONCLUSION

This chapter has detailed the specific methodology used in the data collection and analysis. Subsequent chapters present the findings of the study and culminate in the presentation of a grounded theory of midwifery practice and its contribution to the experience of labour and birthing in a hospital setting.

PART TWO

THE DATA

CHAPTER FOUR

THE PERSONAL AND SOCIAL SETTING FOR CHILDBIRTH

The previous chapter described the methodology used for this study and the constant comparative processes followed in the analysis of data. This chapter introduces **Part Two** of the thesis by providing a picture of the context and background for childbirth in which data collection occurred, thus providing the context within which to view the findings. The chapter blends midwives' and women's perspectives throughout, and describes the period of time a woman and her support person(s) are cared for in the labour and delivery suite. Both the midwives and the woman in labour begin the encounter with a rich personal history of knowledge, experiences, expectations and hopes that will influence what actually happens in the ensuing period. The aim of this chapter is to describe the personal and social settings created between women and their caregivers during the birthing process.

THE MIDWIFE'S HISTORY

The midwife comes to each childbirth event with a complex past or history that encompasses obvious issues such as her educational and experiential background, but that also embodies more subtle concerns as, for example, her personal beliefs and values about childbirth, her thoughts and feelings at the time, and her status and degree of comfort in the ward.

None of the participating midwives in this study received their midwifery education in New Zealand and only a minority had in fact completed their basic nursing education in this country. This is reflective of two general trends in New Zealand: a shortage of practicing midwives, making this area of nursing attractive for overseas nurses on a working vacation, and a history of controversy surrounding midwifery education in New Zealand with a resulting tendency for a significant number of New Zealand nurses to study midwifery elsewhere.

Most of the participating midwives had been educated in the United Kingdom. This emerged as a significant theme in that, these midwives had been educated and had practiced within a system that offered them a considerable degree of autonomy in the care of women experiencing normal births. The relative lack of autonomy in their current work situation was a source of some degree of job dissatisfaction. It was also evident that more recently educated midwives were perceived by those who had been midwives for a number of years as having a different philosophy about childbirth, which led to some feelings of insecurity on the part of the older midwives.

Partly as a result of high turnover in the field of midwifery, many of the practicing midwives in the labour and delivery suite were relatively new employees. This affected their perceived status in the area, not only among midwife colleagues but more significantly among medical colleagues, and in particular with obstetricians. Midwives talked about how hard it was to get to know everyone well enough to be aware of their distinct and individual ways of handling a labour and birth and that they felt as if their expertise as a professional was evaluated by doctors in the light of this contextual knowledge and not with regard to their expertise as midwives. This emerged as a significant source of stress, although it was apparent that all felt confident in their knowledge and skills related to midwifery.

A second theme apparent in the data was that midwives had distinctly different views about childbirth, not related so obviously to how one should go through the experience, but more with regard to their view of the significance of this event in a woman's life. Some midwives expressed the opinion that it was something "one just got on with", while others talked about the impact of the birthing experience on a woman's self esteem and feelings about herself as a sexual being. The philosophy that some doctors hold of providing as pain free labour as possible conflicted strongly with some midwives' views, but was seen as kind and caring by others, again demonstrating various viewpoints about aspects of practice.

It was apparent that midwives personal experiences of giving birth affected their beliefs with regard to practice, and comparing the women they looked after with how they saw themselves giving birth was common. Midwives who had not had their own babies expressed awareness of not knowing what the experience was really like and the conviction that one couldn't "really know"

unless one had had a baby. Interestingly, this lack of experiential knowledge seemed to sensitize these particular midwives to the acceptability of a range of expectations and behaviours on the women's part.

Midwives in this study addressed the concern of their own self esteem and thoughts and feelings at the time of caring for a woman and her support person(s). The relationship the midwife is expected to establish with these people is unique in several ways.

It is a relationship of intimacy, established under difficult circumstances, and there is only a short time to get it right. They expressed an acute awareness of the difficulties inherent in this situation and how important, but also how hard it was, to meet each arriving couple free of the stress of the moment. It was evident that the initial response by the woman and her support person(s) was seen as enhancing the ease with which a relationship was established, or as increasing the difficulty enormously. Midwives talked about meeting some people and sensing an instant barrier. In these few instances, they would leave the room, think about what might have gone wrong, and then go back to try again. They also acknowledged the rare times when they couldn't seem to "click" with a particular couple and the real problem of having to take over for a midwife who had been working well with a particular woman. All found it difficult to try and re-establish a relationship with a woman who had developed trust and rapport with another midwife.

THE BIRTHING WOMAN AND HER PARTNER'S HISTORY

Like the midwife, a woman comes to the childbirth event with a history. For many this is the first experience in hospital, and a first experience of labour and birth. Most will have never seen a woman in labour except on film. All, however come with feelings of vulnerability and anxiety, as well as a picture of what childbirth might be like. This picture varies greatly in terms of accuracy and completeness, but both the woman and those who accompany her have ideas about childbirth and expectations for themselves. Women frequently expressed the wish that they "would do well".

Primiparous women may be seen as especially vulnerable because of their lack of experiential knowledge about childbirth. Attendance at childbirth education classes influences their cognitive knowledge about labour and

birth, but even if they have been to classes offered by the hospital, most lack knowledge with regard to how the system works. Commonly asked questions included; when to go to the hospital, what happens when they get there, who will be there, and when will they see their doctor? In addition, women expressed concern about knowing whether or not they were in labour. Multiparous women often have more knowledge about how the system works and what labour is like, but almost always bring with them concerns and feelings about previous experience(s).

For some women these feelings were very negative. These negative feelings from past births emerged as a frequent theme and affected in profound ways, the women's expectations of themselves and of their caregivers. Some of these women went to considerable effort to prepare for the present birth and to make decisions and choices about how they wanted it to be for them. They accepted responsibility for these choices and possible consequences, and in doing so put pressure on themselves to "do their part." While it was apparent they had greater knowledge about how the system worked, they lacked awareness of their own absence of authority and ability to influence medical decisions in some significant ways. Knowledge about the role, status, and authority of the midwife was absent in both primiparous and multiparous women, but was more noticeable in the former. Along with a general lack of knowledge about midwifery, confusion existed as to the respective responsibilities of the midwife and the doctor.

Neither women themselves, nor their support person(s) described any expectations of the midwife that were related to her professional practice, leading one to question how they would cope in a context about which they seemed to be inadequately informed. Rather, they expressed a more general hope that the midwife would be friendly, warm, tell them what was going on, listen to them, and be there when they needed her. They also expressed an acute awareness of factors that might interfere with the wishes they held regarding their care and noted that the midwife might be too busy to stay with them, that someone else might need her more, or that because of circumstances they might be cared for by more than one person.

There was considerable evidence of accommodating to these circumstances and even of making excuses in advance for the care the midwife or doctor might fail to provide. The lack of clarity about the respective roles of midwife

and doctor led to some inappropriate expectations. For example, the midwife was frequently identified with the hospital and as having considerable control in the situation. At the same time these women had been socialized to believe that their doctor would see them through the whole birthing event. It may be assumed that the doctor emphasized his role, but did not provide accurate information about when he would be there and who would be caring for them throughout most of their labour.

The lack of opportunity for the midwife and people she cares for to share their histories and to learn something about each other is reflective of hospital care, whereby, antenatal visits are made to either the woman's own doctor or to the antenatal clinic at the hospital conducted by midwives who do not attend women in labour. This means that the first time the parturient woman meets the midwife who will care for her is on admission to the maternity unit. At this time the woman is likely to be in active labour and this creates less than ideal circumstances to establish a relationship.

'CARING FOR' WOMEN IN LABOUR

The 'caring for' aspects of midwifery practice may be seen as the most important or what midwifery is all about, and from an institutional point of view, these are sometimes the most valued. Thus the work of assessing labour progress, safety of mother and baby, and of following regimens as dictated by doctors or unit protocols may take priority over other aspects of care. For the midwife, depending on the business of the unit at the time, it might be all she can do to take care of these. Midwives reported that they had too many such days, and that sometimes they felt as if even basic safety care had not been done well. From the labouring woman's perspective, however, this kind of care is at best seen as necessary but not vital to their sense of wellbeing, and at worst, a nuisance, invasion of personal space, and distracting to them in the midst of coping with contractions. What was seen as valuable was the presence of the midwife, and provision of information, given in a way that enabled them to maintain a coherent picture of their experience. Thus women emphasized the salience of emotional concerns rather than the specific activities performed on or for them.

Midwives are caught in a complex web of conflicting accountability. Within the hierarchical structure of the hospital, they are first and foremost, employees

who are accountable to the hospital and the doctor whose patient they are looking after. Although educated within a different framework of practice, and philosophically holding themselves accountable to the women they care for, in practice, this is difficult to achieve. Women may look to their midwife to advocate for them, not realizing the constraints that surround midwifery practice in a hospital. In this way, midwives may be seen by women as participants in the taking of control by caregivers, and not as being relatively powerless in the hierarchy.

Many women, particularly those with previous childbirth experiences, have definite ideas about the conduct of their labour. This was expressed clearly by the women in this study, and along with individual ideas about certain aspects of care, they expressed the recognition that the midwife's approval would be required if what they wished was not 'normal policy'. The midwife who appears open to suggestions and willing to go along with the woman, was perceived to be in tune with them and relaxed about ceding control. Midwives expressed an awareness of their power over certain kinds of decisions, but generally saw themselves as less able to make decisions than women did. Women also expressed the desire for the midwife to offer suggestions and options for care, while the midwives frequently saw this as the couple's responsibility.

Methods of pain relief guided by a technocratic paradigm of care, and commonly used with previous experiences of birth, act in significant ways to diminish women's sense of control. Confinement to bed, diminished awareness of time passing and sequence of events, and the increased probability of the use of interventions frequently accompany the use of pharmacological methods of pain relief.

A need for pain relief may be determined on the basis of many factors and midwives reported it's use when they were too busy to provide one-to-one supportive care, or when a particular midwife or doctor had a personal belief in the advantages of analgesia.

Some midwives expressed awareness of the difficulty women face in making an informed choice about pain relief while in the middle of labour, while others expressed the belief that if "you offered it and they said yes," then pain relief was necessary. The way in which pain relief is offered, the information

given or withheld about consequences, and the picture a woman receives about her progress in labour, all have a profound influence on suggestibility, but were not usually discussed by midwives during research interviews.

Primiparous women seem especially vulnerable to agreeing to accept pain relief on the basis of their immediate experience of pain, while for multiparous women, the decision is more complex. Women in this study, who had had a previous epidural infusion or other forms of analgesia were adamant about not repeating the experience. They related this determination particularly to the experienced loss of control, in the sense of having things done to them, as well as to the repercussions associated with some of the interventions.

It is evident that the midwife works in an environment where there are many conflicting demands on her time and where relationships with other midwives and medical colleagues may take precedence over those with the women she cares for. There is no doubt that the individual midwife's status in her work place and with obstetrical consultants affects her ability to advocate for women, even when she is aware of their wishes for a particular kind of labour. For the delivery itself, advocacy is even more difficult as the midwife relinquishes her care giver place to the doctor.

As the first stage of labour is nearing the end, the midwife is faced with more conflicting loyalties. On the one hand she knows the woman she is caring for is close to birth and that it is important to her to have the doctor there. On the other hand, however, the midwife knows that getting the timing right from the doctor's perspective is critical. If she calls too soon, the doctor will be left to hang around waiting. If she calls too late and the doctor doesn't get there in time for the birth, she has let the woman down and the doctor is likely to be annoyed with her. Midwives expressed great difficulty managing this dilemma, and also dealing with reprimands for a "wrong" decision.

The women's need to have their own doctor actually delivering the baby was not well understood or accepted by midwives, although most acknowledged that the need exists. Women themselves, reported feeling "worried" throughout labour that their doctor "would not make it in time." Women did not see the midwife as powerless in this decision, but rather as controlling when their doctor arrived. They saw it as a lack of advocacy on the midwife's part, when the doctor rushed into theatre only just before the baby was to be

born. There was also speculation expressed that the midwife might deliberately postpone calling their doctor so that she could deliver the baby herself.

With the doctor's arrival the midwife steps back as primary care giver and assumes the role of assistant, and it is at this time that the midwife-woman relationship ends to a certain extent. The midwife is busy with the baby, records, assisting the doctor and then tidying up the delivery theatre. The doctor leaves shortly after the birth and the woman and her support person(s) are given privacy with the baby.

Although this privacy is appreciated, women reported feeling abandoned if it became prolonged and unsure what they should be doing. The midwife has duties related to washing instruments, replacing equipment, and readying the delivery theatre for the next birth. Even if there are no other patients to care for, the midwife may be absent for some time. This absence of the midwife following the birth has the unfortunate consequence of precluding closure of the relationship and of denying a woman the opportunity of talking over her labour and delivery, seeking clarification of events, and checking on how the midwife perceives her performance. The attending midwife seldom sees her again once the fourth stage is over and she is transferred to the postnatal unit. Women frequently expressed the wish that they could see their midwife again. They talked about the need to clarify elements of their birthing experience, but also expressed the belief that seeing their midwife again would make them feel more of an individual person rather than just a birthing body.

CONCLUSION

This chapter has presented some of the historical and interactional issues that provide a context in which women labour and give birth and in which midwives practice. Appreciation of this context provides a necessary backdrop for the understanding of subsequent chapters. Moving on from the overall context to a specific experience, the next chapter describes one participating couples' experience of labour and birthing. This description is provided as a record of continuity of experience, the factors that impact on that experience, and the extent to which midwifery care influences the quality of that experience.

CHAPTER FIVE

LABOUR AND BIRTH: ONE COUPLE'S EXPERIENCE

This chapter presents a descriptive account of one participant couple's labour and birthing experience. The researcher had the unique opportunity of being part of the couple's childbirth experience, incorporating time with them before, during and after the event in a way that is not done by any health professional involved in their care. In the past the continuity of care formed the basis for midwifery practice, and it still does in home birth situations. With hospital births, however, this opportunity for follow through is unusual, and what couples experience, and midwives participate in, is fragmented care from a number of different care givers.

Jill* is a professionally educated woman in her late twenties who worked during her first pregnancy five years ago and until she became pregnant for the second time. While her first pregnancy did not occur within the context of this study, and the investigator did not participate in that experience, Jill talked about this experience at length during the first interview, .and later. In addition, Jill's first experience of childbirth had a significant effect on how she approached her second labour and birthing experience and is therefore described in some detail.

FIRST EXPERIENCE OF CHILDBIRTH

Jill attended one series of childbirth education classes, read a number of books on giving birth and, as well, had taken courses in human anatomy and physiology at university. From a "theory point of view" Jill felt well prepared. In addition, she was very fit and continued her regular exercise regimen throughout her pregnancy. She does make the point, however, that she missed out on the usual tour of the labour and delivery suite and felt that this was a disadvantage because "it's not so scary if you know where to go".

---

* Throughout this report personal names used are pseudonyms.

Jill did not go into labour until some time after her expected due date, and she found the waiting hard. She did have a "show" three days before the baby was born. Those three days were uncomfortable as on the second day she experienced about five hours of false labour. She went into hospital but as she got there the labour stopped.

> as soon as I got in the doors I could smell that antiseptic smell... I got such a fright... everything stopped.
>
> (Antenatal Interview)

Jill was kept in hospital overnight, but was unable to sleep at all due to the noise and the tension she felt with being in hospital. Her doctor saw her in the morning and suggested that she go home. Once at home, labour started again and from about 12 o'clock midday until 6pm. Jill was by herself. She stated that she "must have a low threshold of pain" because she found it difficult coping with the contractions by herself. She was also wondering if "it was going to get worse or stop again".

Contractions continued and Jill and her husband finally went into the hospital at 11pm. that night. When examined, Jill's cervix was only just dilated and the midwife said to her:

> You'll be absolutely ages so you'll have to take this drug....
>
> (Antenatal Interview)

The medication, which Jill took, was some kind of sedative. The name of the drug was not given and its action not explained. Jill continued to labour all night but has virtually no recollection of events. She remembers the pain, almost falling out of bed because she was so drugged, pulling the intravenous line out about 6am. and then being wheeled down to the delivery suite.

> ...as soon as I got to that delivery suite it was like a cold blast of air hit me and I was awake... and then everything stopped again... and I tried to push but I couldn't and... they performed a forceps delivery on me.
>
> (Antenatal Interview)

There had been a changeover of staff and so another midwife was with Jill in the delivery theatre. She describes having:

> ...no feeling left, and they could do what they liked at that stage... in that respect I feel very disappointed in my first labour and delivery because I thought I was schooled up to know what was going on... I had prepared... but never had the chance to participate... so I felt as if I had no part in the birth of S. (baby). So that's why the next time I'm just hoping that I can experience a little bit more, you know, control. ...I don't want any drug like that again.
>
> (Antenatal Interview)

PLANS AND EXPECTATIONS FOR THE SECOND DELIVERY

Jill had talked with her husband about not wanting a "drug like that again". Although she stated that she did not have preconceived notions about pain relief she admitted not being keen on epidural infusion. She had known other women who had experienced a lot of problems after having an epidural analgesic . Jill also expressed the feeling that:

> ...if I can get through it... afterwards I'll feel really great... I mean you feel 100% on what you did....
>
> (Antenatal Interview)

Because of being so drugged during her first labour, Jill felt she would need a lot of help from the midwives for her present labour and delivery. She stated that she couldn't rely on her memories of her previous labour and so would need information about her progress in labour and what was happening. She expressed the hope that the midwife would be available.

> ...I would like to see her fairly frequently even if it was just for a small amount of time- to know that she is there... and hasn't deserted me... I sort of need her to say it won't be long now... and tell me where I'm at... because I think I'm capable of understanding what is happening to my body

> but I need her to let me know where I am in labour... and it would be nice to see her face once the baby is born... so you'd know you weren't just a figure passing in the night and that they did still care about what happened to you and the baby....
>
> (Antenatal Interview)

In addition, Jill noted that in her previous birth experience she could not really talk to the midwife about things because "...they go off fairly quickly (and aren't really there) for most of the time anyway".

Jill admitted to still having questions and concerns regarding her previous labour and delivery. She also expressed the hope that she would be able to participate in decisions made about her care and that she could avoid a shift changeover time as "I think I missed out because of that".

Experience of Labour and Delivery

The investigator received a phone call from Jill at 10.30am., reporting that she thought she was in labour and questioning whether she should go to hospital. After some discussion it was decided that she should.

Jill and her husband arrived at the hospital at approximately 11am. and the investigator about ten minutes after that. Jill was in active labour and her cervix was 3-4 cm. dilated. She was up walking in the room, breathing slowly and deeply throughout her contractions which were 4-5 minutes apart and lasting 45 seconds.

Between contractions Jill described her arrival at hospital. She had been greeted by a student nurse who was unsmiling, apparently not all that interested, and who seemed to Jill "very unconfident". This student could not find the foetal heart which worried Jill and her husband.

Jill stated that when the midwife came in she was able to find the foetal heart. She also examined Jill and at the same time ruptured the membranes. The chart, kept at the foot of the bed, also had the notation that the foetus was in the right occiput posterior position, but as far as the investigator could ascertain, Jill and her husband were not aware of this fact. (Field Notes).

Shortly after the investigator's arrival the midwife returned to say that she would be busy for about half an hour. Between 11.30am. and 1pm. Jill, her husband, and the investigator were alone except when lunch was brought in. Jill did not eat but continued drinking cold water and walking around in the room, leaning over the bed during contractions. She remained relaxed and talked with her husband and the investigator between contractions.

A second midwife came in at 1pm. to check Jill's blood pressure and the foetal heart rate. About 2pm. the midwife who had been with Jill initially returned. She checked the foetal heart rate and stayed through two or three contractions, which were about three minutes apart, and lasting close to a minute. Jill was now lying in bed.

At 2.30pm this midwife returned to say that she would be going off duty soon. She again examined Jill and told her that she was 6cm. dilated and that her cervix was thinning well. Jill was discouraged by the news of the 6cm. dilation. The midwife asked if Jill knew about epidurals and pethidine and Jill replied that she did not really want anything. The midwife explained the use of both and reassured Jill that neither would harm the baby. Jill asked the midwife if she thought it was going to be a long time and the midwife again offered pain relief. A notation in the field notes states that the midwife

> ...doesn't seem to be expressing much confidence in Jill's ability to handle labour with this emphasis on pain relief.
> (Field Notes)

Jill continued to refuse pain relief. The midwife then offered the nitrous oxide, suggesting that Jill think about it and left the room. Jill then turned to the investigator and asked for an opinion. When it was explained that nitrous oxide was a mixture of nitrogen and oxygen and that it would not affect her like a drug, Jill expressed a desire to try it. The midwife returned

about 2.45pm. and the nitrous oxide was started. At the same time she praised Jill's ability to relax and breathe with her contractions. During the time that the midwife was out of the room both the investigator and Jill's husband were massaging her back and applying cool cloths to her forehead. They also encouraged her to move on to her side as she indicated that her back was very painful.

After the midwife left the room Jill asked the investigator what was happening. The shift changeover was discussed as was the fact that her labour was intensifying and she would probably dilate more quickly now. Reassurance was given that she was breathing and relaxing really well.

Shortly after 3pm. Jill said that she felt like she wanted to push. The investigator left the room and interrupted the duty changeover report to ask for a midwife to come and see Jill. The afternoon midwife came in, observed Jill through three contractions and then examined her once the third contraction was over. While she observed she stroked Jill's legs which were shaking. She told Jill that :

> ...there was still a bit of a rim of cervix and not to push yet and that she would get the delivery theatre ready.
>
> (Field Notes)

When the midwife left the room, Jill asked the investigator what that meant. She also made comments like:

> Will I ever get there?...I'm making a mess of this... I'm so stupid....
>
> (Field Notes)

Both Jill's husband and the investigator reassured her that she was doing well, that this was the hardest part of labour and that it would be over soon and she would be able to start pushing. In addition, attempts to breathe with her through the contractions were made and Jill continued to retain control. During this period of about 15 minutes there were numerous interruptions with people coming in and out of the room looking for someone else.

The afternoon midwife returned about 3.20pm. and Jill's bed was pushed down to the delivery theatre. She managed to get across to the theatre table but with some difficulty as she found it really hard to move at this time. Her back was very painful and she was encouraged to turn on her side. Jill's husband was on one side of the very narrow table providing verbal reassurance because Jill was anxious about falling off the side. The midwife was busy getting the room set up and was closely observing Jill as the contractions continued. She examined Jill again and said she was fully dilated and could start to push. She then left the room.

The midwife returned and, after another few minutes in which Jill continued pushing, commented that she thought it might be "epidural time". Jill reacted immediately and reiterated to her husband that she did not want one and that she was trying hard. She again asked what was taking so long. When the midwife left the room the investigator explained to both of them that the baby was a posterior presentation and that her pushes were having to turn the baby around before he could come down.

When the midwife returned the information was provided by the investigator that Jill did not want an epidural and a discussion was held with regard to using epidural analgesia if it seemed that a forceps delivery might be needed. It was clarified for the midwife that Jill had had a previous forceps delivery without an epidural infusion and that she wanted to avoid both if at all possible. Epidural analgesia was not mentioned again.

During this time Jill continued to push. The investigator talked her through a few pushes and then Jill's husband took over. The midwife was assisting with massaging and supporting Jill's legs. The baby was descending well and the midwife was verbally encouraging Jill's efforts. The midwife had brought water into the theatre and Jill continued to take sips.

At about 3.40pm. the midwife said she could see the baby's head when Jill was pushing. She left to call the doctor who arrived just as the baby's head was being born. The midwife stepped back and the doctor cut a small episiotomy after an injection of local anaesthetic but without discussing the need for it with the couple. The baby was born at 3.50pm.

Both Jill and her husband seemed thrilled with their son and held him while the doctor stitched up the episiotomy. The doctor left once that was completed and the midwife continued to clear the theatre, complete the records and then weighed and dressed the baby.

The investigator left about 4.20pm, once Jill and her husband had their tea and were beginning to make phone calls.

Postnatal Period

A postnatal hospital visit was made two days after Jill's baby was born. At that time the progress of her labour was discussed and events were clarified. Jill commented that the first time she knew that her baby was in a posterior position was when the investigator told her during the second stage. She also talked about how after the investigator had left she had felt really alone as the midwife was gone for about half and hour and her husband also left for about 15 minutes while he went to pick up their daughter. She worried whether the baby was all right and also that she might be bleeding too much as they had to give her two injections after the delivery to slow the bleeding down. She also talked about feeling rushed when she was in the shower prior to being transferred from the delivery suite to the postnatal ward, as the midwife seemed to want her to hurry.

During the ensuing interval prior to the postnatal interview, several phone calls were made by the investigator to Jill's home. She reported that generally things were going well and she only occasionally had a question or concern.

The formal postnatal interview took place two months after the baby's birth. During this interview Jill discussed her labour and delivery in a sequential fashion. Again events, comments made, and times that things happened were clarified. Jill reported feeling

> ...more in control until the very end when I found it slipping away a bit... I felt... this is getting unbearable... but I was aware of what was going on most of the time... mind you- you were telling me what was happening... and I sort of feel as if I needed two people there all the time... and I

> know B. (husband) found it really good because he could go out and have a smoke and know that I wasn't on my own... with you (the investigator) rubbing my back I could sort of turn towards B.- because he was there seeing I didn't fall off the bed.... I definitely feel more positive about this birth.
>
> (Postnatal Home Interview)

Jill also discussed how much better she felt this time, both physically and mentally, but qualified this by stating that she still did not feel herself and did not really expect to while she was getting up at night and breast feeding. She stated that she worried about the baby, wondering if she was doing the right things to protect his health.

While discussing her midwifery care Jill stated that she felt as though she had missed out again by having more than one midwife to care for her and also due to the fact that the midwives did not stay with her much. At one stage she recalls wondering if they had forgotten her. She commented that the investigator's presence was "fantastic" and that it was the fact that she had someone else with her that got her through the labour and delivery.

> I still feel good about it (labour and delivery). I don't feel because I didn't have fantastic midwifery care that it wasn't a good experience... but I felt really special really, I suppose that I had you (the investigator) with me...
>
> (Postnatal Home Interview)

Jill attributes much of the positiveness of this birthing experience to the fact that she pushed the baby out herself:

> ...and when I was in hospital I thought about the birth a lot... and even still, at home... and I sort of talk with B. (husband) about it. Little things that would come in my mind and I would ask him about them... and that's the one thing I remember , I did push him out... No, I do feel good about it... if I have another one it might be just spot on...
>
> (Postnatal Home Interview)

CONCLUSION

This chapter has presented an outline of one couple's experience of labour and birth. The description illustrates the continuity of experience, from previous labour and birthing, through the current experience, and into the postnatal period. Two points should be noted in relation to the description. The woman and her partner see a number of health professionals during pregnancy, antenatal preparation, labour and delivery, and the postnatal period, but no one health professional participates with the couple throughout the process. And secondly, while other couples may have different stories to tell, and different experiences to describe, the themes that emerge are remarkably similar. These themes and their significance within the overall experience of pregnancy and birthing are identified and discussed in the next four chapters.

CHAPTER SIX

MAKING SENSE Of CHILDBIRTH

The experience of giving birth within the personal and social setting described in Chapters Four and Five, provide the background for development of a conceptual framework for use by midwives and birthing women. The four components that comprise the framework are presented in the following four chapters. This chapter presents the phase of *making sense*. the first phase of the process, and the first component of the framework. The framework involves the overall process of authenticating and is presented in Chapter Ten.

Making sense is conceptualized as a contemplative and deliberate course of action undertaken in order to render childbirth understandable. This phase reflects a woman's need to seek information about pregnancy and childbirth and to understand her own, or other's birthing experiences. Making sense occurs throughout childbirth and is the rationale for much of a woman's accommodating and rationalizing behaviour. For the midwife, the task of making sense recurs with each new woman she encounters. A midwife develops an historical understanding of the woman she is caring for by making sense of what each woman brings to her childbirth experience and if successful, is able to contribute to the woman's ability to understand childbirth.

To understand what making sense means, requires that one considers answers to the following questions :

(I). What do midwives and women need to make sense of?
(2). How do midwives and women accomplish this task?
(3). What are facilitators and barriers to making sense ?
(4). What are the consequences of making sense or of failing to make sense ?

MAKING SENSE FOR THE MIDWIFE

The Impact of Education and Experience

As already discussed in Chapter Four, a midwife brings to each new experience of childbirth, a composite of her own history and an educational and experiential background that provides her with a framework for practice. In addition, the midwife works within an hierarchical institution that imposes certain constraints on her practice.

For many midwives the need to make sense of practice that occurs within a technocratic paradigm is predominant. Unsuccessful attempts at understanding this aspect of practice leave midwives dissatisfied with their jobs. One midwife who had worked in New Zealand for many years, expresses it this way:

> I don't find practicing midwifery here as satisfying as I would like it to be, but whether that's because I'm older and I have a more jaded view towards people and things and oh, I don't know... it's not your own practice and you're really only working for the hospital board....
>
> (midwife A, interview no.1)

Two other midwives who had only worked in New Zealand for a short time stated:

> At first it was a real shock, I thought I could handle it as I knew before I came that midwives were not independent practitioners. I felt more fulfilled where I worked before.
>
> (midwife B, interview no.1)

> I think the doctor's attitudes toward the role of the midwife the way we're treated degrades midwives... that they're not quite capable of handling the delivery.... And also the

> woman's expectations of the midwife... I found that a lot of women said, "is my doctor coming", you know, "is he going to be here in time"... and I found that hard to comprehend.
>
> (midwife D, interview no.1)

In contrast, another midwife sees working in labour and delivery as having a certain degree of autonomy and has obviously been successful in the process of making sense of her working environment.

> I'm admitting the ladies, with them, I'm making decisions about their care, um, decisions about their pain relief, decisions about when to call their doctor... and I suppose that's the challenge, because... you have autonomy and you do your own thing.
>
> (midwife E, interview no.1)

This midwife enjoys status in the labour and delivery suite with both midwife and medical colleagues which enhances her ability to advocate for women. Her success in making sense of the context within which she works may be an influence in this.

It is also interesting that she is one of the few midwives not educated in the United Kingdom, thus may be experiencing less difficulty in accepting the system as it resembles more closely the one in which she was educated.

A midwife learns her craft, first by undergoing a formal educational programme that varies in length from one, to one and a half years. During that time she is socialized into the role and learns both overtly and covertly what it is to be a midwife and what is considered good practice. A few midwives, educated some time ago, express feelings of insecurity related to a perceived lack of knowledge about the psychology of pregnancy. One midwife comments that she had received:

> ...very little, in terms of, you know, the psychology of giving birth and what the woman needs from you in supporting her.... I think all us older ones who haven't done any further training as it were, or who've come into it and

> gradually picked it up, I suppose we've felt threatened by all the Polytech's (Polytechnic trained midwives) coming in... but some of the midwives who've trained more recently than us perhaps have got technical terms and they're used to teaching and speaking out, and ,um,they're, just perhaps more up to date.
>
> (midwife A, interview no.1)

A more recent graduate from an eighteen month midwifery programme, presents quite a different picture when she notes:

> We covered a real vast range of things... and there was a big emphasis on research and questioning. Questioning everything you do, just because it's the way it's done, is that really the way you should be doing it? They made a big thing about that ... and as I say, they were always emphasizing that you question everything that you do. Because it was alright to be done a week ago, is it alright this week, and besides that, is it alright for the person you're dealing with?
>
> (midwife C, interview no.1)

Another more recent graduate, valued her education for the variety of experiences it offered:

> It was a large hospital, it was multicultural and so I was dealing with families from all sorts of walks of life.... Vietnamese, Greeks, Italians, Turks, Malaysians... I just enjoyed the, the variety and numbers of people and the different ways they sort of coped, with birthing, and the whole involvement of their families... a variety of ways of giving birth and different attitudes.
>
> (midwife E, interview no.1)

The length and type of their midwifery education influenced these midwives in terms of their level of confidence, which in turn, influenced the status accorded them within their working environment. Their education also had important implications for how they viewed the experience of giving birth.

For example, some felt somewhat insecure and out of date, while others felt very confident about the merits of their midwifery education and had come away from it with an open and flexible attitude toward birth. One midwife, a recent graduate, and fairly new to New Zealand, believed that she had received a very "conservative training" but that her first charge nurse had had a significant impact on her practice in the way she respected women's rights. She comments that the charge nurse:

> ...respected couples wishes and put a sign on the door - 'knock before entering' - and everybody did. You knocked and you waited.
>
> (midwife B, interview no.1)

This midwife also believes that she has learned and is still learning from a variety of sources:

> You saw how other midwives practised, you tried things yourself, couples suggest things... and these are all ways I've learned.

The educational and socialization processes a midwife undertakes provide her with a framework within which to practice. This framework may be very skill oriented. On the other hand, equal value may be placed on both technical and interpersonal skills.

Midwives educated within a system that values women's wishes with regard to their labour and delivery, and that sees the midwife's role as ensuring that these wishes are met, along with maintaining safety for mother and baby, feel more confident in their current practice. In contrast, other midwives feel unsure about their ability to always meet women's needs. For example, a midwife describing an incident where she had to take over the care of a woman from another midwife comments:

> She was already beside herself and well gone beyond anyone getting eye to eye contact with her... um, and she was stroppy and nothing and no one could get through to her and I, I tend to raise my voice when I'm trying to get

> through if I don't the first time. [The midwife then described how another midwife heard the exchange and came into the room.] "Her different tone of voice seemed to impinge on her (patient) better than mine ... and so she got through and she more or less took her over and that was, I sort of felt totally inadequate.
>
> (midwife A, interview no.1)

The midwife's ability to make sense of each individual woman's needs in relation to her childbirth experience will depend heavily on her having a broad experiential knowledge base and a flexible or open framework for practice. A midwife who has seen women from different cultures give birth in many different ways, has a variety of images of childbirth and is less likely to believe in, and possibly impose one way of giving birth.

She may be more receptive to cues from a woman and thus able to pick up and act on the salience of various things from the woman's point of view rather than her own.

Factors other than a midwife's education will influence the values she holds about birth. Some midwives appeared to see their role as assisting women to retain control and this value dictated much of their actual practice. For example:

> ...and if the husband or support person isn't, you know, firm with them over breathing and whatever else, then you need to be there.... to get them in control, and to help them through it. But if the husband is helpful and is helping them to control it then you don't need to be there... and really it's a case of observing and checking that they are in control... and if they,re not then I would stay
>
> (midwife D, interview no.1)

Others may see the midwife's role as "being the advocate for that woman and her family", or as a "partnership" with the woman being cared for and valuing the contribution of the woman and her husband first. The woman is seen as:

> ...so vulnerable, ... the midwife has authority in their eyes. I never see it that way, ... that I have more power or that I'm the midwife and you do as I tell you. I just try and see it as a partnership for the length of time you're going to be with them and to do the best I can for them.
>
> (midwife B, interview no.1)

A midwife may see labour and delivery as "very significant at the time and for a long time afterward." This belief in the importance of the experience in a women's life leads her to greater efforts to make the experience as close as possible to what each woman wants. Other midwives, however, are more inclined to see childbirth as a short event, one that is painful, but which has no long term implications, since the woman is seen as fit and healthy and the labour is over in a short time. Thus some midwives seem to lack awareness of the impact that the birthing experience has on a woman and her partner, both in the short and the long term.

The Impact of Midwifes' Own Experience of Childbirth

One of the many myths surrounding childbirth relates to the perception that a midwife who has had a baby is more sympathetic and caring of women in labour. While that may be true for some midwives, there is also the danger of imposing a personal experience or agenda for birth on the women being cared for. Midwives, in this study, who had not had babies commented on how much more important it was for them to listen to what women told them. They seemed to accept each woman's experience of childbirth and way of coping with it, as valid for her. They certainly talked about how they would like to give birth but expressed the opinion that until one did give birth to a baby, there was a lot a midwife did not know. This lack of personal experiential knowledge for some midwives at least, seems to make making sense of women's experience of birth easier. Two midwives exemplify this when they state:

> I've never had a baby... I can contribute because I've looked after people who have, but I cannot tell somebody to do it in such and such a way.
>
> (midwife B, interview no.1)

> What would you know about it?" (a woman in labour talking to the midwife caring for her) "Have you had children?" And I said no... and she made me think about what I was actually doing, and I think that was another turning point. That made me sort of sit up and think, well she's got a point, a very valid point.
>
> (midwife C, interview no.1)

Both of these midwives demonstrate flexible and open attitudes about labour and delivery and seem to hold few expectations for the woman's behaviour. On the other hand, personal experience with childbirth may, for some midwives, interfere with their ability to make sense of other women's experiences. This is especially so when comparisons are made, not as a way of appreciating a range of possibilities, but as a way of defending a particular way of coping:

> I find it strange, not strange, but some women come in and they need a whole crowd of people around them, that they cannot cope unless somebody's stroking and patting them, mopping them or something. And I couldn't think of anything worse than having a whole crowd of people around me... now to me, it's something between your husband and yourself, and I don't really see why you need anyone else there.
>
> (midwife F, interview no.1)

How a midwife is educated, the values she holds in relation to women and birthing and her experiential knowledge, influence the way she makes sense for each new woman she cares for. The midwife who brings to each new encounter a flexible and open view of what giving birth should be like, seems to hold fewer expectations for behaviour, and in consequence is able to see the event through another's eyes. A midwife's ability to reflect on her beliefs and values about birth, how they were shaped, and most importantly, how they affect her practice, is necessary before she can make sense of a couple's beliefs, values and needs with regard to childbirth.

Making Sense of the Couple's Story

Having achieved a degree of awareness about her own history, a midwife is then able to move on to seeing each individual woman and her support persons through their own eyes. A belief in the value of women's knowledge is vital, and so are conditions conducive to surfacing this knowledge. The childbirth setting, as it exists in some New Zealand hospitals is not conducive to this dialogue. The midwife meets a woman for the first time, usually, when she comes to the labour and delivery suite. There are few, if any, notes relevant to her past deliveries or her present pregnancy, and the assessment done on admission is structured toward physical kinds of information. This was certainly the case in the setting used for this present study.

Interactions may also be structured in such a way as to obtain the information the midwife considers most important. Thus the midwife poses the questions she wants answered and in turn, provides the information that she wants, thereby presenting the impression that this is all the information she is interested in. Assessment and nursing care forms that emphasise the physical aspects of labour and delivery may lead to the kind of interaction which stresses only the physical aspects of care. Given the emphasis on the objective, physiological data, in the initial encounter, it is not entirely surprising that in the research interviews midwives did not discuss the necessity of knowing much about the women they care for. Only one midwife commented on how a previous birthing experience might affect the present situation and the way a woman looks at her current delivery. She noted that:

> If their first labour and delivery was terrible and they're back for a second time, then they'll be really frightened. You have to be really, really brave to come back a second time
>
> (midwife B, interview no.1)

In contrast, another midwife wondered why an antenatal class of multiparous women would have more questions than a group of women having their first child:

> I had a lot of questions that were from the groups that were second babies and they said, you know... why did that happen, what was that they did... and that was an interesting group because they were more informed.
>
> (midwife A, interview no.1)

The midwife did not relate these questions to the possible fact that many women had been left with unanswered concerns from previous births and there was little awareness that previous experiences of birth stayed with these women and were being relived as they prepared for another childbirth. This was exemplified in the care Jill received (Chapter 5).

No other midwife commented on the influence previous birth experiences could, or usually do, have on the present one. This was perhaps, more reflective of an "this is the way it is in this system and I can't change it" attitude, than a disregard for the impact of past birthing experiences. Another possible explanation for this apparent lack of interest in previous birthing experiences may be the midwife's expectation that if there was something the women wanted the midwife to know, they would tell her. In the following extract the midwife makes it clear that she sees it as the woman's responsibility to provide information and to accept responsibility for failure to do so:

> ...and you (I) don't always get it right because they (women) don't tell me everything, you know.
>
> (midwife D, interview no.1)

Although all midwives expressed concern that the women they care for experience a positive birth, there was a tendency to view each childbirth experience in isolation. One midwife, when discussing a woman leaving hospital with unanswered questions, wondered:

> ...now whether that's important or not, I'm not certain because in actual fact, the parenting takes over and the business of looking after a young baby sort of takes over so that the labour and delivery actually gets pushed into the background.
>
> (midwife E, interview no. 1)

What is evident from the study is that unless the midwife values the importance of past birthing experiences for women, she will not actively seek knowledge about these events, the effect they've had on the woman and her family, or how these left over thoughts and feelings have influenced the way she views her present situation. Without that knowledge, the midwife cannot possibly make sense of how a particular woman feels about her present childbirth experience.

In spite of their apparent disregard for previous childbirth experiences and a lack of contextual knowledge about the women entering the labour and delivery suite, all midwives expressed awareness of trying to work out what each woman needed from them in relation to this labour and delivery, with the focus being on events as they unfold:

> You're constantly assessing how they react to you and to each other and what they need from you. Subconsciously, I guess, as you go along. You realize what you should or shouldn't be doing, or where you're going wrong... how they're responding... I don't think about it a lot, but I know I do it.
>
> (midwife B, interview no.1)

What one can see in practice then, is that making sense of the couple's experience by the midwife is not altogether easy. The midwives' lack of concern for personal and historical information about women entering the labour and delivery suite and their lack of awareness regarding the validity and importance of historical knowledge of the women they care for, may be understandable in the light of the lack of value placed on it by the system. Nevertheless, these knowledge gaps increase the difficulty of making sense for the midwife enormously.

MAKING SENSE FOR CHILDBEARING COUPLES

Some women begin to make sense of childbearing before they are even pregnant. For most, however, this begins once pregnancy is suspected.

Women review the signs of pregnancy that they are experiencing and compare these with those experienced by friends, or with what they have read. This marks the beginning of the complex task of making sense that continues throughout the pregnancy, labour and delivery, puerperium, and often, for a long time after that.

In present day Western society, women are the recipients of a great many messages with regard to their responsibility for the safety of their unborn child. This responsibility is taken on seriously during pregnancy by many women, frequently resulting in quite dramatic behaviour changes with regard to nutrition, smoking and alcohol habits and exercise and rest. Additionally, women are usually provided with the opportunity to attend some type of antenatal education. The message, that an individual woman must be responsible for the health of her baby and for obtaining the preparation she requires to handle labour and delivery, is taken seriously, and some women go to extraordinary lengths to fulfil these expectations.

Furthermore, many women become aware that there are conflicting attitudes about how a labour should be conducted, and will often be the recipients of differing points of view about such issues as: should they seek birth at home, or in hospital, and if in hospital, should they seek consultant care, accept pain relief, etc.

The task women are faced with then, is to find out as much as they can about the experience of childbirth, and fit that information into a picture that makes sense for them. This task is complicated by the many and varied opinions expressed about all aspects of birthing, the difficulty inherent in taking in information that may be offered at an inappropriate level for an individual woman, and by the tendency of medical caregivers to keep knowledge private.

For a woman having her first baby, the task of making sense of what to expect for labour and delivery is very difficult. One woman in the study, after attending two different series of childbirth education classes and reading a number of books, expresses this difficulty when she comments:

> I wish there was more help and advice I could get and they could sit down and start from scratch and tell me everything. It's been hard but I've got there, lets put it that way, but there's probably a lot that I still don't know or realize what is going to happen until I find out for myself... I still feel as though I'm missing out on a lot. There's still a lot that I don't know. I wish I did know but I think it's because it's your first child and that's, ... it's probably natural that you don't know.
>
> (Amy, antenatal interview no.2)

Despite making intense efforts to gain information, this woman entered labour with a very insecure feeling about what she did or did not know. Throughout the interview it was evident that, in fact, she had a great deal of misinformation about labour.

Another woman, also pregnant for the first time, had attended only a few childbirth education classes. She stated that she found them boring. However, in listening to her talk, it was evident that in fact, there was a lot she did not understand. For example:

> ...and when they said you'd, you know, start timing contractions... and I'd be sitting there thinking, oh, they mean kicking. I didn't even know what they meant when they'd say contractions
>
> (Lisa, antenatal interview no.1)

All women expressed this need to make sense of what labour and delivery would be like:

> If you don't know what to expect, you're, you're more scared of something because you don't know what to expect.
>
> (Margaret, antenatal interview no.2)

In addition to seeking information through childbirth education classes and reading, women pregnant for the first time, talked with their mothers and with friends or relatives who had had babies. Bits of information that were confirmed by more than one source became more real. One woman, while discussing how to keep her body free of tension when in labour, described a friend who told her about how sore her jaw had been after delivery:

> ...and a friend did say about the jaw, just like you did (to investigator, during the antenatal interview), and the shoulders too and the neck.
>
> (Diane, antenatal interview no.1)

This need to make sense of labour and delivery was strong even though women went about it in different ways. One woman felt quite confident about her cognitive knowledge at least and stated:

> If it was just a theoretical exam, I could get 100%.
>
> (Margaret, antenatal interview no.2).

Most women, however, expressed the concern that whatever they knew about the process of labour and delivery, they did not know what they would be like. This was a source of worry and stress:

> I don't know what I'm going to be like,... because you don't know what you're going to be like at the time either... you know sometimes your body can act differently than what you're hoping it would act.
>
> (Diane, antenatal interview no.1)

This concern regarding what they would be like in labour, although expressed in a variety of ways, was pervasive in the data. It was evident that along with taking on responsibility for the health of their baby and preparation for labour and delivery, these women took on responsibility for

behaving appropriately during labour. For most, this meant staying in control of self and being polite to caregivers. For some this meant going through labour in accordance with preconceived ideas about how one should act:

> I'm hoping to do it myself. I usually listen pretty good. I hope I'll let the midwife tell me something, and my doctor.
> (Diane, interview no.1)

> I don't like bugging people so I'll probably not ask for help.
> (Lisa, field notes)

A woman pregnant for the first time, needs to make sense of labour and delivery, and to do that thoroughly she also needs to gain some knowledge about the system in which childbirth takes place. That this knowledge is very difficult to come by was demonstrated by all the primiparous women in the study. Surprisingly, even women who had had babies before were unsure of many aspects related to hospital care. While discussing the care one woman expected the midwife to provide, she stated that she thought the doctor would be there. When the respective roles of the doctor and midwife were clarified, she said:

> Well that's something I didn't know. I wasn't sure what he actually does, you know. I thought, well, if he's only just going to be there in the background, what's the point of him being there?
> (Amy, antenatal interview no.1)

These women lacked information related to when to go to hospital, whether or not to call their doctor, and who would be caring for them once they got there. Knowing whether or not they were in labour, and when it was appropriate to go to the hospital was another source of stress for both primiparous and multiparous women:

> I'm worried about, um, not knowing if I'm going to, when I'm in labour, that's my big fear. I just still can't see me knowing when I... everyone keeps telling me I'll know, they just laugh... you'll know that pain, they say.... I

> wonder often not about going through it, but will I know when I'm in labour? (Lisa, antenatal interview no.1)

Diane had not expressed concern antenatally about knowing when it was appropriate to go to hospital, but in discussing how she went into labour during her postnatal interview, it was evident that she had not known she was in active labour. She described waking at 3 am, thinking her "tummy was just upset". She wandered around the house, and tried to get comfortable in various positions before waking her husband. She was still unsure about what was happening and said to her husband:

> Time me because if I'm making sense, they're getting stronger. And I said, and I didn't know what was going on. they had been five minutes apart, then four minutes apart pretty strong, something like that, and then they didn't make sense, the next one was different again.

They were still uncertain and in fact, did not believe Diane was in labour, even though she was experiencing a lot of pain. She remembered thinking it was false labour and did not want to go to the hospital too soon. She describes her relief at experiencing a sign that she interpreted as permission to go to the hospital:

> I had a show, that's right. I felt something down there and I had a show, and I said to H (husband) "we're on our way. I'd better go... even if I'm not... once you've had that you'd better get to the hospital". So that made me a little bit more better in my mind. I thought, well, something is happening now and I can get going... still thought I had a lot longer to go.
>
> (Diane, postnatal hospital interview)

In fact, Diane arrived at hospital fully dilated with the baby very close to actually being born. Despite attendance at childbirth education classes, reading and confirming information with friends, Diane and her husband had difficulty making sense of what labour would be like, but in addition, like Jill (Chapter 5), they were concerned that they not arrive at hospital too early. This was not unique to primiparous women.

Women pregnant for the second or third time are often seen as knowledgeable about childbirth by their caregivers, and as requiring less information, either antenatally or during labour itself. Having been through the actual event of labour certainly confers a degree of experiential knowledge, at least in relation to what labour feels like, how the system works, and what happens to you in the hospital. Having this experiential knowledge is usually seen as positive by midwives, in that a multiparous woman should be less frightened and more aware of what is happening. What is frequently not acknowledged is the fact that women enter childbirth for a second, third or fourth time with a complex blend of thoughts and feelings about their past births.

For many women, past birth experiences remain problematic for a long time and even if a woman is successful at suppressing negative feelings after labour and delivery are over, these feelings will undoubtedly surface when pregnant again:

> ...but afterwards, especially when you're pregnant again, you start to think about it... and actually getting sort of tinges of antenatal depression, which I didn't have before, and sort of thinking, you know, what have I done? I'm having another baby, what am I doing it for? Do I really want to go through it again?
>
> (Christine, antenatal interview no.2)

All of the multiparous women in this study, spoke spontaneously and in great detail about their past birth experiences. It was obvious that they remembered them clearly, and while a few details in relation to sequence of events might be missing, their thoughts and feelings associated with the experience were vividly recalled. As was evident in Jill's previous experience of childbirth (Chapter 5), other multiparous women in this study had experienced a discrepancy between what they expected labour and their performance to be like, and what actually happened. For some this discrepancy was enormous. Whether the gap was perceived by the

individual women as large or small however, all described their attempts to make sense of their experience and their reaction to it. One woman had been planning and preparing for what she termed an active birth. She had attended three different sets of childbirth education classes, including ones centred around "active birth."

She had communicated her desire to be an active participant in her first birthing experience to her doctor:

> I went along to him and said, well I don't want an episiotomy, I don't want stirrups, and I don't want forceps, and I ended up having all of them.
>
> (Christine, antenatal interview no.1)

Things started to go wrong for Christine when her baby was born six weeks premature. She grieved for those lost weeks and the birth, itself, was not what Christine had expected. She suffered from undiagnosed postnatal depression for about one year after the birth of her baby, and relates that to how she gave birth:

> The actual birth, itself, I felt very disappointed in all of that, because, um, everything was more or less taken out of my hands, and looking back, it wasn't the type of birth I really would have wished for.... I was very depressed for weeks on end. Just about every second day would be my crying day. I spent all my time crying.
>
> (Christine, antenatal interview no.1)

During the next two years, this woman made strenuous efforts to make sense of her experience. She acknowledged that she "reflected on the birth for months." She tried talking with her doctor about all sorts of issues, such as, why the baby was premature, and why he "got stuck" if he was so small.

The relationship between an epidural infusion and the increased incidence of forceps delivery was never explained and so Christine was left believing that the reason she had to have forceps was because the "baby got stuck," which worried her during this pregnancy. She eventually concluded that her

doctor was not interested in helping her find out answers to her questions, and turned to other people who had had similar experiences as well as to books about prematurity and postnatal depression. This helped answer some of Christine's questions and every time something she had experienced was confirmed by another source, it made it easier to put aside, if not actually forget. For example, Christine described reading that it was common to be depressed after the birth of a premature baby, and the sense of relief and confirmation she felt on realizing that it was a normal reaction. The more knowledge she gleaned about the consequences of prematurity and of an interventionist birth, the more her own thoughts and feelings made sense to her. Thus, for this woman at least, one year following the birth of her baby was taken up feeling sad and depressed, and in attempting to understand her birthing experience in a way that explained why things had happened the way they did, and why she had felt as she had. Throughout, much of her explanation revolved around her own deficiencies. In relation to her forceps delivery, she said:

> If I'd had time, to you know, just sit and push for a while, and just sort of, think about it,... I might have been alright. It was sort of a very bustly experience.... And if I'd had a good night's sleep the night before... or maybe if I'd started my contractions first thing in the morning instead of later, maybe I wouldn't have been so tired.
>
> (antenatal interview no.2)

It was common for women to make sense of their childbirth experience by "taking on" responsibility for it, in much the same way they took on responsibility antenatally. Jill, while talking about being in labour with her first baby, alone at home, commented:

> I must have a low threshold of pain because I found it really difficult. B. (husband) had to go back to work and I was there on my own trying to cope with these contractions.
>
> (Jill antenatal interview no.1)

Another woman had enjoyed her first experience of labour and birth, thought her care was wonderful, and although she acknowledged her forceps delivery was probably unnecessary, she still "took on" some of the responsibility for it. At the same time she indicated clearly that she was aware of how the system worked:

> I remember feeling vaguely disgusted with myself, that I didn't have the strength... I don't know whether exercises would have changed that, or whether it was just lack of pelvic desire, because I was strong enough to push. (and later)... He (specialist) had another delivery to go to and he was a bit pushed for time... so the baby had come down, I don't know how far but it was just about out, and he decided to hurry it along with forceps.
>
> (Jocelyn, antenatal interview no.1)

Jocelyn made sense of her experience by taking on some of the responsibility for events, such as not pushing properly, and by accommodating to her doctor's needs. In addition to accommodating and taking on responsibility, women also rationalized decisions made about their care:

> It didn't worry me at all. I sympathized... if there is another lady who needs his attention too, I don't mind having that (forceps). I also know that obstetricians get paid a higher fee if they use forceps.... I had heard there were a lot of forceps used in private practice, and I'd heard that before hand so it didn't surprise me. I rationalized his action by knowing he had to get out.... He also said the babies heart was slowing down, which I think it does when it's being squashed.
>
> (Jocelyn, antenatal interview no.1)

Another woman experienced an extremely painful episiotomy. It was not until just before leaving hospital that a midwife discovered that part of the perineal tissue had been stitched to a haemorrhoid. She rationalized both the doctor's error and the midwives lack of supportive care during labour:

> ...and of course it meant that I couldn't sit down or walk.I think there was just so much to stitch up and all the flesh was rather loose, so I suppose he (doctor) didn't realize. I suppose they (midwives) don't like to interfere because they feel it's an intrusion.... or maybe it's me, but I was disappointed.

Other women also "took on" responsibility for a lack of supportive care by their midwife:

> I wondered all the time, what I had done to make her mad.
> (Amy, postnatal hospital interview)

The need to make sense for multiparous women is complex. It involves explaining why things happened as they did during labour and delivery, and why they reacted as they did. As was evident with Jill's experience (Chapter 5), the lack of continuous care giver and the fact that childbirth occurs in hospital makes the task of understanding even more difficult.

WHAT DO MIDWIVES MAKE SENSE OF AND WHAT ARE THE BARRIERS TO MAKING SENSE?

It is apparent that while making sense is important for both the midwife herself, and the care she provides, it is not an easy task. It requires time to reflect on her own education, beliefs about childbirth, and how these affect her own practice. It requires encouragement from the system she works in, and involves time for, and valuing of, the assessment and meeting of women's needs in an individualized way. Making sense for the midwife requires that one has the opportunity to develop knowledge and understanding of each woman she cares for. Both the fact that midwives meet women for the first time when they are already in labour, and that there are no systems set up whereby midwives can gain information about a woman's plans and hopes for this birth or her feelings about past births, act as barriers to making sense for the midwife.

Consequences of Making Sense

If a midwife is able to make sense of how her own beliefs and values about childbirth affect her practice, then she is able to acknowledge her own agenda for birth. Unrecognized, however, a personal agenda for birth may be imposed unthinkingly or unconsciously. If a midwife can go further and make sense of the hopes, needs, and fears of each woman she cares for, then she is able to reframe her own picture of childbirth for the individual women she cares for.

WHAT DO WOMEN MAKE SENSE OF AND WHAT ARE THE BARRIERS TO MAKING SENSE?

The task of making sense is also difficult for women. Those experiencing pregnancy and birth for the first time, have the need to gain knowledge and understanding about labour, and the system in which childbirth takes place. This is often difficult as childbirth education classes may be structured by special interest groups that provide the kind of information that they see as necessary, rather than providing information relevant to the context which the woman will experience. The fact that women come with varying degrees of knowledge about their own bodies and about labour, and the fact that classes are usually given to groups of women at one time, make it hard, if not impossible to meet individual needs. The very complexity of labour and delivery, and the variety of kinds of experiences women have, increase the difficulty.

It is rare that knowledge about the system in which childbirth occurs is acknowledged as being important, or addressed in an informative way. Sometimes, classes offered by the institution in which childbirth takes place, discuss the way things are done there. The implied message, however is that the woman must adapt, while the system stays as it is. On less frequent occasions when classes address the need for women to retain control and to fight for the right to have their wishes considered, the inherent dependency of a labouring woman is seldom acknowledged, and ways to succeed in changing the system, are not taught.

Consequences of Making Sense

Primaparous women often enter labour with a hazy and incomplete picture of what will happen. Often this picture is not just incomplete and jumbled, but inaccurate in a few or many ways. Understanding their birthing experience as it unfolds, then, is almost impossible. A consequence of not being able to make sense of labour as it unfolds is relinquishing control. Because the birthing woman does not understand what is happening to her she is unable to keep an intact picture of labour and delivery that provides her with sign posts as to her progress. She becomes increasingly vulnerable to messages given by her care givers and susceptible to relinquishing control of herself to them. Afterwards, she may deal with her feelings about relinquishing control by rationalizing professional decisions, or taking the responsibility on herself, thus leaving her with a sense of personal failure.

Multiparous women, although often seen as knowledgeable and experienced with regard to childbirth, may have an equally incomplete picture. In addition, they come to their present childbirth experience with thoughts and feelings about their last one. For many women this is problematic in that they perceive a discrepancy between what they expected childbirth to be like and the reality of it for them. Even if they have been able to make sense of this discrepancy and explain it satisfactorily to themselves, they often approach their present experience with definite plans and hopes. They may also fear that this birthing experience will somehow be like the last one. Some women will have made sense of a previous experience by taking on personal responsibility, and assigning themselves the label, "didn't cope." For these women, the present labour is even more frightening. They have determined that what went wrong last time was their fault. They have often gone to considerable trouble to prepare "better" for this labour and delivery. "Failure to cope" a second time will have severe consequences for their self esteem.

FACILITATING THE PHASE OF MAKING SENSE

For all women giving birth, making sense can be facilitated by provision of the opportunity to share histories with their midwife, and by receiving complete and accurate information about labour as it progresses, and in a way that is understandable, as was illustrated in the case of Jill (Chapter 5). The system in which birthing occurs acts as a significant barrier to the ability of women to make sense. In particular, these barriers include: the interchangability of midwives caring for women, a lack of previous association with, and knowledge about each other, and the fact that at least two different care givers (the midwife and the doctor), operating from diverse paradigms provide care.

CONCLUSION

A consequence of making sense before the onset of labour, and as it unfolds, is the ability of a woman to continually reframe her picture of what is happening, and why it is happening. Since no one can predict what kind of labour a woman will have, she has an ongoing need for updating and reframing her picture of labour as it progresses. The phase of *reframing* is discussed in the next chapter.

CHAPTER SEVEN

REFRAMING THE IMAGE OF CHILDBIRTH

Reframing is conceptualized as the process of developing a mental structure that gives shape and support to one's picture of childbirth. It involves the ability to move forward with events, continually refocusing one's image with regard to the immediate and unfolding situation. A woman's ability to reframe her picture of childbirth depends to a large extent on whether or not the midwife assists her in the process. In this chapter the need to reframe is discussed as it relates to both midwives and birthing women. The consequences of successful reframing and of failure to do so are presented at the end of the chapter.

A midwife reframes or redesigns her own picture of childbirth as she gains experience. It is possible for her to do this without necessarily making sense of how or why she does it. In this case she may be unaware of the basis for the beliefs and values she holds, and how these affect her practice. If however, she has reflected on the origins of these values, and has raised to conscious awareness what she thinks the experience of childbirth is like for women, then she knows what her personal picture of childbirth is comprised of. Some midwives have not reflected on such things, and therefore, practice from habit or on the basis of externally imposed standards.

The important task for the midwife, whether or not she has made sense of her own philosophy of birthing, is to have the ability to reframe her view of childbirth in the light of the historical understanding she gains about each woman, and with regard to the circumstances of this particular birth. Thus making sense and reframing of the woman's image of birth confers configurational and relational knowledge to the midwife.

Reframing for the midwife begins as soon as she meets the parturient woman and continues until the relationship is over. Reframing is inextricably linked with making sense and both go on simultaneously.

When a woman is admitted to labour and delivery, it is routine to assess the physiological status of her labour. The time a midwife has available for reframing obviously depends to some extent on the results of that assessment.

In the following example from the study the time was clearly limited. The midwife heard the door bell ring at 6am (the outside door to the maternity annex is locked at night). She was not expecting the ring as she had not received a telephone call saying that anyone was coming in and so lacked even basic information with which to assess this couple. She greeted a man at the door, who told her his wife was in the car and "couldn't come out." The midwife assessed Diane's labour quickly, just by watching her for a minute, and knew that she would have to get her inside very quickly. She kept repeating to her, " you're safe now, you're safe here with me." The midwife tried talking with Diane, but quickly realized Diane could not hear her, or at least could not respond to the directions being given. The midwife described how she realized that Diane was listening to her partner, and so started to give directions and encouragement to Diane through him. Diane illustrates the phase of reframing when she recalled the midwife giving her directions with regard to pushing, but also interpreted the midwife's comments in terms of an earlier explanation provided by the investigator:

> I remembered what you (investigator) had said about the scivvy (turtle neck sweater, and pulling it over one's head), and then I remembered all the different bits, and I must have started thinking straight.

Diane's baby was born about ten minutes after arriving at the hospital. Knowing that Diane would be shocked, both because the birth was well before her expected due date, and also because of the speed of the labour, the midwife spent time talking with both Diane and her partner before they left the delivery room area. She then saw Diane twice on the postnatal ward before discharge and telephoned her at home.

In explaining these actions during the research interview, this midwife talked about knowing that Diane would have a very fragmented and incomplete memory of her birthing experience and that she would have many questions about what had happened and why. Although it was routine for this

particular midwife to visit women after the birth of their baby, she made more of an effort than usual to maintain contact because of her recognition that this first birthing experience would not have gone as Diane would have expected.

By providing Diane with more than one opportunity to clarify events and ask questions, the midwife increased the likelihood of this couple understanding what had happened during their birthing experience. There was no time to assist them in the phases of making sense and reframing during the actual birthing event, but her contact afterward assisted them in reconstructing these phases retrospectively.

The midwives' ability to make sense and reframe under hectic circumstances is well illustrated by the comments of Diane's partner:

> She was good (midwife) because she, um, tried talking to Diane, and in the end, she started talking to me, and I would talk to Diane... kind of relaying messages. It was the only way to really work it.
>
> I (Diane) remembered voices, but not making sense, but your voice (to R.) and what you said, I could make sense.
>
> (Diane, postnatal home interview)

If a midwife admits a woman who is in early labour, she is provided with more opportunity to start developing a sense of historical understanding, as well as an image of what this particular woman's picture of childbirth is like. For various reasons, however this does not usually happen.

A common myth that midwives seem to hold is that if women have attended childbirth education classes then they have knowledge about the birth process. Often midwives act on the basis of that assumption and do not assess individual women's understanding. They therefore provide information that they see as relevant and understandable, without seeing the need to check how the information they have given fits in with what is already known. Before reframing for an individual woman can occur, the midwife must assess a woman's current knowledge about and image of birth. Thus finding out how she feels about previous labours, what she

understands about labour and the terms used, and what she thinks this labour might be like is crucial. In addition, the midwife must develop a sense of what is most salient for this woman, and what she expects both from herself and her care givers. If the midwife is able to gain an understanding of the meaning of this experience for a woman, she is able to start out caring for her knowing what is most important to her and what goals the midwife needs to accomplish with her care.

For many women, as it was for Jill (Chapter 5), participating actively in the process of labour and birthing is of most concern. If the midwife caring for Jill during her second experience of childbirth had the benefit of knowing about, and understanding the significance of her previous experience, she would have been able to frame a picture of birthing that coincided with that of Jill's. Without benefit of the opportunity to share information, thoughts and feelings, midwives must rely on picking up cues from women as labour progresses. Many times this is difficult as women, in the unfamiliar and often frightening environment of the hospital, feel obligated to take on what they consider appropriate patient behaviour. This frequently consists of being passive, agreeable, and subjugating their own needs to what they see as the more important needs of the institution. Thus a midwife may not be given 'real' cues as to what women are feeling and what they require in care.

Because Jill's labour occurred during the day, and on a very busy day in the area, she missed out on both frequent midwife contact and care from the same midwife. It may also be that the midwives were unable to sense her need for supportive, one to one care, as she presents herself as very controlled and confident. This lack of presence and support from a midwife meant that Jill relied on her husband and the investigator for assistance in making sense and reframing as labour progressed. The historical understanding already developed and continuity of presence, made this possible.

Midwives face the difficult task of reframing their own image of childbirth for each woman they care for. If successful, they are able to develop what Benner (1988) refers to as 'salience understanding', what it is that is most important to a particular woman. Often what the midwife sees as most important is not what a woman values for her care in labour. It is through making sense and reframing that a midwife merges her view with that of the

women she cares for. The opportunity to make sense for each individual woman is crucial to her ability to reframe an image of childbirth that is at least in part congruent with that of the woman she is caring for.

As labour progresses, a midwife needs time to be with the woman, opportunity to share information, and to receive feedback about care given. In this way, the midwife is able to continually update her image of what is most salient to a woman as the circumstances of her labour change. The barriers to reframing are similar to those for making sense , ie. lack of historical understanding about the women being cared for, and lack of time to stay with one woman throughout. In addition, the unfamiliarity of the hospital situation, makes it difficult for women to provide meaningful cues as to their real needs and wishes.

In the following extract, the midwife shows clearly her willingness and her ability to reframe her image of how analgesia should be used in accordance with individual women's views.

> I take them as they are and how they respond to you. If someone comes in and wants to do their own thing, with no pain relief... that's fair enough. I tell them what's available and let them know it's their decision, and they can change that decision any time.... If somebody else comes in and wants pain relief right away... that's their right too. It's as wrong for me to push pain relief as it is to withold it.
>
> (Midwife B, interview no.1)

Other midwives, however, believe that they:

> ...have to persuade some people that look, you really need something. I think if somebody really wants to be without and they're sufficiently psyched up to do without sedation, and they can, good on them. I mean I'm not going to push sedation on anybody if they don't want it. But I think some people have got so psyched up that... I'm not going to have sedation, and they don't know what labours about, and they don't know how they're going to

> feel. ...and then they feel ashamed of themselves if they have to admit that it's too much for them. And if they say when they come in... well I don't want any sedation, I say, well that's fine.... But you know, there's a time when you may feel you need something, now don't be a martyr and don't feel ashamed if you find you can't cope.
>
> (Midwife F, interview no.1)

By relating the need for analgesia to a woman's inability to cope, this midwife frames the need for pain relief around her own beliefs and values. When this is related to a particular woman's experience, it shows how the midwife's views can reframe the experience in a negative way. For example, Margaret, pregnant for the second time, believes in the use of analgesia, and has no intention of suffering pain if she does not need to. She sees the use of analgesia as pragmatic and states:

> It's there and I would take it if I'd had surgery, why not for a baby?
>
> (Margaret, antenatal interview no.2)

She does not relate the use of analgesia to an inability to cope at all, however, given that message by her midwife might cause Margaret to question her performance in childbirth, in a way that she would not have done without such a comment.

Another woman had the fortunate experience of having the same midwife care for her during the birth of both of her babies. Even with her first birth, she commented:

> It seemed like she was , she was part of the family with us... it was as if you'd known her for years... she always let you know what was going on.
>
> (Faye, postnatal home interview)

Faye went on to say that when the midwife greeted them at the door when they arrived at labour and delivery door the second time, they could not believe their luck.

> She had a big grin, and we had a big grin. She remembered the whole three of us... and we remembered her, you know it was a really neat feeling. No, it was good seeing her face there.

A past history with this couple enabled the midwife to make sense and reframe quickly, and she was able to provide both Faye and her partner with information as to how this labour was different than last, and what Faye needed to do in relation to pushing, for example. Faye's previous labour and birth had been a forceps delivery with an epidural infusion. Throughout, the midwife helped keep Faye's image of this experience coherent and linked with her previous labour and birth. This time Faye proceeded on to normal birth, without the use of either epidural infusion or forceps.

Another midwife describes how she assists couples to reframe as things occur during labour and delivery that are unexpected, or that the woman has wished to avoid.

> I think how a woman feels about her birthing experience has to do with the midwife who has looked after her. And for women who have epidurals and forceps... the midwife has to do a lot of positive empowering, so that those women feel good that they've produced a live healthy baby.

She goes on to say that when things are not going according to plan, then the midwife must provide them with information so that they are aware of how and why the situation has changed.

> ...and once again, you need to put it so that the people have the decision for themselves... and that they are still saying... oh, it's not going this way, I've got the power to make a choice in this.
>
> (Midwife E, interview no.1)

Midwives who do not recognize the need to reframe, or who are not provided with the means and opportunity to do so, may impose their own view of childbirth on women. If this is successful, and it usually is, the

woman is left to deal with unresolved feelings and concerns related to birthing on her own, and usually after the birth of her baby.

One midwife commented on how she can manipulate women if necessary:

> You can find out what their thoughts are , but you can wriggle them around to your thinking, if you have to change them for some reason. It's all in the way you talk.
> (Midwife F, interview no.1)

Another common consequence of failing to reframe may be for the midwife to become judgemental, as exemplified in this statement:

> ...just couldn't stand on her own two feet at all, she wasn't independent in the least... but a lot of girls are totally inadequate in coping with themselves, I think.
> (Midwife A, interview no.1)

Midwives who manipulate or impose judgements on women, fail to make sense and reframe for each woman they care for, and are, therefore, unable to truly be 'with women' in childbirth.

CONCLUSION

Women rely on their midwife to assist them in the reframing of their image of labour and birth as it occurs. To do so, the midwife is required to assess and develop her ideas about what each woman knows about childbirth and what is most important to her. Then as labour progresses, this picture must be updated by the midwife in the light of changing circumstances for each woman. Communicating with each woman in a way that keeps her picture whole, coherent, and intact is crucial to reframing for her. It is particularly important that the midwife adjusts to changing circumstances during labour, and to changing expectations each woman holds in relation both to the labour and to herself. While a midwife often cannot control what occurs during labour and delivery, she can assist in clarifying what is happening, and why it is happening, in such a way as to provide acceptable explanations for women. It is in this way that she continues to help women make sense and reframe throughout the experience of childbirth.

CHAPTER EIGHT

BALANCING BY MIDWIVES AND WOMEN DURING LABOUR AND DELIVERY

Balancing is a process of weighing factors against each other in terms of their significance and relative priorities, and then making choices about one's actions. As with making sense and reframing, balancing goes on for both midwives and women before they come together during labour, and throughout the time they interact. A woman is required to balance her own needs with those of the baby, her expectations of herself with other's expectations of her, and the reality of this particular labour compared to the vision she had at it's beginning. If a woman, with the help of a midwife is making sense and reframing her image of labour and birth as it unfolds, then there is less need to expend energy on balancing. In any case, a labouring woman can exert very little control over the phase of balancing.

Indeed, the woman relies strongly on how the midwife caring for her balances the constraints that exist in her own working situation, and priorities with regard to which relationships are most valued. In addition, a midwife must balance the relative advantages and disadvantages of either expanding or contracting boundaries in her care of labouring women. Most women are quite unaware of the complexity of issues that each midwife must balance throughout the time of caring for them.

BALANCING BY THE LABOURING WOMAN

It is frequently believed that women do balance the needs of their unborn child with their own. While such balancing is usually evident antenatally, it is not so apparent during labour and delivery. The evidence from the study strongly suggests that the immediacy of the labouring experience and in particular, the pain associated with it, takes primacy and overwhelms women, to the extent that other concerns become secondary. Certainly, the turning inward, that is so noticeable among labouring women is not conducive to their ability to balance their needs against those of their baby. Then too, women may believe that if, for example, analgesia is offered by

their care giver, it must be safe for their baby. Interventions are commonly advised on the basis of safety for the baby and accepted by women as inevitable for that reason. After labour and delivery are over, women do frequently make sense by rationalizing these unanticipated aspects of their birthing experience as being necessary for the safety of their baby, but still wonder if there was something they could have done to avoid the necessity for such interventions.

Women come into labour with a set of expectations for themselves that relate to being good patients, able to behave according to their own, but also others' expectations. For one woman, the concern was to behave acceptably with regards to her language, and she expressed the hope that she "wouldn't swear too much". Others hoped that they would listen and be able to do what health professionals expected of them. At the same time women also wanted to give birth in an active way, labouring and expending energy, as if to earn the right to enjoy the reward of a baby at the end. As one woman expressed it:

> ...you have a good fight for it and you see the reward afterward, and it's all worth it.
>
> (Diane, antenatal interview no.1)

This need to participate in giving birth, to be worked with and not done to, was very strongly expressed, and it became an expectation that women put on themselves, even though decisions were made by others which deprived some of the women from full and active participation in their labour and birthing. Where this had happened in a previous labour, it left a lasting memory of passivity and alienation, well illustrated by Jill (Chapter 5):

> I feel as though I had nothing to do with the labour. I wasn't with it. They performed a forceps delivery on me... and I felt like, um, like a cork being popped, I suppose.
>
> (Jill, antenatal interview no.1)

Women who had relinquished control in previous childbirth experiences, took upon themselves the responsibility for that happening and came into labour with the expectation that they would not let it happen again. Multiparous women that had received analgesia in a previous labour,

rejected it's use for this birthing experience. This was especially evident with regard to the use of epidural analgesia. Women who had received this form of pain relief in previous labours, were determined not to repeat the experience. For these women there was nothing to balance in terms of pain relief.

In retrospect, they could see the effects of analgesia only in a negative light, either because it failed to provide the promised relief of pain, or more frequently, as in Jill's case, because it reduced their ability to participate actively in what was happening. It was not so much that they felt they had failed because of needing pain relief, but more that the consequences of epidural analgesia were unacceptable to them. The following statement may use atypically strong language, but the sentiments are shared by others:

> Once you've had an epidural, you're buggered because you don't know what the hell's happening.
>
> (Faye, postnatal home interview)

Most women reported the initiation of the epidural infusion as stressful and painful. During this time they not only continued to have pain, but were deprived of whatever coping strategies they had been using up to that point (eg., walking, having their back rubbed). Such an experience is not easily forgotten:

> I got a person to give me an epidural that hadn't done one before, I think, and it didn't work. He spent an hour grilling in my spine, trying to get an epidural in... and having to lie still for him to do it, ... and all he could say was, Oh, it's because you're too thick, I can't get it in.
>
> (Allison, antenatal interview no.2)

It was evident, too, that the decision to accept pain relief was frequently based on inadequate information about progress in labour and about the consequences of epidural infusion. The woman who had experienced a great deal of pain during the insertion of the epidural catheter also experienced pain for some days afterward. In her words:

> I couldn't lie on my back for two weeks after, it was so bruised.
>
> (Allison, antenatal interview no.2)

Another woman could not void once the urinary catheter was removed, and so was recatheterized for forty eight hours. By the time this catheter was removed she had contracted a urinary tract infection that took well over three weeks to cure.

Some women felt that they were victims of inaccurate information, presented in such a way as to undermine their confidence. One woman, for example, agreed to an epidural infusion when a doctor, already in the labour ward to start an epidural on another patient, put his head through the door and said:

> Oh, she's only three centimetres dilated (from looking at the chart at the foot of her bed), are you in a little bit of pain, dear? Do you want something?

The woman recalls thinking to herself and responding:

> My God, if this is only three centimetres by the time I get to ten I'm going to be a cot case. So I said, yes please.
>
> (Jessica, antenatal interview no.2)

As it turned out, by the time the midwife got the equipment organized, the woman was pushing, and her baby was born before they could get her to the delivery room. The noted, 3 cm dilation was the woman's admission record but in communicating out dated information, the doctor in fact undermined this woman's confidence in her ability to handle the rest of her labour.

Inadequate, inaccurate information, and the manner in which it is presented can affect a woman's ability to make a sound decision about pain relief medication. In the case of epidural infusion, however, the most damaging consequence seems to be the loss of control women experience, in the way things are done to them. Insertion of a urinary catheter, application of a monitor, often internally, and the frequent use of forceps to deliver the baby are all seen as unacceptable consequences from a woman's point of view. Thus in balancing the benefits of a pain-free labour with the consequent

perception of being passively delivered, many women, choose to eliminate analgesia. For the eight women in this study who made the decision not to accept any analgesia this time, the resolve remained firm throughout the course of labour. Postnatally, all expressed very positive feelings about staying in control and the correctness of their decision not to accept offers of analgesia.

Primiparous women undertook a great deal of balancing work regarding analgesia, before the onset of their labour. Often the information received in childbirth education classes and from friends and relatives influenced their thinking. There was no doubt that societal pressure to give birth naturally and without medication was communicated, causing some degree of stress for women who had not experienced childbirth before. One can see the balancing going on, as the pregnancy nears its completion, and as uncertainty remains, in spite of all the information and opinions received:

> Well I didn't want to take any drugs what so ever... but now I've woken up to it a little bit more, and thought that perhaps I might need a little bit. Everyone tells me I shouldn't take anything for the pain, um, but I don't know... not sure how I'll be...
>
> (Amy, antenatal interview no.1)

> ..I haven't been there or gone through... so I don't really know how I'll be.
>
> (Lisa, antenatal interview no.1)

Another woman commenting on seeing coloured slides of women in childbirth, including one woman having a 'natural' birth stated:

> ...and oh, she went through what everyone would go through and then she was rewarded afterward, and the sigh of relief that was on her face, and the baby,... and she seemed more happy than the one who was knocked out with drugs... At the time, I might regret what I've said now, and think... why didn't I take the easy way out.
>
> (Diane, antenatal interview no.1)

What is evident is that while women expressed the hope that they could have their baby without medication, they also expressed strong awareness of not knowing what labour was really like, or how they would cope with it. Anxiety related to how they would cope with the pain of labour was much more prominent than awareness of the various factors that influence the length and type of labour a woman has. For these women, concern revolved around their performance and how they would handle pain.

It is not surprising, therefore, that sometimes during labour, a woman *balances* the very real pain she is in, with the knowledge that pain relief is available, and chooses analgesia. Often she is not helped to try alternative ways of relieving pain, nor is she provided with enough information to make an informed decision. Even more damaging, perhaps, is the conflict that sometimes occurs between a woman and her partner regarding different choices. He may reflect back to an antenatal decision not to take any medication for the pain, while she, caught up in the intensity of the pain experience, makes her decision to accept analgesia. This situation is more likely to occur if a midwife has not helped the couple in making sense and reframing have not been occurring during labour.

In addition to the work of balancing the advantages and disadvantages of accepting pain relief, a woman is frequently put in the position by the midwife of having to balance whether or not it is appropriate to call her. On admission, a midwife instructs the women how to use the call bell but not necessarily when to use it, and then, due to other commitments, the midwife usually moves in and out of the labour room. This presents a dilemma for labouring women, in that they must balance their need for the midwife against the unknown. The assumption is often made by women that the midwife must be busy with something more important, or she would be with them. They are reluctant to call her, thus increasing their stress.

How women balance choices about their level of participation in labour, whether or not to use analgesia, and the appropriateness of calling their midwife to be with them, depends strongly on the quality of information a woman gains about labour antenatally. These decisions are also extremely dependent on the amount and quality of making sense and reframing that occurs during the process of labour. Thus women are dependent on their

care givers with regard to the type and amount of balancing work they must do. If a midwife balances in favour of institutional demands and thus is not available to the labouring woman, making sense and reframing will become more difficult or only partly accomplished, leaving gaps with regard to knowledge, regrets about actions taken or not taken, and possible anger about some aspect of the experience that may persist into the next pregnancy.

BALANCING BY THE MIDWIFE

Balancing poses a serious dilemma for the midwives as well. On the one hand, they have been educated to be 'with women' in childbirth, and to rely on their interpersonal and human skills of caring to assist women in labour. On the other hand, they work for, and to some extent under the direction of, a medical and hospital hierarchy. This results in blurred perceptions of responsibility and autonomy for the midwives. In addition to having to continuously balance their vision of midwifery with the reality existing in their work place, midwives must balance priorities with regard to use of their time, respective value of relationships, and the health and well being of both foetus and the labouring woman.

Midwives can balance toward the needs of women they care for, or toward their own needs within the institution. It does not always have to be for women or for the system, but it often becomes just such a choice. Boundary marking, a concept developed by Boettcher (1985) is related to balancing and may help to explain it further. Boundary marking is defined as a social process that promotes or restricts access to environmental resources. Boundaries can be expanded or contracted, and boundary marking can be implemented by nursing interventions, medical interventions or institutional policies. Childbearing women experience contracted boundaries as a result of the physiological process of labour itself. Moreover, personal boundaries shrink with a woman's lack of control over the hospital environment and policies, invasion of personal space, and vulnerability with regard to number and type of care givers.

On entry to hospital, women forfeit personal control with regard to many choices and decisions. A midwife, because she is there with women in labour, exerts some control over the process of boundary marking. Ultimately, however, it is institutional policies and medical interventions that have the most influence on whether a labouring woman's boundaries are further contracted, or alternatively, expanded in accordance with individual needs.

Midwives control their use of time in a very limited way. Staffing patterns are set by established organizational structures and there is no system in place for routinely calling in extra midwives if the labour and delivery area becomes busy. As long as the care provided is deemed to be safe (even though not optimal), no need is seen by those in authority to increase the number of midwives on duty that day so that one to one care is possible. Under such circumstances, and it is not an infrequent occurrence, midwives balance individual women's physical safety needs, against psychological needs. The latter are thus given lower priority and the pattern is set for future balancing when psychological needs will again be pushed in to the background. This type of balancing was evident in the care Jill received (Chapter 5). One of the midwives describes the problem:

> This morning when I came on, there wasn't even time to get report. I went into one of the theatres and took over from S. (another midwife). That lady didn't know me and I didn't know her... She delivered and I had to leave her and get the instruments washed, I knew we'd need it, all four theatres were full. After that I went into a labour room to check on a lady in premature labour. Someone had brought her in and put her in a room... put her on a monitor and then left. I don't know who. She was feeling like pushing, I heard her from the hall that's why I went in. I checked her and she was 8 centimetres. She didn't know who I was and she was frightened. All the theatres were full and there were still two other women close to delivery... That was a horrible day. I was torn all day, knowing I wasn't being any good for anyone. You seem to be meeting yourself coming back all day.
>
> (Midwife B, interview no.1)

The important point, however, is that while women in labour may miss out on a midwife's care and feel deprived as a result, the midwife may still gain some satisfaction from the tasks accomplished, rather than from providing optimal care for an individual woman in labour. Nevertheless, the recognition that the care provided was not optimal is also there.

> ...and then you get a situation like we had the other day. I just felt... although you're busy and you feel like you've achieved a lot by running up and down the corridor and seeing about twelve women come through, I don't feel like I've gained anything, because you just can't be there with them all the time.
>
> (Midwife C, interview no. 1).

Midwives describe these as "bad days". Although they work hard and mothers and babies are safe, they feel no satisfaction in the kind of care they have provided. It is in these sorts of situations, that midwives describe the increased use of interventions, ie. the balancing of physical safety against close, individualized care, frequently resulting in a situation where:

> You put women on monitors because you can't be there often enough to check the foetal heart.
>
> (Midwife B, interview no.1)

When midwives are very busy, analgesic medication may be resorted to more frequently than individual women's needs would require:

> ...It's so that they can get the patient relaxed, then they (midwife) can be out of the room
>
> (Midwife C, interview no.1)

In addition to balancing priorities of care with insufficient staff for the circumstances, midwives are continually balancing patient care needs with the need to complete other duties. Midwives are expected to deliver meal trays, wash instruments, replace equipment in theatres, keep patient notes up to date and accompany doctors when they see patients. The fact that midwives become occupied with cleaning duties immediately after a

delivery, can be especially problematic for women. Midwives see their absence after the birth as providing privacy and time for the woman and her family to be with their newborn baby. Women, however, report needing a much shorter time on their own. When the midwife's absence becomes prolonged, women report feeling abandoned, unsure what they should be doing, and concerned about the baby. Moreover, once the midwife returns, often an hour or more after delivery, she is frequently in a hurry. Women report feeling rushed during the time they showered before being transferred to the postnatal area. Jill commented that she had felt so rushed, that she was unable to void and she did not feel she could take the time to brush her teeth:

> ...I just felt really rushed and consequently when I got to my room (in the postnatal area) and settled in bed, I had to get back up and go to the bathroom. It was a pain having to get up that quickly, but I had to go, and also I had to brush my teeth. She (midwife) hadn't given me time for that.
>
> (Jill, postnatal hospital interview)

Probably the biggest concern midwives have with balancing is related to the need to get the doctor to the delivery in time, but not so early that he or she has to wait. Some midwives who have worked in the area for some time, feel relatively successful at this, at least from their perspective:

> ...It was difficult at first getting the timing right, and, you know, I delivered a few of the obstetrician's ... who weren't very pleased and I thought, Oh heavens, why should a woman stop pushing just because you're waiting for a doctor to come. you know.... but now I can do it and I nearly always do get the doctor there.
>
> (Midwife A, interview no.1).

For many midwives, though, this dilemma of when to call the doctor remains problematic. Midwives are conscious of the women's perspective and know that many women worry about their doctor making it on time. However, they must balance women's needs against the problems they will face if the doctor is called too soon:

> ...but to get it timed to go perfectly, to get a doctor there without twiddling his thumbs and playing with the perineum and cutting an episiotomy because he wants to get away... or actually getting him there before the baby is born, ah, very hard to assess. That's probably the hardest thing.... I find that's quite distressing. Some of them (doctors) get quite irate because you haven't timed it perfectly.
>
> (Midwife C, interview no.1)

The midwife is faced with the need to balance the woman's desire for a doctor's presence and his intent to be there,with the knowledge that if he comes too soon, the woman may experience more interventions, and in addition the doctor may be angry with the midwife, doubting her skill and possibly her motives as well. The midwife also acknowledges another facet to this dilemma:

> I also don't like the way a midwife has to turn her attention to getting the doctor there on time when, in fact, it's the most critical time for the woman.
>
> (Midwife C, interview no.1)

All midwives reported experiencing conflict with doctors over this issue of timing, so that they are constantly forced to balance the very real threat of complaints by doctors for mistiming their calls, with the needs of the women at that particular time.

Balancing the respective value of relationships poses another difficulty for midwives. Relationships with the women they care for are transitory. They meet during labour, interact through the birthing process, and for about three hours after the birth of the baby. Then the woman is transferred to another ward and to the care of a new group of midwives. In contrast, midwives develop long term relationships with their colleagues. In terms of responsibilities they are entrusted with, credibility, and status in their working environment, it is relationships with colleagues that count. If these relationships are positive, a midwife gains increased status, doctors place more trust in her judgement and decisions, and she is in a stronger position

to advocate for women. If, however, midwives do not enjoy such relationships, advocacy becomes more difficult. The personal cost in terms of stress and self esteem for a midwife new to the labour and delivery area, and who is relatively unknown by doctors can be very high. It is especially difficult trying to advocate for a woman without the benefit of status and credibility.

One such midwife describes the situation in which she has attempted to advocate for the woman, balancing in favour of her desire to deliver the baby without technical intervention and is rebuked by the doctor in front of the patient:

> She was pushing so well, the epidural had worn off, and she was getting it right. You could see the top of the baby's head, and the foetal heart was good. The doctor came in and said to "top up the epidural, I'm going to do a forceps delivery". I prepared everything and went back in to tell her what was happening. She summoned energy from nowhere and pushed and pushed. A few more pushes and the baby would have been born. The consultant came in and was mad because I hadn't given her more medication yet. I think he had decided the baby was going to be born at a certain time because he was going out. At least that's the way I saw it. But I got in a lot of trouble over that.
>
> (Midwife B, interview no.1)

It is difficult for the midwife under these circumstances to place the most value on her relationships with women. Women themselves, not understanding the midwife's expertise and role in labour and birth, may increase the midwife's difficulty by looking to their doctor for guidance and by valuing his contribution to the birth of the baby over that of the midwife.

Within her working environment then, a midwife balances priorities of care, how she uses her time, and the respective value she places on relationships with women, other midwives, and doctors. Her decisions with regard to these complex issues affect the manner in which she either expands or contracts boundaries for birthing women. For example, one woman in the

study specifically requested that she not be moved to a delivery theatre when it was time for her baby to be born. The midwife caring for her made it clear that she did not like the idea, however, agreed to try it. After about ten minutes of second stage pushing, the midwife told the woman that they would have to move to the theatre in case forceps were needed. In another case, however, the woman refused to get into bed at all. She spent her whole labour walking around. The midwife caring for her accommodated to this agreeably and waited patiently until the woman felt she could get up on the bed to be examined.

When midwifery practice focuses on the woman, rather than established routines, then it can recognize that some women may prefer more contracted boundaries. It is important that balancing is in favour of the individual woman, rather than a view or ideology held by a midwife. Midwives themselves recognize that a colleague may have very set ideas about what women giving birth need, and with the very best intentions, impose that way on them:

> ...for all the best reasons, for wanting so much for your ladies to have a normal labour and delivery... that perhaps they don't quite recognize that that really isn't where the lady is at....that she doesn't really want all that. She wants to have an epidural, she wants all the pain away and she wants it to be done for her. There's not many like that, but it's important to recognize, (be)cause not everyone is into doing it for themselves.
>
> (Midwife C, interview no.1)

It is equally important to recognize when a woman needs to retain choice and ability to participate in her labour and delivery. In this situation, flexible policies and judicious use of interventions that contract boundaries are necessary.

CONCLUSION

The success a midwife has with regard to making sense and reframing for women influences her ability to balance priorities, boundaries, and time, in a way that meets individual women's needs and fulfils her mandate to mutually engage with childbearing women. *Mutually engaging* will be discussed in the next chapter.

CHAPTER NINE

REACHING THE POINT OF MUTUAL ENGAGEMENT BETWEEN THE WOMAN IN LABOUR AND THE MIDWIFE

Engaging mutually is a reciprocal process of intense involvement between the midwife and birthing woman. It is the culmination of the midwife's expertise in comprehending the phases of making sense, reframing, and balancing in accordance with each woman's lived experience of labour and delivery. It is by mutually engaging with women that midwives confirm women's uniqueness, individuality, and inherent worth, thereby demonstrating caring practice. It is through caring practice by midwives that they fulfil their mandate of truly 'being with' birthing women.

Women embark on labour and delivery with differing pasts associated with their feelings about and confidence in themselves as women. A woman may commence labour full of confidence in herself and her ability to give birth. Alternatively, as Jill illustrated (Chapter 5), a woman may be frightened, unsure of her own capabilities, and anxious about how she will fulfil her role in birthing. Some women come into labour with a very negative self concept, which may be partly due to previous birthing experiences. They may feel weak, vulnerable and anxious about their feminine identity and ability to give birth. Engaging and 'being with' women, then is difficult, for a midwife since it means very different things for different women. If a midwife is successful at making sense, reframing, and balancing as she cares for labouring women, it is more likely that the two will mutually engage.

Engaging implies that the midwife and the woman are in tune with each other, fitting in, having a sense of rapport, and at ease with each other. Women, themselves describe their perception of engaging with their midwife in a variety of ways:

> ...it was like she (midwife) was part of the family.
> (Faye, postnatal home interview)

> ...she just knew me, I felt like she knew who I was... not just any woman, but me. I felt 'special'.
>
> (Margaret, postnatal hospital interview)

> ... she was really very nice, low key. I liked that ... very matter of fact, yes, she was good.
>
> (Jocelyn, postnatal home interview)

There can be no magic formula to engaging mutually since women need different levels of care and involvement from their midwife. The process, nevertheless, does require that the midwife have positive feelings about being with women during labour and delivery, that the midwife and the woman develop an historical understanding with each other, and that the midwife be flexible in reframing and balancing during the course of their evolving relationship. In addition, a midwife needs to be aware of the relationship between a birthing woman and her partner. Women often feel worried for and anxious about their partner and his inclusion in the relationship is important.

Women enter labour and delivery with the knowledge that they will be cared for by a midwife for at least part of their time in hospital. All express concern that this relationship will go well, and many describe a feeling of responsibility that it does. Women feel like guests in hospital, but whether they feel welcomed and treasured as guests, depends on the relationship established between the midwife and the labouring woman and her partner.

INITIATION OF THE RELATIONSHIP

As already discussed in Chapter's Four and Five, it is rare for midwives to have met the woman prior to the commencement of labour. Midwives in the labour area expect to be telephoned before a woman actually comes into hospital. This is communicated during childbirth education classes, but is not always known or remembered by women themselves. For some, telephoning becomes impossible, due simply to the rapidity with which labour progresses. Others forget in the stress of the moment or have too many other arrangements to make. It is not unusual then for a labouring woman to arrive unannounced. If a woman is able to make a telephone call, then sometimes the midwife taking the call, will be the one who greets her at

the door and takes over her care. Midwives working the night duty make every effort to ensure this follow through, however, it works less consistently during the day.

Talking to a particular midwife, and then being greeted by and cared for by that same midwife, was not described by women as being a significant aspect of beginning their relationship with her. What did emerge as very significant for women was the manner in which they were greeted. If the midwife appeared harassed, impatient, or unfriendly, women felt unwelcome and anxious. These feelings remained throughout their interaction together, even if the midwife's behaviour changed. An initial negative impression seemed to make it difficult, or even preclude engaging mutually between the midwife and the labouring woman.

> When we arrived the first impression was "what sort of an iceberg is this?"... very cold. She was awful at the door, really awful. (investigator, " and that was the same one who was with you all along?")... Yea, yea, she changed. We rung the bell, she came down, she opened the door, she didn't say a thing to us. She didn't say, oh who are you... or anything. She just said come upstairs... there was no hello, there was no what's your name, there was no, I'm such and such, or anything. We just went up the lift, and she said, go into that room.... She said, I'm just going to examine you, and she did. (investigator, "and she hadn't introduced herself?") No, not until you came.
>
> (Allison, postnatal home interview).

This couple went on to explain that the midwife was busy in another room, and that as a result, she might be preoccupied. However it was obvious that their initial negative impression affected their trust and confidence in the midwife.

> I obviously didn't feel totally confident with her, not to do the final (delivery of the baby). My security was in knowing that my doctor was there.... I think the initial impression left me unsettled with her the whole night.... the way she met us at the door probably left me uneasy with her ...

> because with none of the other nurses have I ever worried about whether or not he (doctor) was going to be there.
> (Allison, postnatal home interview).

The initial meeting between midwife and labouring woman has an impact on the kinds of feelings established. Women who feel welcomed and feel that they are cared about as a person by the midwife, also describe feeling safe with her. Often this feeling of safety is not related directly to a woman's perception of the midwife's competence, although in Jill's case being met by an anxious student nurse did increase her own anxiety (Chapter 5). This feeling of safety is often related more to feeling safe emotionally.

> It was wonderful to see her there. I felt like I could let go and stop worrying, and she could take over. She would do the thinking now and I could stop...
> (Diane, postnatal, hospital interview)

The initial feeling of being safe and cared about, aids in the establishment of trust and rapport that are crucial to engaging mutually. In contrast, women who are made to feel unwelcome or a nuisance, carry these feelings with them throughout their labour. They describe relating with, and being cared for by the midwife as an additional source of stress.

Midwives, on the other hand, acknowledge the difficulty of greeting each new woman fresh and free of the stress of the moment, since very often these stresses can be considerable. Midwives also recognize the value of receiving positive feedback from the women, and note that this kind of mutual exchange enhances their self confidence.

The importance of this interpersonal relationship, from a woman's point of view cannot be ignored, especially if one recognizes the longterm effect of those initial negative feelings. As already stated, engaging between labouring women and midwives is much more difficult, if not impossible, if the first impressions are negative. The woman's need to trust in her caregiver may be impeded and the midwife may lack confidence in her ability to relate positively with this particular woman.

CONTINUING THE RELATIONSHIP

It is very much the midwife's role to both initiate and continue a relationship that is mutually engaging . It is the midwife who is familiar with the routines and physical environment of the hospital, and it is the midwife who controls much of that environment. Engaging mutually with women manifests in caring practice that enables women to feel worthwhile, strong, and proud in giving birth.

Women in this study often remarked on how negatively the hospital environment affected them. One woman stated that she felt "clammy" every time she walked through the door, while another woman reported feeling like she would be "sick" as soon as she entered a hospital. The role played by a midwife in either increasing or decreasing the stress that women associate with a hospital was evident in these women's reports.

Partly because of their tenuous guest-like status in the usually unfamiliar, and frequently frightening hospital environment, women look to their midwife to advocate for them. This occurs especially in relation to technology. It is only possible for this advocacy to occur if a midwife knows the women she cares for. Because women come into labour with disparate feelings and expectations about both labour and themselves, and because women experience very dissimilar labours, advocacy is different for each woman. If the woman and the midwife caring for her are engaging mutually then the midwife knows how and when to advocate. Some midwives put themselves in the woman's place, and advocate from the perspective of how they would like to be cared for. Other midwives may advocate from an ideological perspective, thus imposing their own ideas on the women in their care. To be truly 'with women', however, a midwife needs to advocate from the woman's vantage point and to do that, she must be able to make sense of and reframe the unfolding experience. Her advocacy for them is also reflected in how the midwife balances her time and priorities with regard to individual women. As discussed in Chapter Eight, balancing care priorities against other institutional demands is a reality in a midwife's working environment.

Advocacy usually involves the midwife supporting a woman's position with regard to some aspect of care. This may occur in relation to a simple activity such as walking around during labour, but more frequently it occurs in relation to the use of technology. Whatever the case, the midwife has to be able to understand the woman's viewpoint and then communicate that view to the doctor. For some midwives this is difficult because of their perceived or real lack of tenure and status in their working environment. For others, who enjoy colleagial relationships with doctors, advocacy is easier.

> I don't have many hassles with the doctors. I don't have rows with them....um, they may come in and say, "oh, why don't you have an epidural in?" And it's me... often saying, well actually she doesn't want one. (investigator, "and so they work and consult with you?") Oh, yes, very much so.
>
> (Midwife E, interview no.1)

This ability to advocate and the perception of being consulted by doctors was unusual. Most midwives described situations where they had been unable to advocate for women, and had been in conflict with doctors for trying. Most felt much less successful in this aspect of their practice than they would have liked.

Engaging and being with women in labour requires also that a midwife use herself as a therapeutic tool. Midwifery practice is based on non interventionist, natural birthing, and that in turn is dependent on each midwife's expertise in using her human skills to assist women in giving birth. The concept of presence exemplifies this beneficial use of self. Benner & Wrubel (1989) describe 'presencing' as being with someone in a way that acknowledges or participates in the person's experience. To be present in this way means that the midwife is perceived to be available and accessible to labouring women so that they feel understood and supported. A midwife's ability to 'presence' herself then, with labouring women, is one of the ways she ensures mutual engagement.. From a labouring woman's point of view, presence is seen as one of the most important functions of the midwife.

Antenatally, women expressed the hope that they would have their "own midwife", that this familiar midwife would stay with them, and that there would not be too many people involved in their care. Women consistently expressed the desire that the midwife would stay with them as much as possible. As was evident in Jill's care, this was not always the case (Chapter 5). Quite apart from being busy with other women or tasks, some midwives felt that couples frequently "didn't need" them, were "doing well on their own", or that the woman had "enough support people with her." In fact, a number of midwives expressed concern about being an intrusion rather than a source of support when they were present without carrying out specific interventions:

> Sometimes I stay away from patients because they are obviously getting enough support... and that's what they want. They don't want you there.... if they need me, that's fair enough.... I find it very difficult when there is a hundred and one people there.
>
> (Midwife D, interview no.1)

Interestingly, the only time women talked about experiencing a midwife's presence as an intrusion was when they did not feel engaged with her, and in particular if the relationship had begun badly:

> ...she (midwife) wasn't supportive... and then she kept interrupting.... but she kept coming in and she just sat there for ages, just sat there watching.... I wondered why she couldn't go out of the room.
>
> (Amy, postnatal home interview)

The midwife's presence was perceived as an intrusion because there had been no trust or rapport established and the midwife failed to communicate warmth and support. Rather, the woman felt as if she was being judged, a feeling that increased her stress.

Midwives may assess a woman's need for their presence from their own, rather than the woman's perspective. For some midwives, the lack of a support person, or one that seems disinterested, signals a need to spend more time with the labouring woman. Others consider their presence to be

necessary if the woman is perceived by them to be not coping well. For some midwives, presence is not a valued concept with regard to their practice:

> I feel that if they've got a good partner there, then you don't really need to be in the room with them all the time. You go in and you do your thing and you say what you think about it... and you keep going back in and out, but they need some time together, and to get on with it together, because it's something you've got to live through... I mean, perhaps it's not the right time to grow but I still feel that if you've got that sense of together, together we did it.... I don't think the midwife necessarily should be to them the all important person.
>
> (Midwife A, interview no.1)

Midwives sometimes redefine the situation and the woman's need for their presence on their own terms, and without validating this perception with the woman concerned. Reframing, in light of individual woman's experience is, therefore not occurring, and mutual engagement is precluded.

Midwives frequently confuse indirect statements about their proximity with being available to the women in labour. The assumption is made that if a midwife tells a woman where the call bell is, and that she should call if she needs anything, then that constitutes presence and availability. Women, however, do not perceive the instruction to call the midwife as being sufficient. They express hesitancy in calling at all, and uncertainty about whether it is important enough to call the midwife. Just wanting the midwife with them is not perceived as being important enough, and women in fact do not usually call until they become frightened and unsure about what is happening. There can be no mutual engagement if a woman and her partner are alone in a labour room, frightened and yet reluctant to call for help:

> ...I was really frightened, remember after lunch sometime the midwife hadn't been near us for ages. I asked you (investigator) to get her because I was sure the baby was coming ...
>
> (Jill, postnatal home interview)

Mutual engagement requires that midwives stay in the labour room long enough to at least make sense and frame a picture of birth for the particular women. They must then be with them often enough after that to reframe this picture and keep it updated. This requires time to be present physically as well as the energy and commitment to be present psychologically.

Presence as a Dimension of Mutual Engagement

Gardner (1985) describes physical and psychological presence as being manifested in three dimensions. The first, the cognitive dimension, requires the midwife to communicate empathy and understanding of what a labouring woman is experiencing. This is especially important with regard to verbal acknowledgement both for the hard physical work involved in labour, and the pain associated with it.

In actual practice, midwives frequently miss opportunities to provide this verbal reassurance. For labouring women, comments such as: "you're doing a great job," "I know it's hard, but you can do it," or "I know it hurts, but you're beautifully relaxed," stood out not only because they were welcomed, but also because they were relatively rare. While such comments served to confirm for women that labour was progressing normally and that the woman herself was coping well, provision of verbal reassurance seemed to be something that midwives took for granted. During research interviews few midwives discussed this type of communication as being an important aspect of their practice. In fact, some midwives seem unaware of the effect of what they say, and how they say it, on the women under their care. For example, during second stage labour, it was not infrequent for a labouring woman to be told: "you're not pushing right", "not that way, into your bottom", or "those aren't very good, you're wasting your energy." These messages were usually accompanied by directions related to how to do it better, but the messages were perceived by the women quite differently:

> ...and I almost gave up then. I was trying so hard, and I was so tired... I just thought I can't do this right ..."
>
> (Jill, postnatal, hospital interview)

> ...what does she mean, "push into your bottom". I know that's not right, that's not going to work... so then I just turned her off.
>
> (Christine, postnatal home interview)

When midwives did give positive supportive messages, women reported a renewed surge of energy and confidence, and often succeeded in what ever it was that they were attempting. The following is an example of a supportive message, that produced the intended result:

> These are great pushes, I think that baby is being a little bit stubborn, but you will bring him down. Let's keep trying.
>
> (Midwife's comment to Allison, field notes).

What the foregoing discussion illustrates very clearly is that for midwives to engage with women, it is critical that they are able to communicate empathetic understanding of what a birthing experience is like for women themselves. This needs to be done in a way that speaks to the individuality of each woman. For example, some women do not wish or need a lot of verbal reassurance. For others, such support is important in enhancing their self concept and their ability to persevere with labour. What is clear, however, is that all women benefit from messages that are positive confirming ones, rather than being negative and demeaning.

The second dimension of presence described by Gardner (1985), relates to the affective domain and involves a midwife's ability to communicate positive regard for, and a genuine interest in, the woman she cares for. The language a midwife uses can have a positive or negative effect on such communication and hence on the potential for engaging mutually. The manner in which midwives offered suggestions, provides examples of both kinds of communication:

> I wonder if it would work better if we could get you propped up... these beds are really hard to work with. Do you want to try leaning into the bean bag?
>
> (Midwife to Christine, field notes)

> You're not coping well at all. I'll get you something for the pain.
>
> (Amy, recalling comments made by her midwife, postnatal hospital interview).

The first example demonstrates communication of positive regard and respect for the woman's ability to make choices. In contrast, the second example focuses on the failure of the woman to perform according to the midwife's expectations, assumes the cause without validation, and proposes a course of action without consultation. The comment is brief but the effect is likely to diminish the woman's ability to cope, and remove any possibility of choice from her. The issue is not whether analgesia should be offered or not, but the manner in which the communication occurs. Some women may require support and even permission from the midwife with regard to a legitimate use of analgesia. The midwife who is participating in the phases of making sense and reframing with the woman she is caring for will be able to frame the need for analgesia in a way that is understandable and acceptable to the woman and her partner.

In addition to the way a midwife makes suggestions, the kind and amount of feedback she provides is seen by women as either raising their self esteem of as diminishing it. Comments like: "just relax, it will be easier if you can relax better," were seen as blaming. Women who received such messages reported that they felt they were not doing anything right, and that it was their fault the pain was so bad. In contrast, the midwife who encouraged, and stayed with a woman during contractions, was seen as helpful: "you're doing so well, it's just about over now. Keep breathing, that's good... that's good... just let yourself go, you're so relaxed..." Most women felt that they had not received as much verbal encouragement and positive feedback as they would have liked. Their particular vulnerability during labour and the exposure to the scrutiny of others was seen to increase the women's need for messages that confirmed their competency in handling labour.

The third dimension of presence (Gardner 1985) involves physically being there. As already discussed, midwives may under-estimate a labouring woman's need for their physical presence, and for positive confirming messages. In addition, physical presence can and often does involve the use of touch and massage. Midwives, especially during the latter part of the first stage of labour, are more likely to stay in the room with the woman and perform such activities as leg or back massage, hand holding or provision of a cool cloth. For the most part, these activities are greatly appreciated:

> ... and when she (midwife) got me the cold water... that was really nice...
>
> (Jocelyn, postnatal home interview)

> ... the cold cloth on my face, I couldn't have pushed without it...
>
> (Allison, postnatal home interview)

> ...when you (investigator) rubbed my feet, I could feel myself go loose all over...
>
> (Jill, postnatal hospital interview)

Some women in the study indicated quite clearly that they did not want to be touched, thus again illustrating how necessary it is to care for women as individuals.

The relationship a midwife has with a woman during labour, although short and intense, is remembered for a long time afterward by that woman. The expertness with which a midwife uses herself as a therapeutic part of the labour and birthing process, and her ability to make sense , reframe, balance, and mutually engage with women is what makes the difference in that relationship. Women can come away from their birthing experience feeling happy, victorious, and capable, or, alternatively, sad, powerless, and weak. The manner in which the midwife relates to women has a great deal of influence on how they perceive their immediate experience, how they feel about it and about themselves, and what becomes the beginning of their personal history that those of them who will have other children will bring into their next birthing experience.

CLOSING THE RELATIONSHIP

As discussed earlier in Chapter Four, closure of the relationship between the midwife and the birthing woman occurs rather haphazardly. It is not unusual for the midwife who attended the woman during labour and delivery to be called away and for a less skilled person on the staff to complete the necessary tasks before transferring the woman to the postnatal unit. In this case, there is little, if any time for discussion between the woman who has just given birth and the midwife who cared for her. Many midwives described this situation as unsatisfactory, but gave no indication of acting to overcome it. Only one midwife acknowledged the importance of closing the relationship, and described how she routinely did so.

> I tend to see all my ladies afterwards. It's just a time for them to ask anything about their labour and delivery that they don't remember...
>
> (Midwife E, interview no.1)

Women expressed the need to see the midwife after delivery for a variety of reasons. Many have questions or concerns, but most also think that it would help them to feel more of an individual and not just a birthing body:

> I would have really liked to see her (midwife) again. There were lots of questions I could have asked her. If I hadn't been able to ask you (investigator), there would have been lots I couldn't put together.... You know it would just make me feel more special... not so much like two ships that pass in the night.
>
> (Allison, postnatal hospital interview).

There is no doubt that the need to be recognized as an individual after giving birth was important. In addition, women expressed the need to talk over their labour and delivery with someone knowledgeable about the process. All had areas of uncertainty that could be easily addressed, given time and opportunity to talk with their caregiver. In fact, because she had been present throughout labour and had developed rapport with the women and their partners, the investigator was asked many questions related to events in the labour and delivery area during postnatal visits in the hospital

and later, at home. Since midwives who assist with birthing do not make such follow up visits, the investigator was glad to engage in this process of clarification with the women. Nevertheless, it is clear that in the usual course of events this need to talk about their experience, clarify their understanding of what had happened and why, and gain a sense of closure, is not being met.

CONCLUSION

Mutually engaging occurs only as a result of deliberate activities on the part of the midwife. In a hospital setting, the relationship between a birthing woman and a midwife is an unequal one. Women rely on the midwife to establish and maintain an engaging relationship. The achievement of mutual engagement is the culmination of the ability of the midwife to make sense, reframe, and balance with regard to each individual woman's experience of childbirth, and lies at the heart of midwifery practice. Together, the four phases constitute the overall process of **authenticating**.

Chapter Ten completes the discussion of study findings by presenting a conceptual account of the authenticating.process and a framework for midwifery practice based on this process.

PART THREE

DISCUSSION AND CONCLUSION

CHAPTER TEN

THE AUTHENTICATING PROCESS: A FRAMEWORK FOR MIDWIFERY PRACTICE

This chapter introduces Part Three of the thesis. The findings of the study are presented in chapters six through nine are discussed and a conceptual account of the **process of authenticating** is presented. This is followed by a discussion of the contextual factors surrounding a hospital birth that impact significantly on the practice of midwifery and the experience of birthing for women. The chapter concludes with a discussion of the significance of the process of authenticating.

THE AUTHENTICATING PROCESS

Symbolic interactionism, from which grounded theory is derived, rests on the assumption, that people develop a sense of themselves through interaction with others. Past personal and professional experience has sensitized the investigator to the significance of the birthing interval in a woman's life. Data generated by the present study confirm this significance. Through interaction with their caregivers, women develop an identity of self in childbirth, as successful and strong, or as failing and weak. The process of authenticating, grounded in the data collected through the observation and direct reports of midwives and birthing women is proposed as a conceptual framework for practice. It addresses the mutuality of women with the midwife caring for them.and lies at the heart of midwifery practice when such practice is true to it's ancient meaning of 'being with women'.

To authenticate is defined in the Collins English Dictionary (1985) as establishing something as genuine or valid. Authenticating, in the context of this study denotes a process that is engaged in by both midwives and birthing women in order to establish practice and the experience of giving birth as being individually genuine and valid. To accomplish this a woman must understand her experience of childbirth and ascribe positive meaning to it, and in this way, incorporate it into self as a woman, sexual being and parent. It is through authenticating that a woman achieves a sense of

closure with regard to her pregnancy and birthing experience, and is able to move on to her new role of mothering.

Authenticating is multifaceted and can be seen to involve the four phases of making sense , reframing, balancing, and mutually engaging (Chapters 6 through 9). These are not linear steps but rather intertwined, simultaneously occurring phases (Figure 1, p.126). At any particular moment, a midwife or the woman herself, may be focusing on any one or a combination of these phases. Authenticating occurs over time and is never totally complete or finished. A woman pregnant for the second or third time will often re-live this process in relation to her previous experiences of giving birth. This need to authenticate will be especially great if satisfactory resolution of feelings did not happen at the time of previous births.

Viewed as the outcome of grounded theory research, authenticating is presented here as a core category that reoccurs frequently and is central in the data, explains variation in both observed and described behaviour, and relates meaningfully with other categories. The process of authenticating involves phases over time and is deemed relevant to the action as described in the data. In addition, this process is continually qualified and modified as it is dependent on what is going on within and among people in the field.

The first phase of the authenticating process is conceptualized as making sense (Chapter 6), which involves a contemplative and deliberate course of action undertaken in order to render childbirth understandable. Figure 2 (p.127) summarises the key concerns related to the phase of making sense and other phases of the process. Framing or creating a coherent picture of childbirth results from successful accomplishment of making sense.

Reframing (Chapter 7) refers to the process of developing a mental structure that gives shape and support to one's picture of childbirth. This is accomplished by fitting many disparate pieces together. Reframing confers an ability to see childbirth in new and different ways much like a movie film is a process of 'moving forward' with the events. Reframing requires flexibility and alertness even to minor changes and cues, thus providing continual reorientation to the immediate and the unfolding situation. These two phases of authenticating are intertwined, occurring simultaneously and dependent on each other.

Figure 1 **THE AUTHENTICATING PROCESS**

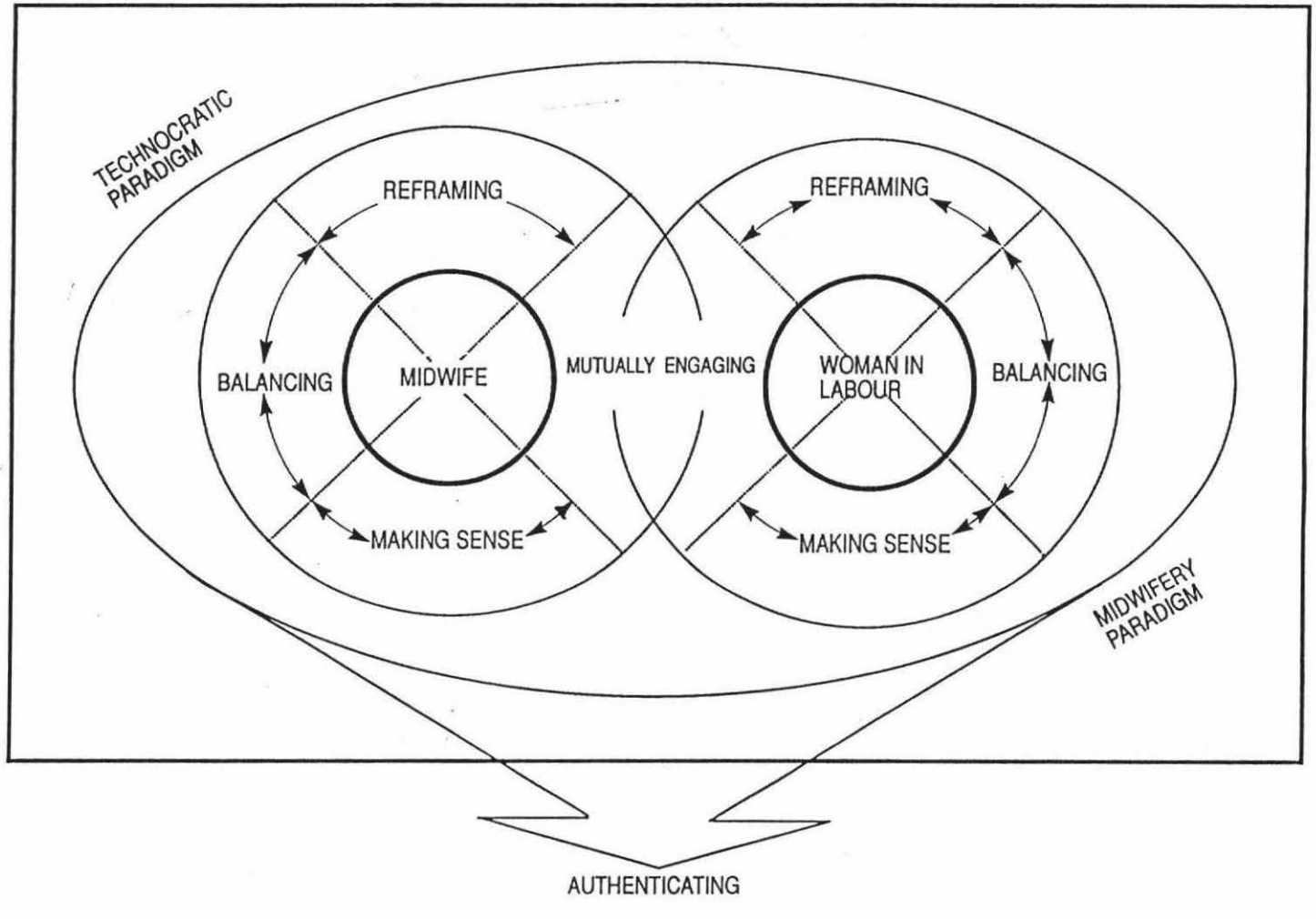
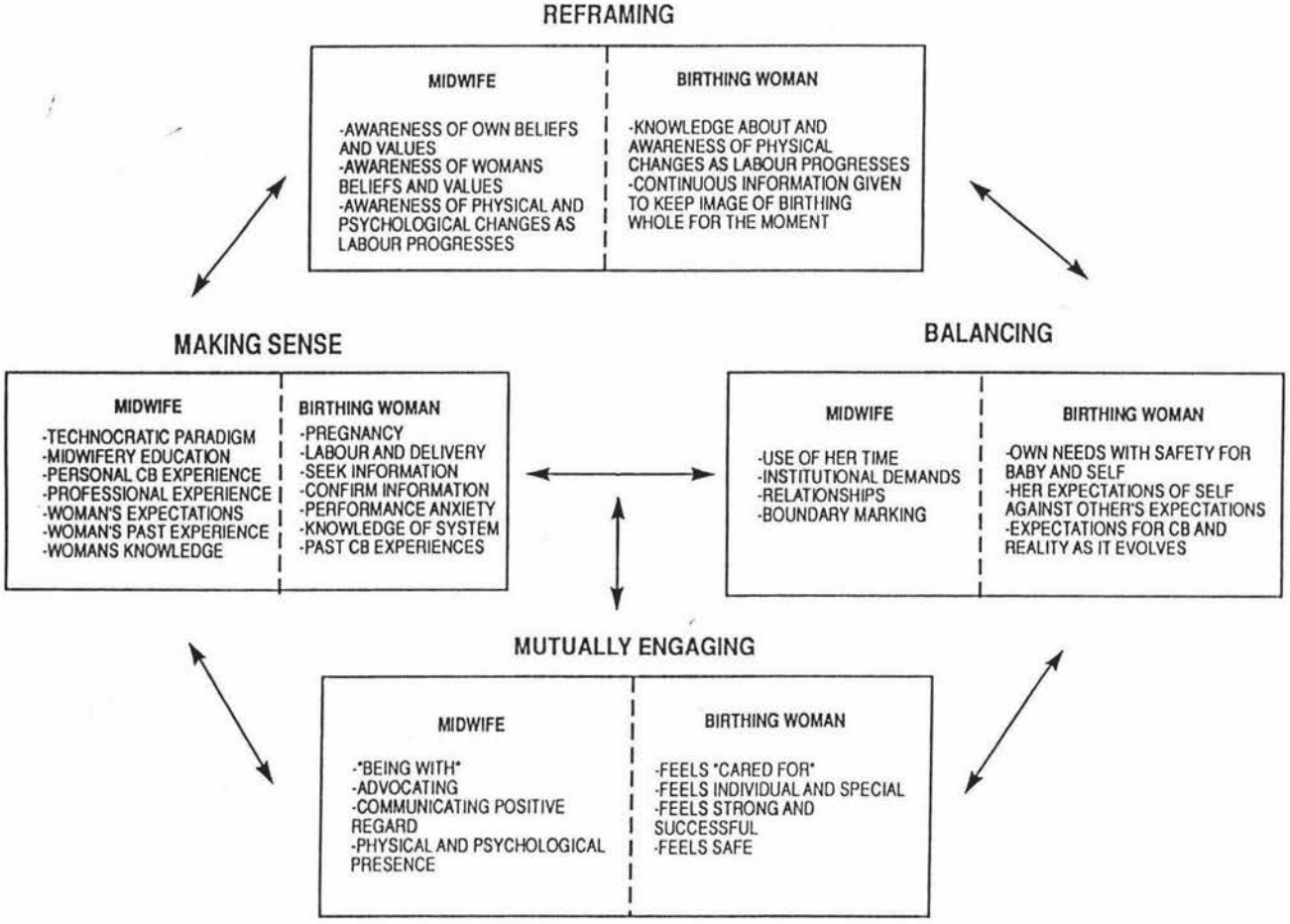


Figure 2 **SUMMARY OF THE PHASES OF THE AUTHENTICATING PROCESS**



Balancing (Chapter 8), another phase of the authenticating process refers to the act of weighing factors against each other in terms of their significance and relative priorities, and then making choices to continue observing or to act in particular ways. Making sense and reframing are invisible, cognitive activities, while the results of balancing become more visible. The physical assessing tasks that are so much a part of midwifery practice serve to provide information with which to engage in these three phases, and when a midwife is engaged in truly 'being with women', then the phases also serve as the basis for decision making and specific interventions. .

Mutually engaging (Chapter 9), the final phase of authenticating, is defined as an intense reciprocal involvement shared by two people that forms the basis for a special expression of caring. Mutually engaging means being connected with and caring about each other, and fuses 'thought, feeling and action' (Benner & Wrubel 1989). It indicates a special kind of rapport, shared understanding and mutual respect for each person's contribution to the accomplishment of a safe and satisfying birth. As suggested in the framework of authenticating (Figure 1) the degree of intensity of involvement is flexible and varies with the needs of individual women and their partners, as well as with the configurational knowledge the midwife develops as she engages in making sense and reframing.

AUTHENTICATING BY WOMEN

Whether labour and delivery is viewed as a crisis, an opportunity for growth, a developmental task, a significant life event, or all of these, a woman's positive feelings about her experience are important in her transition from pregnant woman to parent. Women report a variety of emotional reactions arising from their experience of giving birth. They reflect on and think about their birthing experience regardless of whether the events are perceived positively of negatively. The process of authenticating addresses this observation and attempts to provide a way of conceptualizing care that is responsive to this need of women, to understand their birthing event and to put it behind them.

Women giving birth in hospital face a dilemma. On the one hand, they have been socialized to trust the doctor as a specialist in childbirth care, and to believe in the prominence of scientific progress and technology in medicine.

On the other hand, as maternal and neonatal safety has become almost assured, the values of society are changing. The total experience of birthing for women is becoming recognised and the focus is altering from a primary emphasis on foetal outcome to one of active participation by the woman in a natural birth.

Authenticating is a necessary process for women to undertake whatever their experience of childbirth has been like. Passage through the process is likely to be easier if a woman has experienced the kind of childbirth she expected or desired. Women giving birth in their own home have many advantages over women who have their baby in a hospital, and are more likely to authenticate as the experience advances. They are likely to know their caregiver well, and to have shared and common beliefs about birthing. In addition, they and their partners are in a familiar and comfortable place, and the midwife and doctor are invited guests. Women giving birth in a hospital, on the other hand, are likely to be cared for by unfamiliar people, who may or may not have similar beliefs about labour and birthing.

Most women begin labour with the expectation that they will actively <u>give birth</u> to their baby and not be merely <u>delivered</u> of a baby. A consequence of this expectation is performance anxiety (Crouch & Manderson, 1987) and women feel required to perform appropriately for the doctor, the midwife, their partner, and in accordance with their own expectations of themselves. As it is almost impossible to meet the expectations of all of these people, the woman often feels that she has failed someone. Although a hospital, with it's associated technology, may seem like a very safe place to be if the health of either the woman or her baby are at risk, women still experience a great need to understand what happened and why. Thus, although they feel safe and well cared for, as well as grateful for the safe birth of their baby, the discrepancy between what they thought childbirth would be like, and what it was like for them, remains problematic until authenticating occurs.

A woman's support partner plays a vital role in the process of authenticating. Being witness to the event of childbirth confers a degree of understanding not possible through attainment of cognitive knowledge only. In addition, being there enables a woman's partner to participate in discussions and assist her in clarifying events associated with the experience and her understanding of that experience. In this way he assists her in the process

of authenticating. For the woman giving birth, having her partner there is invaluable for the physical and emotional support he can provide. However, in part, a woman's need to authenticate also involves her support person. She needs to understand how he perceives the event of birthing and as well, how he sees her part in it.

Women begin the authenticating process early in their pregnancy, continue it antenatally, during labour and delivery, and postnatally during the puerperium. Data from this study indicate that women have less need to authenticate following a birthing experience in which their attending midwife is able to assist them in making sense and reframing their vision of childbirth as it occurs. Women who feel engaged with, and cared for, by their midwife experience less of a discrepancy between their expected and actual experience of childbirth. Literature supports the notion that a woman's satisfaction with her birthing experience relates to the similarity between her expectations and actual experience (Nelson, 1982; Birch, 1982). Perceived satisfaction has not, however, previously been related to the care provided by midwives.

When authenticating is an essential part of midwifery practice, women can become more active partners in giving birth. This need to participate in decisions about their care and to be 'done with' and not 'done to' was especially important to the women in the study and is well supported in the literature (Jacoby, 1987; Humenick, 1981). Midwives who were able to participate in the phases of making sense, reframing and balancing with women were more likely to engage mutually. If women feel this sense of rapport and trust that is part of engaging then the midwife's presence is perceived by women as providing physical and emotional support. The importance of support to labouring women is well documented (Field, 1985; Shields, 1978). Being able to rely on their midwife for real caring means lesser reliance on analgesia, and the experience of sequelae that so frequently accompany it's use.

It was evident in this study that no matter how clear, complete or accurate a woman's knowledge about childbirth is, the very nature of labour and the intensity of pain associated with it forces a dependency and vulnerability on women. They must rely on caregivers to assist them with making sense and reframing their image of labour and delivery as it unfolds. Primiparous

women are especially vulnerable because of their lack of experiential knowledge of the extreme demands of labour in terms of energy and coping, their own capacities and limits of endurance, and their ability to gain from outside sources of support. Many go to great lengths to gain cognitive knowledge about childbirth, which is a difficult task because of the variety of types of labour experienced and the complexity of the process itself.

Multiparous women, often seen as less in need of midwifery care, bring with them residual thoughts and feelings with regard to previous births. For many, these feelings are extremely negative, authenticating has not occurred, and they are left feeling anxious and scared about their present experience of labour and delivery. In addition, society confers on women responsibility for the health and wellbeing of their baby, as well as the type of labour and delivery they experience. Women accept this responsibility, and will almost always make sense of a previous negative experience by assigning fault to themselves. Actions of caregivers, are assumed to be rational and necessary for some, usually unknown, reason. Women accommodate to and rationalize their care at the time, but are often left feeling guilty and sad about an experience of childbirth that did not meet their expectations. McClain, (1981) reported a similar finding and hypothesized that women can be effectively 'managed' by professionals because they have been socialized to trust and ultimately to yield to professional authority.

What McClain did not report, but the present study clearly indicates, is the persistence of negative feelings following their experience of giving birth for women who relinquished control and then were not helped to fully understand their experience.

While authenticating may be an almost integral part of a woman's home birth experience, in a hospital setting it becomes both more necessary and more difficult, largely as a result of the conflicting beliefs and practices that surround childbirth. The potential for intervention in childbirth in a hospital is great. The hospital environment itself is detrimental to women's confidence. Unfamiliar caregivers, the use of technical language, and reliance on analgesia for pain relief, rather than one to one supportive caring, all detract

significantly from a woman's ability to participate actively in giving birth. The alternative, 'being delivered' is unacceptable to many women, leaving them with feelings of failure, and of having been unable to make their bodies act in a way that would not have necessitated technological interventions.

AUTHENTICATING BY MIDWIVES

Midwives engage in authenticating as a means of strengthening and confirming the worth and value of their practice. Midwives who practice autonomously probably engage in less complex personal authenticating than the midwives who practice as secondary caregivers in hospital. As well, midwives can purposefully apply the process of authenticating in practice as a means of assisting birthing women through the passage of their own authenticating.

Midwives are accorded the privilege and the responsibility of caring for women during a significant transitional event in their lives. Midwifery practice has an ancient tradition, and has always had at it's core, the mandate of 'being with women' in childbirth. Midwives are required to develop and use complex physical and cognitive skills in the assessment and care of birthing women. It is not, however, the successful attainment and use of these skills that enhances the act of 'being with'. It is instead, a midwife's ability to use her technical expertise as an adjunct to her interpersonal skills that goes some way to fulfilling that mandate. The process of authenticating, when applied as a conceptual framework for midwifery practice acts in an abstract way to surface and define those interpersonal skills. Physical aspects of care assist in providing an information base, both with regard to safety and the process of authenticating.

Making sense (see Figure 2) refers to a contemplative course of action that involves a midwife's ability to reflect on her educational and experiential knowledge about midwifery and birthing, and then to define and articulate these beliefs and values. As a result of this making sense of her own history, a midwife frames a picture of childbirth that she carries with her as she cares for birthing women. A midwife is then challenged to make sense of each individual woman's history, along with her beliefs, values and knowledge about childbirth. On the basis of sense made, the midwife can then reframe

her vision of birthing in a way that is congruent with what makes sense to the woman being cared for. The need to make sense and reframe continues as labour progresses and changes as the nature of the process evolves.

A midwife's expertise in these two phases of making sense and reframing affects her potentiality for mutually engaging and truly being with women in childbirth. It is through mutually engaging that a midwife demonstrates physical and psychological presence and communication of empathetic understanding and positive regard. In this way a midwife confirms the worth and individuality of the women she cares for and thus meets their particular and special needs for care. The model developed to conceptualize the process of authenticating illustrates the interdependence of the phases, as well as the fact that mutual engagement is reliant upon successful merging of the midwife's and the birthing woman's perceptions of events.

In addition to making sense and reframing, a midwife must constantly balance, or weigh, practice priorities with the realities of her working environment. She balances her time, priorities of interaction, and the relative advantages and disadvantages of boundary marking for labouring women. The process of authenticating occurs within the confines of the midwifery and technocratic paradigms. It is apparent that at times, a midwife is balancing her own needs within the technocratic institution against those of the women she cares for. These realities frequently hamper a midwife's opportunity for and freedom to participate in the authenticating process, either for herself, or in conjunction with labouring women.

The ability of the midwife to engage mutually is a strategy for authenticating but also a consequence of making sense, reframing and balancing. Engaging mutually implies that a woman and midwife are in tune with each other, and this relationship forms the basis for caring practice. If this phase of the process is reached, less energy needs to be used by either the woman or the midwife for authenticating, and is available for the work of labour.

CONTEXTUAL FACTORS THAT IMPINGE ON THE PROCESS OF AUTHENTICATING

Starting from an interactional perspective, the present study explored the relationship between midwives and birthing women in a hospital. In so doing, it uncovered the significant impact of contextual factors on the interactional processes between midwives and birthing women. In order to understand the proposed framework of authenticating, and to appreciate that the process does not occur in a vacuum, these contextual factors are identified and discussed. Organisational, ideological and political factors intensify the need for authenticating by both women and midwives, and impact on the configuration of the process itself. Moreover, contextual factors exert an important influence on how successful or unsuccessful the process of authenticating will be.

Organizational Factors

Childbirth takes place within an organizational and interactional context that impinges both on the practice of midwifery and the experience of birthing for women. Understanding the hospital as a bureaucratic organization is crucial to viewing the experience of childbirth in it's totality, and hence the greater necessity for the authenticating process. (Fagerhaugh & Strauss 1977)

Traditionally hospitals were established to provide a place to care for ill people who needed the specialized services of doctors and nurses. Placing childbirth in a hospital setting has had the consequence of imposing routines and procedures, established for the care of sick people, on birthing women whose needs are quite different.

Twenty four hour a day staffing by nurses and midwives is required in a hospital setting. This twenty four hours is traditionally divided into three shifts. The application of this seemingly inviolate rule has enormous impact on a labouring woman's experience of midwifery care. Any woman

experiencing a labour of longer than seven hours will have a minimum of two different midwives caring for her, and even a woman labouring for no more than three or four hours may experience change in attending midwives, if her labour occurs over the time of a shift change.

Not only does this absence of a continuous relationship with one midwife make the process of authenticating more difficult, but it may also increase a woman's need to authenticate. The more caregivers a woman encounters during her labour, the more likely she is to be exposed to differing philosophies about such diverse issues as the amount and type of information provided, pain relief measures used, and the type of control a midwife exerts in relation to mobility, support persons etc. It is not infrequent for a woman to encounter a new midwife at a critical time in her labouring process. A woman may find this new midwife congenial in relation to beliefs about care, or she may not. In any case, a woman in advanced labour is not in the best position to discuss her beliefs, debate how she should be cared for, or assert herself in terms of her needs. In such situations, a woman's personal resources, already being utilized in full with regard to labour, are depleted further and she becomes increasingly dependent.

Along with the sheer number of people a labouring woman must deal with, she is faced with people of varying levels of skill. This applies to technical as well as interpersonal skills. Midwives are usually well educated in technical skills, even though less emphasis may have been placed on interpersonal skills during their midwifery education. This can mean that a woman who has been working well with a particular midwife, and loses her due to a shift change, may not be able to expend the same kind of energy in establishing another relationship. If she is interacting with a midwife less able to use her human skills, then trust and rapport may diminish, and the birthing woman may be left to cope on her own. Midwives' ability to inspire confidence, to empower birthing women, and to acknowledge their contribution to the process of childbirth is dependent on their interpersonal expertness. Women receiving messages that confirm their strength and autonomy, are more likely to feel strong and autonomous (Flint 1986)

Another organizational feature of labour and delivery areas is that there are slow and busy times. The staffing pattern usually remains consistent, however. This has the unfortunate effect of providing very different

experiences for birthing women. If a woman is lucky enough to go into labour during a slow period, then she may have the option of one to one care. If the opposite happens, though, and it is very busy, then it will be unlikely that she will have a midwife with her throughout most of her labour.

The presence of a midwife during labour has been identified as extremely important by the women in the present study. Recent research (Hodnett et al, 1988) provides support for the notion that continual presence is beneficial to labouring women and that the present hospital practice of intermittent midwifery care does undermine women's confidence and ability to give birth normally. There is no doubt that intermittent care interferes with the activities of making sense, reframing, balancing, and mutually engaging.

Organizational factors act in significant ways to diminish a woman's confidence in herself, comfort in the setting, and confidence with her caregivers. This diminished confidence makes her far more vulnerable and often results in the perception that intervention in the normal process of birth is necessary. A birthing woman has little information about organizational factors and the way they can and do affect her care, as they are seldom acknowledged. A woman will, therefore, frequently assign responsibility for unacceptable happenings to herself, rather than to the structures that are in place in the childbirth setting.

Ideological and Political Factors

Childbirth in hospital is an ideological issue, immersed in divergent philosophies for reaching the common goal of 'concluding' the pregnancy with a 'healthy' baby and mother. How one defines 'healthy' and how one defines 'concluding' a pregnancy, varies depending on one's ideological perspective.

With few exceptions, doctors are educated and practice within an acute care model, in which their actual experience with normal labour and delivery is limited. The very fact that childbirth takes place in hospital, reinforces the notion that 'active management' of childbirth is desirable, and with the very best of intentions, childbirth is 'managed' according to a set of specific rules. There is support in the research literature for the notion that the availability of technology and the attendance by doctors during normal birth increases the

intervention rate, without ordinarily improving outcomes (Slome et al., 1976; Beal, 1984; Sharp & Lewis, 1984; Nichols, 1985). In most cases, midwives are educated in a totally different paradigm. In addition, it is seldom acknowledged that because they are a witness to the process of labour and birthing, they gain experiential knowledge in a way that a majority of doctors never do. Midwives view childbirth as an experience the birthing woman manages with the help of a caring midwife and the process of giving birth is assumed to progress normally most of the time, making intervention unnecessary.

When women enter hospital, they come into an unfamiliar and frequently frightening place, the home terrain of doctors and midwives. There is a well established hierarchy and set of rules of which women are mostly unaware. By it's very nature and structure a hospital renders women dependent. To some extent, labouring women are guided into taking on a patient role. They have been socialized to believe it is in their and the baby's best interest to give birth in as normal and natural a way as possible, and yet they are in a hospital which has been set up to treat illness. Women in labour are looked after by medical and midwifery personnel, from two very different ideological frameworks. This, however, is usually implicit and as a result most women are unaware of differing philosophies of care.

The issue of pain management for labouring women serves to illustrate both ideological and political factors surrounding a hospital birth. Midwives traditionally assist women to handle the pain associated with labour by providing continuous one to one support and presence, and by verbally encouraging and assisting with relaxation techniques. In addition, midwives make suggestions with regard to labouring women being mobile and changing their location from chair to bathtub or to the floor. They also encourage women to adopt a variety of positions for second stage. The midwife uses her knowledge about the woman she is with, the pain associated with contractions, relaxation techniques, and measures to reduce anxiety, as a first and most important aspect of her practice in relation to pain relief.

Many midwives in this study identified their ability to inspire confidence in each birthing woman being cared for as their most important tool, but acknowledged the difficulties of spending enough time with one woman

during labour to always accomplish this goal. Women giving birth in hospital are deprived of many non-pharmacological pain relief measures. Moreover, anxiety is increased due to their unfamiliarity with a hospital environment, as well as the lack of privacy and control they experience. Under the circumstances, the pain a woman experiences may become overwhelming. Without access to alternative forms of managing pain, women become vulnerable to accepting pharmacological pain relief measures and furthermore, within the political arena of the hospital, one-to-one care of labouring woman is not given high priority.

Within the technocratic ideology, pain can easily be taken care of with the administration of an analgesic drug, and this is usually the first option from the doctor's viewpoint. With the administration of analgesia, the dependency and hence, the vulnerability of the labouring woman is intensified, and she becomes increasingly subject to the possibility of an ever increasing array of technological interventions.

Throughout pregnancy, women are given the explicit message that they are responsible for the safety of their unborn child. They receive specific directions with regard to the hazardous practice of taking drugs, including alcohol and tobacco. Instead, breathing exercises, massage techniques and position changes are usually advocated as safe and desirable ways of coping. It is only to be expected then that many women embark on labour with the expectation that they will be successful in using these techniques. A woman who nevertheless requires analgesic medication during labour is unaware of the political and ideological realities surrounding the issue of pain relief. She is only aware of her own failure to work with her labour and successfully give birth. The more technological intervention she experiences, the greater will be her sense of failure, and the more divergent her experience of childbirth will be from her expectation. This relationship between an interventionist birth and a sense of failure finds support in recent research literature, (Sandelowski, 1988; Jacoby, 1987; Nelson, 1982) even when technology is presented as being critical for the safety of the baby. Women, although they may feel safe and relieved at the time of birth, continue to experience the need to relive the experience and to understand what happened and why it happened.

Women have the expectation of themselves that the 'conclusion' of the pregnancy will result from their own efforts and that they will participate actively in the process. A woman experiencing an interventionist birth is forced to make sense and reframe both her image of birth and her image of herself. Often this happens without adequate information and by herself, after returning home. Once her delivery is over, a woman does not have access to the midwife that cared for her. Her doctor, operating from a different knowledge perspective often does not understand a woman's need to review her experience of giving birth. It may be that he sees it as in the past and successfully accomplished, especially if both mother and baby are healthy. In any case, having usually been absent for the most part of the labour, and having arrived only in time to deliver the baby, the doctor is seldom in a position to understand what a woman has been through, even if he were inclined to discuss her labour at some length with her.

Practice in a hospital setting often impinges on the midwives' ability to operationalize practices that reflect women's beliefs about childbirth and how they should be cared for. In relation to the organizational structures, and especially in relation to the medical profession, a midwife has little political power and as a result, is vulnerable to the imposition of a technological paradigm on her own practice. Midwives are continually needing to make sense and reframe for themselves in relation to divergent belief systems while at the same time they are trying to assist women in this process. In addition, they must continually balance their beliefs about caring for labouring women with their real and perceived lack of authority with regard to the care they provide.

Within the technocratic model concluding pregnancy is a high risk activity. Birthing is seen as a dangerous process, women's bodies are seen as unreliable, and women's skilled participation in, and knowledge about childbirth is seen as being only marginally important. A woman is divorced from her labour and birthing, and the 'means' to achieve the 'ends', a safe birth, are separated, at least from the perspective of this model of childbirth. The interventions considered necessary to achieve the goal, are seen as innocuous or beneficial, rather than as carrying physical and psychological risks. The way that information and knowledge can be kept private and the technological language used, serves to further isolate a woman from participation.

Ideology implies a bond with and focus on a paradigm, whether it be midwifery or technocratic. This results in the paradigm being central in the attention of caregivers. If caregivers attend instead, to women and their individuality in giving birth, and if care is mutually directed, then there will be less disparity in the way women wish and prepare to give birth, and the manner in which childbirth frequently occurs. The ideological context of competing paradigms of care in which childbirth occurs in New Zealand and in other parts of the world, accounts for much of the discrepancy between what both midwives and birthing women want and what they actually experience. This tension between paradigms goes beyond disagreements about birth procedures and their consequences. It is partly a fundamental clash between belief systems and birthing women find themselves at the centre of this clash. As a consequence, women have a great need to authenticate and assign meaning to their experiences.

The conceptualisation of midwifery care as a process of authenticating suggests that the differences between the technocratic and midwifery models of childbirth care need not be set up in opposition to one another. What the process of authenticating seems to clarify is that the use of the technocratic paradigm in normal childbirth is inappropriate and poses significant difficulties for women. Highly specialised technological intervention is necessary in some situations and it is the appropriate use of technology and specialised skills that is important in the care of childbearing women. The respective roles, areas of expertise and of practice for doctors and midwives need to be clarified in order to decrease the tension existing between these two paradigms and in order to provide the best possible care for women in childbirth.

SIGNIFICANCE OF AUTHENTICATING AS A CONCEPTUAL FRAMEWORK FOR MIDWIFERY PRACTICE

The conceptual framework of authenticating stemming from the present study, could be seen to be immensely practical when applied in practice, even though further research is clearly necessary. The framework offers not only another way of looking at midwifery, but has useful implications for midwives and women giving birth. It addresses the reality of practice and birthing worlds for both midwives and women. To be useful as a framework

for practice the process of authenticating must be understood within the context of the technocratic and midwifery paradigms. Neither one is negated or promoted within the proposed framework. The surfacing of ideological and organizational factors that impact on and impede midwifery care within this framework for practice is valuable, as these factors are usually unacknowledged in practice.

Authenticating, as a framework for use in the practice of midwifery, legitimizes the value of midwives 'being with' women, and diminishes to some extent, the uncritical acceptance of the technocratic paradigm. It offers a new way of looking at the technology associated with childbirth, and a way of encouraging it's more appropriate use. Midwives, able to assist women in labour with making sense and reframing their image of childbirth, help these women keep the picture whole and accurate. Women who are aware of what and why something is happening are much more capable of participating in informed decisions with regard to their care. Successful authenticating as labour and birth progress, serves to involve a woman in the immediacy of her own experience and enhance her ability to participate in mutually directed care, that has at it's core, her needs, values and wishes. Balancing in favour of women and not the institution and mutual engagement between midwives and birthing women strengthens and empowers both.

Through authenticating, an ideological position on certain aspects of care, such as pain relief becomes unnecessary as women will and do feel differently about these issues. The woman herself becomes central in the decision making process and is made fully aware of the rationale for and consequences of her choices.

The use of the authenticating process as a core of midwifery practice, facilitates a woman-centred approach in childbirth. This research has described and conceptualized midwifery practice and in so doing, has provided midwives with tools useful in caring for women whatever their experience of birth is like. Using this conceptual framework in practice, enhances and strengthens the personal resources of women, which is a valued philosophical premise underlying midwifery care.

> How a woman gives birth is a reflection of societies regard for women. If a woman is revered and respected during childbirth, if she is empowered and supported, she starts off her role as a mother strong and self confident. Her child has a mother who is victorious and happy. But if a woman is humiliated and pushed around during childbirth - however kindly that is done - if she is made to feel like a powerless child - if she is infantalized - if she feels like a victim of birth, who has had things done to her,and who has been deprived of the birth experience - she starts off her mothering feeling depressed and powerless, a victim of childbirth. Her child has for it's mother, someone who is sad, someone who is weak, someone without power and someone full of grief - someone who has been deprived. Childbirth is supremely important. It really matters how women give birth.
>
> (Flint, 1988)

CONCLUSION

The process of authenticating derived from the study data is proposed as a possible framework for midwifery practice. It is a process that provides a conceptual framework for the seemingly independent activities related to the physical and emotional care of birthing women. Through the phases of making sense, reframing, balancing, and engaging the process of authenticating points to the mutuality of the birthing woman and the midwife.

Chapter 11 concludes the thesis and discusses limitations of this study as well as implications for education and practice. In addition, directions for future research are proposed.

CHAPTER ELEVEN

CONCLUSION AND RECOMMENDATIONS

This study has generated data for the systematic development of a conceptual framework of the process of authenticating. Derived from the worlds of practising midwives and birthing women in a hospital setting, the process of authenticating addresses that which is most meaningful to both women and midwives. Within this framework both are viewed as partners, both 'work' and both make an essential contribution to a safe and satisfying passage through the childbirth experience.

LIMITATIONS OF THIS STUDY

The pioneering nature of the study, its scope, and time constraints limit the findings in terms of generalisability. There is clearly a need to research midwifery practice and the experience of childbirth in a variety of settings in New Zealand and with a larger and more diverse population. Nevertheless, the study findings provide tentative implications for midwifery practice, education, and research, and these are presented in this final chapter.

IMPLICATIONS FOR PRACTICE

The ultimate aim of nursing research is to improve the quality and relevance of the care offered by nurses. The study proposes the process of authenticating as a means to achieving greater quality of care in midwifery practice. Each phase of the process addresses issues raised by midwives and childbearing women and is a conceptual way of merging the cognitive, physical and interpersonal skills that comprise the profession and practice of midwifery. Although the process addresses midwifery practice within the context of the hospital, the level of abstraction encourages application in other situations where childbirth takes place. At the very least, awareness of the authenticating process may sensitise midwives to the impact they have on childbearing couples. In addition, the use of this process has the potential for making the care offered by midwives more congruent for each woman and her experience of childbirth. Thus, although the process of

authenticating addresses the birthing period, the nature of the process itself, and its level of abstraction may make its application useful in other areas of the childbirth experience such as antenatal education and postnatal care.

Use of this conceptual framework emphasises the need to know a woman before caring for her. The difficulty of doing this, with the way childbirth care is offered in the present fragmented system, is acknowledged. Nevertheless, the necessity remains for expanded history forms that take account of a woman's past experiences of giving birth, her knowledge about the process of labour and her plans and expectations for the present experience.

Midwives are clinical experts in the care of birthing women. The present way in which childbirth care is offered limits options for practice and detracts from the recognition of the midwife as expert practitioner. Creative use of the authenticating framework may provide a means of surfacing and defining midwifery expertise so as to yield a way of communicating to the public, and other health professionals, the value of midwifery practice and the role that midwives play in normal childbirth. This role is different from medical obstetrics and valid in its own right.

Because this qualitative study took place within the context of a hospital setting, and due to the nature of data collection methods used, the strong impact that the setting has on both midwifery practice and the experience of giving birth became clearly evident. Thus a fresh perspective on midwifery care is offered by this study. Considerable tension exists between the knowledge and skill base that a midwife has and the way in which she actually practices in the hospital. The constraints that are a part of the setting negatively affect the care offered to birthing women. If this care continues to be offered in a hospital setting then there are a variety of issues that need to be addressed by the administration and other health care professionals. The importance of one-to-one care by the midwife, continuity of care for birthing women and colleagiality between doctors and midwives are examples of these issues. Structures that preclude the involvement of one midwife with one birthing woman require attention. In addition, public education is required that addresses the respective strengths, as well as the

roles and responsibilities of the doctor and the midwife so that women have realistic expectations for each. This study demonstrates the importance of a woman having knowledge about the system within which childbirth occurs, since without such knowledge both women and midwives are disadvantaged.

The study has succeeded in identifying both the strengths and problems that are part of midwifery practice in a hospital setting. As such, it has value as a means of confirming the worth and importance of midwifery care for birthing women. Many of the problems identified in this study are of an organisational and ideological nature and pose particular challenges for change in the organisation and delivery of midwifery services. Indeed, the study confirms the importance of traditional midwifery beliefs and values and could serve as an impetus to change the way that midwifery is practiced in the context of normal childbirth. Independently run midwifery units, staffed by a group of midwives who provide continuity of care for birthing women and who practice within a paradigm of mutuality as described within the framework of authenticating is just one example of change that could be considered.

The 'fit' and 'work' of the framework is yet to be tested in actual practice. Discussions held with childbearing women and practicing midwives provide initial support for the process of authenticating, as valid and important. It is recognised, however, that further research is needed.

IMPLICATIONS FOR EDUCATION

The educational process that a nurse undertakes to become a midwife plays an important part in how she practices. Socialisation into the profession of midwifery must take into account the complex blend of differing paradigms within which childbirth care is offered. The conceptual framework developed in this study addresses these disparate paradigms and promotes a more appropriate, women-centred approach to care. Thus women and their caregivers are partners in childbirth. Use of this framework in education would aid in socialising midwives into a philosophy of mutuality with women, but it would also necessitate a more integrated approach to the learning and development of interpersonal skills.

In addition to promoting women-centred practice, the process of authenticating reestablishes caring as a central concept in midwifery, and provides both a practical and a conceptual way of addressing caring. Thus interpersonal skills of caring are not taught as a theoretical part of midwifery practice but become the central core around which other knowledge and skills required to care for childbearing women revolve. In addition, the emphasis in the process of authenticating on both midwives and women is important because it directs educators to focus on the impact that one has on the other.

The study confirms the centrality of the midwife in the care of the birthing women and identifies her as a practitioner capable of giving expert care. There is a great need for the educative process to aid in the development of a strong sense of identity in new midwives and to surface the critical role they play in the care of birthing women. Use of the authenticating process in the education of midwives could aid in the accomplishment of this task.

IMPLICATIONS FOR RESEARCH

The present study represents a beginning attempt to explicate midwifery practice and how midwives influence the experience of giving birth for women. The conceptual framework, identified as the process of authenticating, is grounded in the data and therefore in the worlds of midwives and childbearing women. It has not, however, been tested in that world. There is a need for similar studies, in a variety of settings, and with different populations.

The process of authenticating does challenge midwives to reflect on their own practice and, in addition, offers tentative support for previously researched constructs such as, for example, a mastery model of childbirth. In addition, as this research has attempted to identify ways in which midwifery care can enhance the quality of care offered to women, testing of the conceptual framework with regard to womens' views of their care is a priority, and studies that address each of the conceptual phases of the process and their dimensions are necessary.

Perhaps one of the most innovative and exciting research endeavours would be to test the theory in action by setting up a midwifery unit whereby the process of authenticating could provide the framework for practice. In addition to providing opportunity to test the value of the process with regard to a woman's experience of her care, such a unit could provide opportunity to assess the expertness of midwives and reward individuals who exemplify expert practice while assisting others to improve their practice. Such a unit could provide an excellent clinical teaching and preceptoring experience for student midwives.

Appendix 1.

Explanation Of The Study And Informed Consent

During initial phone calls to potential participants information about the researchers credentials and background was given, and explanation and description of the following points was made:

* Nature and purpose of the study. For example...
"I am interested in discovering how a midwife can most positively care for you during your labour and delivery and what your expectations of her role are."

* Usefulness of the study. For example...
"I believe that information gained from this study could be useful to you and the midwives who work with you and others. Talking through your birthing experience is a helpful way of checking out details and putting it in perspective with your pregnancy and life as a parent. Research that is focused on the care midwives give can assist in identifying practices that enhance the birthing experience for couples."

* Free access to information. For example...
"You will be free to ask questions or request further information at any time during the study."

* Freedom to withdraw from the study. For example...
"You are free to decline initial participation or withdraw at any time without prejudice to your care."

* Assurance of confidentiality and anonymity. For example...
"Your name will not be used in any of the reports of this study and recorded conversations will be erased once analysed."

In addition, requirements for participation were explained as follows:

* You will be asked to take part in at least one antenatal interview, taped if possible, with the focus being on your expectations regarding the care to be provided by the midwife; two post birth interviews, one during your time in hospital and the second after your discharge; and one follow up interview, once data analysis is completed."

* You will be asked to allow the investigator to be present during your labour and birth.

Appendix 2

Massey University
Department of Nursing Studies

Staff Member's Consent To Participate In A Research Study

1. **Title:** Midwifery Practice: A study of the care provided by midwives to couples experiencing a hospital birth.

2. **Investigator:**
Joan L. Bassett-Smith, Masterate student,
Department of Nursing Studies,
Massey University.

3. **Venue:** Palmerston North Hospital, Labor and Delivery Suite.

4. **Aim of Study:**

The primary aim of this study is to describe the care you provide to birthing couples.

5. **Your Involvement in the Study:**

If you agree to participate in this study you will be asked to take part in an interview with the researcher where the focus would be on describing the care you provided to the couple. You will also be asked to have the interview tape recorded, or recorded in writing, as well as to allow the investigator to be present during part of the couple's birthing experience. The couple you are caring for will also be participating in an interview.

6. **Requirements of the Study:**

The success of this study requires a willingness on your part to share with the Investigator both your time and your thoughts about your practice as a midwife.

7. Statement By Staff Member:

"I have read the above and have had all questions answered to my satisfaction. I understand that this study has been approved by the Hospital Research and Ethical Committee and that I may withdraw agreement at any time. I understand that complete confidentiality and anonymity is guaranteed. I understand that any information I provide or any observations of my behavior will be used for research purposes only and will not be communicated to anyone in a way that would identify me personally. I further understand that oppertunity to discuss the findings of this study will be provided by the Investigator. I agree to take part in this study. I agree to have the interview(s) tape recorded/recorded in writing."

Signature of Staff Member:
Date:

Signature of Investigator:
Date:

Appendix 3

Massey University
Department of Nursing Studies

Couple Consent to Participate in a Research Study

1 Title: Midwifery Practice: A study of the care provided by midwives to couples experiencing a hospital birth.

2 Investigator:
Joan L. Bassett-Smith. Masterate student,
Deptartment of Nursing Studies,
Massey University.

3 Venue: Palmerston North Hospital, Labor and Delivery Suite.

4 Aim of Study:

The primary aim of this study is to discover how midwives care for couples during their birthing experience and how their practice influences the couple's experience of labor and birth.

5 Your Involvement in the Study:

If you agree to participate, you will be asked to take part in a minimum of three interviews which will be either tape recorded or recorded in writing. You will also be asked to allow the Investigator to be present during part of your birthing experience. The midwives who are caring for you will also be asked to participate in an interview.

6 How Will This Study Affect You?

Your care will not be altered in any way as it is the purpose of this study to look at the usual care given. Investigator presence could cause increased stress to you and your support person. Every effort

will be made to avoid this, principally by getting to know both of you before admission to hospital. If you agree to participate, you may be assured protection of the following rights:

(i). You are free to ask for further information at any time.

(ii). You are free to decline participation or withdraw from the study at any time without prejudice to your care.

(iii). Complete confidentiality and anonymity is assured.

(iv). Oppertunity for discussion of study findings will be made available.

7 Statement By The Patient:

"I have read the above and have had all questions answered to my satisfaction. I understand that this study has been approved by a special hospital committee and that I may withdraw my agreement at any time. I have been given to understand that any private information will be treated with the strictest confidence. I understand that taking part in this study will not interfer with my medical or nursing care and that my doctors and nurses are in agreement with my taking part in this study. I agree to participate in this study and to have interviews tape recorded/recorded in writing."

Signature of client:
Date:

Signature of support person:
Date:

Signature of Investigator:
Date:

REFERENCES

Andrews,C. (1987)
ADN review: a call for midwifery changes. **New Zealand Nursing Journal**, May: 26-27.

Arizmendi, T.G. & Affonso, D.D. (1987)
Stressful events related to pregnancy and postpartum, **Journal of Psychosomatic Research**, 31 (6): 743-756.

Arney, R. & Neill, J. (1982)
The location of pain in childbirth: natural childbirth and the transfer of obstetrics. **Sociology of Health and Illness**, 4 (1): 1-24.

Artinian, B. (1982)
Conceptual mapping: Development of the Strategy. **Western Journal of Nursing Research**, 4 (4): 379-393.

Barnett, F. (1987)
The experience and management of pain in childbirth. **Midwifery Practice: An Exploration**. Proceedings of a workshop on midwifery practice. Palmerston North: Dept.of Nursing Studies, Massey University. 10-19.

Beal, M.W. (1984)
Nurse-midwifery intrapartum management. **Journal of Nurse Midwifery**, 29 (1): 13-19.

Beck, N.C., Siegel, L.J., Davidson, N.P., Kormeier, S. Brifenstein, A. & Hall, D.G. (1980)
The prediction of pregnancy outcome: Maternal preparation, anxiety and attitudinal sets. **Journal of Psychosomatic Research**, 24: 343-350.

Benner, P. (1988)
Seminar presentation at Massey University, Palmerston.

Benner, P. & Wrubel, J. (1989)
The Primacy of Caring: Stress and Coping in Health and Illness. Menlo Park, Calif.: Addison-Wesley.

Birch, P. (1982)
Mothers' Decision-making During Labour and Delivery. Unpublished Masters Thesis, McGill University.

Blummer, H. (1969)
Symbolic Interactionism: Perspective and Method. Engelwood Cliffs, New Jersey: Prentice Hall.

Bonica, J. (1969)
Principles and Practice of Obstetric Analgesia and Anesthesia. Vol.2. Philadelphia: Davis.

Boettcher,E. (1985)
Boundary marking. **Journal of Psychosocial Nursing**, 23(8): 25-30.

Breen, S. (1987)
After the birth. **New Zealand Nursing Journal**, August: 18-19.

Broom, D.H. (1984)
The medicalisation of childbirth: A new role for the midwife. **Healthright**, 4 (1): 10-14.

Catanzaro, M. (1988)
Using qualitative analytical techniques in
Woods, W. & Cantanzaro, M. (Eds) **Nursing Research: Theory and Practice**. Toronto: Mosby.

Chenitz, W.C. & Swanson, J.M. (1986)
From Practice to Grounded Theory. Qualitative Research in Nursing. Menlo Park, Calif.: Addison-Wesley.

Christensen-Szalanski, J. (1984)
Discount functions and the measurement of patients' values. Women's decisions during childbirth. **Medical Decision Making**, 4 (1): 47-58.

Clark, M. (1987)
The alternative birthing area at Queen Mary Hospital, Dunedin. **Midwifery Practice: An Exploration**. Proceedings of a workshop on midwifery practice. Palmerston North: Dept.of Nursing Studies, Massey University. 37-39.

Cogan, R. (1980)
Effects of childbirth preparation. **Clinical Obstetrics and Gynecology**, 23: 1-14.

Collins Dictionary of the English Language. (1985)
London: Collins.

Conners, D. (1988)
A continuum of researcher-participant relationships: An analysis and critique. **Advances in Nursing Science**, 10 (4): 32-42.

Crawford, J.S. (1985)
The midwife's contribution to epidural analgesia and delivery. **Midwifery**, 1: 24-31.

Cronk, M. (1987)
Listen to Mothers. **Nursing Times**, April 15: 46-47.

Crouch, M. & Manderson,L. (1987)
Changing Images of Childbirth. Unpublished paper presented at A.N.Z.A.S.S. January.

Davenport-Slack,B. & Boylan, C.H. (1974)
Psychological correlates of childbirth pain. **Psychosomatic Medicine**, 36 (3): 215-222.

Davis, L. & Katz, B.M. (1979)
Knowledge and attitude toward nurse-midwifery among women taking childbirth education classes. **Journal of Nurse Midwifery**, 24 (4): 18-26.

Dick-Read, G. (1956) **Childbirth Without Fear: The Principles and Practices of Natural Childbirth**, 3rd edition. London: Heinemann.

Doering, S.G., Entwisle, D.R. & Quinlan, D. (1980)
Modelling the quality of women's birth experience. **Journal of Health and Social Behavior**, 21: 12-21.

Donley, J. (1986)
Save the Midwife. Auckland: New Womens' Press.

Donley, J. (1987)
'Rival and colleague'. **Midwifery Practice: An Exploration**.Proceedings of a workshop on midwifery practice. Palmerston North: Dept. of Nursing Studies, Massey University. 1-10.

Duchene, P. (1988)
Pain, biofeedback and childbirth. **International Journal of Childbirth Education**, 3 (1): 12-13.

Fagerhaugh, S.T. & Strauss, A. (1977)
Politics of Pain Management: Staff-Patient Interaction. Menlo Park, Calif.: Addison-Wesley.

Field, P.A. (1985)
Parents' reactions to maternity care. **Journal of Midwifery**, 1: 37-46.

Field, P.A. (1987)
Maternity nurses: How parents see us. **International Journal of Nursing Studies**, 24 (3): 191-199.

Flint, C. (1986)
Sensitive Midwifery. London: Heinemann Midwifery.

Flint, C. (1988)
The Vision For Midwifery. Paper Presented at Midwifery Conference, Auckland, N.Z.

Fridh, G., Kopare, T., Gaston-Johansson, F. & Turner-Norvell, K. (1986)
Factors associated with more intense labor pain. **Research in Nursing and Health**, 11: 117-124.

Gardner, D. (1985)
Presence. in Bulechek, G. & McCloskey, J. (Eds) **Nursing Interventions. Treatments For Nursing Diagnoses**. Sydney: W.B.Saunders.

Gaskin, I. (1980)
Spiritual Midwifery. Summertown, Tenessee: The Book Publishing Co.

Gaston-Johansson, F., Fridh, G. & Turner-Norvell, K. (1988)
Progression of labor pain in primiparas and multiparas. **Nursing Research**, 37 (2): 86-90).

Geden, E., Beck, N., Anderson, J. Kennish, M. & Mueller-Heinze, M. (1986)
Effects of cognitive and pharmacological strategies on analogued labor pain. **Nursing Research**, 35 (5): 301-306.

Glaser, B.G. (1978)
Theoretical Sensitivity: Advances in the Methodology of Grounded Theory. Mill Valley, Calif.: The Sociology Press.

Glaser, B.G. & Strauss, A.L. (1967)
The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago: Aldric Publishing.

Griffith, P. (1988)
Midwives' attitudes: Promoting normal birth. **Australian Journal of Advanced Nursing**, 5 (3): 33-39.

Haire, D. (1972)
The cultural warping of childbirth. Seattle: International Childbirth Education Association.

Hasslacher, B. (1988)
Birth at Home. **New Zealand Nursing Journal**, April, 25-26.

Hedstrom, L. & Newton, N. (1986)
Touch in labor: A comparison of cultures and eras. **Birth**, 3: 181-186.

Highly, B.L. & Mercer, R.T. (1978)
Safeguarding the laboring woman's sense of control. **Maternal Child Nursing**, Jan/Feb: 39-41.

Hodnett, E. (1982)
Patient control during labour: Effects of two types of fetal monitors. **Journal of Obstetrical, Gynecological and Neonatal Nursing**, March/April: 94-99.

Hodnett, E.D. (1987)
The environmental load of childbirth settings: Development and testing of a measurement tool. **Nursing Papers**, 19 (2): 3-16.

Hodnett, E.D. & Abel, S.M. (1986)
Person-environment interaction as a determinant of labor length variables. **Health Care for Women International**, 7: 341-356.

Hodnett, E.& Osborn, R. (1988)
The Effect of Continuous Supportive Care on Childbirth Outcomes. Canada: National Health Research and Development Program, Health and Welfare.

Hodnett, E.D. & Simmons-Tropea, D.A. (1987)
The labor agentry scale: Psychometric properties of an instrument measuring control during childbirth. **Research in Nursing and Health**, 10: 301-310.

Humenick, S.S. (1981)
Mastery: The key to childbirth satisfaction? A review. **Birth and the Family Journal**, 8 (2): 79-83.

Humenick, S.S. & Bugen, L.A. (1981)
Mastery: The key to childbirth satisfaction? A study. **Birth and Family Journal**, 8 (2): 84-90.

Jacoby, A. (1987)
Women's preferences for and satisfaction with current procedures in childbirth-- findings from a national study. **Midwifery**, 3: 117-124.

Jordan, B. (1987)
High technology: the case of obstetrics. **World Health Forum**, 8: 312-328.

Kalish, B.J., Kalish, P.A. & Clinton, J. (1980)
How the public sees nurse midwives: 1978 news coverage of nurse-midwifery in the nations press. **Journal of Nurse Midwifery**, 25 (4): 31-39.

Katz Rothman, B. (1982)
In Labour. Women and Power in the Birth Place. New York: W.W. Norton.

Kitzinger, S. (1987)
Giving Birth: How it Really Feels. London: Victor Gollancz.

Klaus, M. & Kennel, J. (1976)
Maternal Infant Bonding. Saint Louis: Mosby.

Klein, M. & Westreich, R. (1983)
Birth room transfer and procedure rates-- what do they tell about the setting? **Birth and the Family Journal**, 10 (2): 93-97.

Klusman, L.E. (1975)
Reduction of pain by alleviation of anxiety during pregnancy. **Journal of Consulting and Clinical Psychology**, 43 (2): 162-165.

Korr,K., Block, C.R., Charles, A., Meyering, S. & Meyers, E. (1977)
Explaining pain and enjoyment in childbirth. **Journal of Health and Social Behavior**, 18: 260-275.

Lincoln, Y. & Guba, E. (1985)
Naturalistic Inquiry. Calif.: Sage.

Litoff, J.B. (1982)
The midwife throughout history. **Journal of Nurse Midwifery**, 27 (6): 3-11.

Littlefield, V.M. & Adams, B.N. (1987)
Patient participation in alternative perinatal care: impact on satisfaction and health locus of control. **Research in Nursing and Health**, 10: 139-148.

Lowe, N.K. (1987)
Parity and pain during parturition. **Journal of Obstetric, Gynecological and Neonatal Nursing**, Sept/Oct.: 340-346.

Lynn, N. (1987)
Pain theory and childbirth. **International Journal of Childbirth Education**, May: 21-32.

McClain C. (1981)
Women's choice for home or hospital birth. **Journal of Family Practice**, 12 (6): 1003-1038.

Moccia, P. (1988)
A critique of compromise: Beyond the methods debate. **Advances in Nursing Science**, 10 (4): 1-9.

Mehl, L.E., Ramiel, J.R., Leinenger, B., Hoff, B. Kroenthal, K. & Peterson, G.H. (1980)
Evaluation of outcomes of non-nurse midwives: Matched comparisons with physicians. **Women and Health**, 5 (2): 17-29.

Mein-Smith, P. (1986)
Maternity in Dispute in New Zealand 1920-1939. Historical Publications Branch, Department of Internal Affairs. Wellington, N.Z.: Government Printer.

Melzack, R. (1984)
The myth of painless childbirth. **Pain**, 19: 312-337.

Mercer, R.T. (1985)
Relationship of the birth experience to later mothering behaviours. **Journal of Nurse Midwifery**, 30 (4): 204-210.

Mercer, R.T. & Ferketich, S.L. (1988)
Stress and social support as predictors of anxiety and depression during pregnancy. **Advances in Nursing Science**, 10 (2): 26-39.

Mullen, P. & Reynolds, R. (1978)
The potential for grounded theory for health education research: Linking theory and practice. **Health Education Monographs**, 6 (3): 280-293.

Nelson, M.K. (1982)
Client responses to a discrepancy between the care they want and the care they receive. **Women and Health**, 6: 135-153.

Newton, N. (1977)
Maternal Emotions. New York: Paul B. Hoeber Inc.

New Zealand Nurses Assoiciation (1984)
Policy Statement on Midwifery. Wellington: N.Z.N.A.

New Zealand Nurses Association. (1988)
Consumer Survey 1987-1988. Ad Hoc Committee On Midwifery: Policy Statement, March. Wellington: N.Z.N.A.

Nichols, C.W. (1985)
The Vale nurse-midwifery practice. Addressing the outcomes. **Journal of Nurse Midwifery**, 30 (3): 159-165.

Oakley, A. (1986)
Feminism, motherhood and medicine- Who cares? in
Mitchell, J. & Oakley, A. (Eds), **What is Feminism**? Oxford: Blackwell. 127-150.

Odent, M. (1984)
Birth Reborn. New York: Random House.

Older, J. (1982)
Touching and birthing. **Touching is Healing**. New York: Stein & Day.

Olds, S., London, M. & Ladewig, P. (1988)
Maternal Newborn Nursing. A Family Centered Approach. 3rd Edition. Menlo Park: Addison-Wesley.

Perry, A. (1988)
Letter to the Editor. **New Zealand Nursing Journal**, November: 3-4.

Peterson, G. (1981)
Birthing Normally. A Personal Growth Approach to Childbirth. Berkley: Mindbody Press.

Rice, A. (1988)
Nurse midwifery, the first step. **RNABC News**, March/April: 10-13.

Richards, M.P.M. (1982)
Commentary: the trouble with choice in childbirth. **Birth and the Family Journal**, 9 (4): 253-259.

Rosenblatt, R., Reinken, J. & Shoemack, P. (1985)
Is obstetrics safe in small hospitals? **The Lancet**, August 24: 429-431.

Rubin, R. (1984)
Maternal Identity and the Maternal Experience. New York: Springer.

Sandelowski, M. (1986)
The problem of rigor in qualitative research. **Advances in Nursing Science**, 8 (3): 27-37.

Sandelowski, M. (1988)
A case of conflicting paradigms: Nursing and reproductive technology. **Advances in Nursing Science**, April: 35-45.

Schatzman, L. & Strauss, A. (1973)
Field Research: Strategies for a Natural Sociology. New Jersey: Prentice Hall.

Sharp, E.S. & Lewis, L.E. (1984)
A decade of nurse-midwifery practice in a tertiary university-affiliated hospital. **Journal of Nurse Midwifery**, 29 (6): 353-365.

Sheilds, D. (1978)
Nursing care in labor and patient satisfaction: A descriptive study. **Journal of Advanced Nursing**, 3: 335-550.

Simkin, P. (1986)
Stress, pain and catecholamines in labor: Part I. A review. **Birth**, 13 (4): 227-233.

Simkin, P. (1987)
Comfort measures for labor and how they work. **International Journal of Childbirth Education**, May: 5-7.

Simkin, Whalley & Keppler, (1984)
Pregnancy Childbirth and the Newborn. Seattle, Washington: Penny Press.

Slome, C., Wetherbee, H., Daly, M., Christenson, K., Meglen, M. & Thiede, H. (1976)
Effectiveness of certified nurse-midwives. **American Journal of Obstetrics and Gynecology**, 124 (2): 177-182.

Smythe, E. (1988)
Personal communication.

Sosa, R., Kennells, J., Klaus, M., Robertson, S. & Urrutia, J. (1980)
The effect of a supportive companion on perinatal problems, length of labor and mother-infant interaction. **New England Journal of Medicine**: 303-598.

Stern, P..N. (1980)
Grounded theory methodology: Its uses and processes. **Image. The Journal of Nursing Scholarship**, xii (i): 20-23.

Stern, P. & Pyles, S. (1985)
Using grounded theory methodology to study women's culturally based decisions about health. **Health Care For Women International**, 6 (1): 1-24.

Strauss, A. (1986)
Qualitative Analysis. England: Cambridge University Press.

Strid, J. (1987)
Midwifery in revolt. **Broadsheet**, November: 14-17.

Sutherland, P. (1984)
The birth centre at the Royal Hospital for Women, Paddington. **Healthright**, 4 (1): 10-14.

Swanson-Kauffman, K. (1986)
A combined qualitative methodology for nursing research. **Advances in Nursing Science**, 8 (3): 59-69.

Thomson, A. (1988)
Management of the woman in normal second stage of labour. A review. **Midwifery**, 4: 77-85.

Trandel-Korenchuk, D. M. (1987)
The effect of social and care environments on the disclosure practices of nurse-midwives relative to methods of pain management in childbirth. **Journal of Obstetric, Gynecological and Neonatal Nursing**, July/August: 258-265.

Waldenström, U. (1988)
Midwives' Attitudes to Pain Relief During Labour and Delivery. **Midwifery**, 4: 48-57.

Walker, J.F. (1976)
Midwife or Obstetric Nurse? Some perceptions of midwives and obstetricians of the role of the midwife. **Journal of Advanced Nursing**, 1: 129-138.

Wellish P. & Root, S. (1987)
Hearts Open Wide. Midwives and Births. Calif.: Wingbow Press.

Williams, S., Hepburn, M. & McIlwaine, G. (1985)
Consumer view of epidural anaesthesia. **Midwifery**, 1: 32-36.

Wilson, H.S. (1985)
Research in Nursing. Menlo Park, Calif.: Addison-Wesley.

Young, I.M. (1984)
Pregnant embodiment: Subjectivity and alienation. **Journal of Medicine and Philosophy**, 9: 45-62.