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Autonomy, Clinical Freedom and Responsibility:

**The paradoxes of providing
intrapartum midwifery care in a small
maternity unit as compared with a
large obstetric hospital.**

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

at Massey University, Palmerston North, New Zealand.

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2000**

Abstract

Small maternity units are an important historical feature within New Zealand. Over time many of these facilities have been closed and birth has increasingly occurred in large obstetric hospitals with the availability of technology and on-site specialists. A qualitative study using Van Manen's (1990) method of hermeneutic thematic analysis has been designed to answer the question: How is the provision of intrapartum care by independent midwives different in a small maternity unit, as compared with a large obstetric hospital?

Ten independent midwives were interviewed, and data were analysed to uncover the meaning of the differences when providing intrapartum care in both small and large maternity settings. There are two data chapters that contain substantial extracts from the midwives' transcripts in order to illustrate the themes identified from the analysis of their narratives.

'Real midwifery' shows that independent midwives feel more autonomous and are able to let the labour 'be' when practising in the small maternity units. The midwives use their embodied knowledge and skills to support women to labour and birth without technological interference. In contrast, the midwives feel that employing technology such as fetal monitoring and epidurals at the large hospital, places the focus on the machines and the midwife does not use all of her skills.

The second data chapter, called 'carrying the can', illustrates the additional responsibility that can at times be a worrying responsibility in the small maternity unit. When practising in the large obstetric hospital, specialist assistance is nearly always at hand and the midwives are considered to be practising in the safest place according to the dominant medical model. The paradox for midwives practising in small maternity units is that while these are a setting for natural birth, the midwives need foresight and confidence to avert or manage any problems that might arise.

When midwives practise in the setting of small maternity units, they are more autonomous and have the clinical freedom to practise unshackled by technology. The art of midwifery might be lost if midwives continue to practise midwifery only in medicalised environments.

Acknowledgements

Firstly I would like to thank the independent midwives who generously shared their experiences with me and also showed a continuing interest in the completion of this thesis. The names chosen by the participants for inclusion in the thesis are: Bronnie, Cluain Meala, Elizabeth, Grace, Joyce, Kirsty, Mary Byrne (Mary), Nettie, Rosemary and Tyrrell. Your narratives have been a stimulus to my enjoyment of this study.

Thanks to my supervisor Cheryl Benn for her academic and midwifery wisdom. She has provided ongoing guidance and inspiration. Cheryl's feedback assisted me to explore participant's narratives further and to take time to dwell with the data. Cheryl guided me forward through the journey of this study.

Thanks also to Elizabeth Smythe for her critique of my interpretation and her encouragement throughout this study. Liz generously gave her time and her expertise to review the process of thematic analysis.

Jackie Gunn (my employer) has assisted me in every way she possibly could, and I appreciate her consideration and concern.

To all of my colleagues and friends, thank you for the ongoing dialogue about midwifery practice and your support.

My nephew Brent and niece Cara gave computer and editing assistance, and other family members have always been encouraging.

Thank you to Massey University for assistance from the Graduate Research Fund.

Finally, thank you to Glenn for his support and understanding of the time this study has taken. He has also assisted me with equipment and resources in order to undertake and complete this study.

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Chapter 1: Orientation to the Study

Introduction

This study explores the experience of independent midwives providing intrapartum care in small and large maternity facilities. Ten independent midwives who practise within the region of Auckland were interviewed during a four-month period between 1999 and 2000. The research question, aims and method are overviewed in this chapter, and background information that prompted this study is provided within the justification and the study context. While acknowledging that readers are likely to be familiar with midwifery phrases, terminology is clarified with respect to different maternity settings. A brief history of midwifery in New Zealand and of independent midwifery practice is given to place this study within a current context. I share my background as a midwife to make explicit my pre-understandings as part of Van Manen's (1990) method. Research that has contributed to the background for this study is discussed alongside the challenges to the practice of independent midwifery. Finally, an overview is given of each of the following chapters.

Research Question and Aims of the Study

The research question is:

How is the provision of intrapartum care by independent midwives different in a small maternity hospital, as compared with a large obstetric hospital?

Participants were asked to describe their experience of providing labour care to women, both in a small maternity unit and a large obstetric hospital.

The aims of the study are:

- To describe the experiences of independent midwives providing intrapartum care in both a small maternity unit and a large obstetric hospital
- To highlight the differences in providing labour care in the different settings

- To identify issues that influence independent midwives' choice of environment for provision of intrapartum care

No studies were located in the literature that addressed the differences experienced by independent midwives providing intrapartum care, between small maternity units and large obstetric hospitals. It therefore seems important to establish what is the experience of independent midwives within New Zealand, in relation to the research question. To achieve this, I have undertaken a qualitative study using Van Manen's hermeneutic thematic analysis. The philosophical underpinnings of this study are Van Manen's (1990) research method and Heidegger's (1927/1962) hermeneutics. The 'existentials' of lived body, lived time, lived space and lived other are used as a guide for reflection in the research process. Crotty (1998) described existentials as "structures of being that make human existence and behaviour possible-and on to a grasping of Being itself" (p. 98). Heidegger used the term 'Dasein' the 'being-there' to describe our being in the natural world, and he used the existentials of time and space to assist our understanding of 'being-there'.

This study explores the meaning of independent midwives practising differently in small maternity units as compared with a large obstetric hospital. Ten independent midwives were interviewed and willingly shared their experiences of providing intrapartum care. Being a midwife is essential to the conduct of this study and my role as a researcher is influenced by my experience as a midwife practitioner and teacher. Further detailed description of my pre-understandings and the research method are provided in chapter three.

Justification for the Study

Three midwife managers had indicated that the number of women birthing in small maternity units is not increasing, while the pressure on the base obstetric hospital, which is becoming increasingly overcrowded, has not been relieved. The midwife managers and I are interested in reasons why the small maternity units are under-utilised for intrapartum care. The uncovering of differences experienced by independent midwives who provide intrapartum care in both small and large

hospital environments, may assist understanding of the midwifery skills required to practise in each of the settings.

Although small maternity hospitals have been shown to be 'safe' by a variety of research studies, the number of women birthing in small hospitals has declined. Thus occupancy frequently consists of women who have birthed in a large obstetric hospital, and then transferred to a small hospital for postnatal care (R. Kerins, personal communication, May 5, 1999). The Health Funding Authority report (1999) showed that in 1997 there were 4,285 New Zealand births that occurred in 'primary maternity hospitals' (small maternity units) and birthing units. This figure represents only eight percent of the total births occurring in hospitals. The Health Funding Authority report did not reveal data concerning birth outcomes with relation to place of birth. During 2001, Conroy will publish quantitative research concerning outcomes of births occurring in selected small maternity units in New Zealand (C. Conroy, personal communication, November 28, 2000).

Historically, despite good birth outcomes, many small maternity units in New Zealand have been closed. Rosenblatt and Reinken (1984) reported that approximately one third of rural maternity units in New Zealand were closed between 1970-1983. Initially these 29 small units were closed because of concerns about the quality of care provided, while in later years cost saving was the driving force. The authors reported two major factors related to the likelihood of a unit's closure; namely low utilisation and proximity to another obstetric facility. The authors reported that 28% of births in New Zealand occurred in small general practitioner maternity hospitals during 1982 and "the most remote hospitals serve counties with relatively high Maori populations" (p. 24). Rosenblatt and Reinken described three types of maternity facilities existing in New Zealand at the time of their study:

Level 1 hospitals	82 in total, designed for normal deliveries and healthy newborn babies
Level 2 hospitals	18 in total, providing specialist obstetric and paediatric staff, and acting as limited obstetric and neonatal referral centres

Level 3 hospitals 5 within New Zealand, that are major referral centres for difficult obstetric and neonatal cases (p. 5).

In comparison, data from 1997 revealed six birthing units, 38 primary maternity facilities, 20 secondary facilities and six tertiary facilities (Health Funding Authority, 1999). From the time of the unpublished report by Rosenblatt and Reinken (1984), almost half of the small maternity units have been closed, whereas an additional three secondary and tertiary hospitals have been established. A study from the United Kingdom also reported declining numbers in small units where less than 10,000 women delivered in isolated general practitioner units, representing less than 1.6% of all deliveries reported to the survey (Smith & Jewell, 1991).

Study Context

The study was conducted within the Auckland region where four small maternity hospitals exist in rural and urban areas. One of the small maternity hospitals was built in 1991 (against the trend of centralisation) to relieve the pressure of overcrowding at the nearby large obstetric hospital which accommodates around 5, 000 live births per annum (Health Funding Authority, 1999). Three of the small maternity units are public facilities and 925 births were recorded in these three units during 1997 (Health Funding Authority, 1999). The Health Funding Authority (1999) released data for the year 1997 that showed 17,782 births occurred in tertiary and secondary hospitals within the Auckland area, representing 95% of all births. The disproportion of births occurring in the secondary or tertiary facilities is evidence of the culture of births occurring in high technology environments.

Terminology

Clarification of terminology used in this thesis enables the writer and reader to be sure of shared meaning. Throughout the thesis there is reference to phrases peculiar to midwifery and childbirth. I assume that most readers will be familiar with such words and I have not clarified their meaning. All midwife participants are women, hence the terms 'her' or 'she' may be used during this study in

relation to a participant. Participants used the words 'consultant' and 'specialist' interchangeably and this referred either to an obstetric and gynaecology specialist or, less commonly, to a specialist paediatrician.

Maternity settings

Various terms have been and are currently used to describe maternity settings within the New Zealand context. Selected terms related to this study are defined. The Health Funding Authority (1999, p. 24) published the following definitions:

Birthing Unit – Inpatient service during labour and delivery; no postnatal stay. (In contrast, American birthing units tend to provide for postnatal stay).

Primary maternity facility – Inpatient service during labour and delivery and the immediate postpartum period until discharge home. (These units may also be referred to as Level 0 or Level 1 units, cottage hospitals, rural maternity units, satellite units, General Practitioner units, isolated/stand alone general practitioner units or attached/integrated general practitioner units).

Secondary maternity facility – Provision of additional care during antenatal, labour and birth and postnatal periods for mothers and babies who experience complications and have a clinical need for referral to the secondary maternity service. (These hospitals may also be called Level 2 facilities, with availability of epidural analgesia and theatre facilities for caesarean section operations).

Tertiary maternity service – Service supplied on a regional basis for women/fetuses with complex and rare maternity needs who require access to a multidisciplinary specialist team. (These facilities may also be known as Level 3 facilities, specialist units, or base hospitals that provide care for normal and abnormal birth with provision of a special care baby unit and theatre facilities).

For the purpose of this study the terms 'small maternity unit' and 'large obstetric hospital' will be used to differentiate between a low technology unit (primary maternity facility) and a high technology hospital (tertiary facility). The small maternity units referred to in this study are public hospitals with provision for antenatal visits, labour and birth facilities and postnatal care. The small units do not have any specialist medical staff on site and general practitioners (GPs) would only be present when attending a woman booked under their care. At the time of this study there was at least one hospital-employed midwife on duty as 'core staff', and independent midwives remained with women throughout their labour and would attend the small unit to conduct postnatal visits. The small maternity units referred to in this study are low technology units and do not offer epidural analgesia, syntocinon augmentation, anaesthesia for manual removal of placenta, caesarean section operations or sick baby neonatal services.

Large hospitals may be secondary or tertiary facilities according to the Health Funding Authority (1999) definitions. For the purpose of this study, a large hospital is classified as one of the 'tertiary level facility' hospitals situated within the geographical region where the midwives practise. If women do not wish to go to the small maternity unit, or require the facilities of the large hospital, then the closest hospital is one of two tertiary facilities.

Midwifery in New Zealand

In this study, the words 'independent midwives' are used to represent the participants. The historical background of midwifery in the New Zealand context is described prior to discussion concerning the term 'midwife'. The New Zealand College of Midwives (NZCoM) has adopted the World Health Organization definition that determines that a midwife must have completed a prescribed course and achieved the qualification. Murray (1995) explored various definitions of a midwife and applauded the NZCoM philosophy of midwifery which recognises that a midwife derives knowledge from the arts and sciences "tempered by experience and research" (New Zealand College of Midwives, 1993, p.7). Pelvin (1996) believes that midwives develop with experience yet, being a midwife frequently means "being in a state of not knowing and ready for any eventuality

... some of them traumatic and life-threatening, some profound and wonderful (p. 15).

Historical Background

New Zealand midwives have experienced a loss of status over the years (prior to 1990), and through hospitalisation of birth, midwives themselves have become increasingly medicalised (Donley, 1986). The 1971 Amendment to the Nurses Act ended autonomy for midwives by requiring all births to be supervised by a doctor. According to Donley, the reality at that time was that few midwives were working in domiciliary practice, therefore few midwives were practising autonomously. Donley commented that midwives working in large obstetric units were simply members of the medical team where there was little opportunity for individual accountability to the mother and baby.

In contrast, according to Donley (1986), "Midwives working in smaller maternity hospitals have retained a modicum of independence, even though their 'patients' are under the supervision of a doctor" (p. 16). Donley expressed concern for student midwives' opportunities to learn normal childbirth if small maternity units closed and homebirth experience was limited. Donley stated adamantly that midwives would not get experience of normal birth in an obstetric unit in a large hospital where women are subjected to unnecessary interventions.

It was initially consumers who challenged the loss of normal childbirth and the need for interventions. Pairman (1998b) reported that midwives were slower to grasp the implications of medicalisation and hospitalisation for their profession. In 1983 the Nurses Act had been further amended to allow pregnant women to be cared for by nurses who might or might not be midwives. This change highlighted the need for political activity if midwives were to survive as a profession. Fortunately, domiciliary and hospital midwives united to oppose any further subsuming of midwifery by nursing. Donley (1986) and other midwives protested against the declining number of midwives, midwives' lack of autonomy, and the acceptance of the medical model of birth by some consumers and midwives. With Donley, Guilliland, and other charismatic midwives leading the charge, consumers and midwives united to press for legislative change to restore

midwifery autonomy. There was a united realisation that women need midwives and midwives need women.

Independent midwifery practice came about after much lobbying of government and opposition Members of Parliament by consumer groups and midwives to amend the 1977 Nurses Act. The Nurses Amendment Act was passed in 1990 and enables a midwife to take responsibility for the care of a woman throughout her pregnancy, childbirth and postnatal period (Department of Health, 1990). A midwife has professional responsibility for maternity care and does not need to consult with a doctor unless there is undue concern for either the woman or the baby. Donley (1990) stated, "Outside of Holland which has never wavered in its support of midwives, this legislation is probably a world leader in the industrialised world in restoring midwives to their proper and traditional role" (p. 7). Page (1995a) wrote, "New Zealand developed radically new systems of midwifery care that recognise the midwife as an autonomous practitioner" (p. 228). Thus the change in legislation that enabled midwives to provide sole care during childbirth is considered to be a landmark for midwifery practice internationally.

Clark (Department of Health, 1990), as Minister of Health hoped that the implementation of the Nurses Amendment Act would increase the choices available to women and their families in childbirth services. She acknowledged that a change in legislation on its own does not necessarily bring about change. A change in attitude on the part of consumers and health professionals was necessary. Guilliland and Pairman (1994) stated, "midwifery accepts its responsibilities as an emancipatory change agent" (p. 5). Midwives and women/families were ushered into a new era of maternity care where changes were rapid.

With the exception of a small group of domiciliary midwives who had effectively been practising as sole providers of maternity care, midwives had to learn different ways of practice. The change to various acts enabled midwives to access laboratory tests, prescribe drugs as necessary, admit women to hospital, and claim for services provided from the Maternity Benefit schedule (Pairman, 1998b).

Independent Midwifery Practice

The Nurses Amendment Act (1990) has enabled practising midwives to be self-employed, or alternatively to be employed by an independent provider contracting with a government funding agency. Practising midwives can also continue to be employed by various hospital services and either provide continuity of care (eg. Know Your Midwife/Team¹ midwives) or be employed on a rostered shift basis. Hospital employed midwives perform many other roles including specialising in maternal mental health, diabetes, fetal assessment and management. Returning to the notion of independent midwifery, Pairman (1998a) said:

The midwifery profession has defined independent midwifery as the practice in which the midwife works in partnership with the woman to provide all care throughout pregnancy, labour, birth and the postnatal period on her own responsibility. The critical elements of 'independent practice' therefore, are the midwife's partnership with the woman, autonomy and continuity of care (p. 7).

Pairman (1998a) stated that independence is defined by the way in which the midwife practises and not by her employment status. Pairman described self-employed midwives as those who are paid for their work by the state funded system, and added that not all self-employed midwives are recognised as practising independently. However, Stewart (1999) alleged that being an independent midwife enables the midwife to be the primary care giver or lead maternity carer (LMC). This involves considerable responsibility for midwives who provide antenatal, intrapartum and postnatal care, but it also allows for true autonomy.

The participants in this study practise as lead maternity carers and all participants provide continuity of care to their clients. The participants are therefore

¹ Know Your Midwife (KYM) or Team scheme midwives differ from hospital-employed shift midwives in that they provide continuity of care during pregnancy, labour and the puerperium. These midwives continue to be employed by a hospital (as opposed to being self-employed) and generally care for 50-60 women per year, being on call for their intrapartum care.

independent and self-employed. For practical purposes they will be referred to as independent midwives.

A choice was made to interview independent midwives only within this study in order to achieve homogeneity with regard to employment of the participant sample. Homogeneity in this regard refers to the fact that the independent midwives are free to select where to provide intrapartum care, as they are not affiliated to any particular hospital. Midwives in this study have a choice to provide intrapartum care in the woman's home, at a small maternity unit, or in a large obstetric hospital. All self-employed independent midwives in New Zealand are state funded and receive reimbursement from Health Benefits Limited, a government appointed funding authority. The Health Funding Authority (1999) indicated that more than half of women (57%) registered with a midwife as the Lead Maternity Carer in 1997.

My Background

I am currently working as a midwife teacher and work with midwifery students in large hospital settings and in small maternity units. I hear students say that the environments are different; some student midwives have great affinity for the small maternity units while others prefer the experience at the larger hospital. I have worked in both small and large maternity hospitals and attended homebirth over my 18 years of midwifery experience. A number of years were spent in a large hospital delivery unit where I developed skills of rapid assessment and being able to adapt to a busy environment where many women might be labouring simultaneously. As midwives, we felt we worked hard, provided the best care possible to women within the resources available and we were proud of our midwifery culture.

During my own midwifery education, I recall a midwife teacher asking, "What would you do if you were at Te Puia Springs hospital?" She was trying to make us think as independent midwives, as opposed to thinking about practice in the large hospitals flush with medical staff. We were predominantly placed in large hospitals however in order to 'catch' sufficient babies to register as midwives. In

1982 as student midwives we could not imagine a time when midwives would legally be allowed to be responsible for the care to women. However, a few student midwives including myself were able to contemplate working in small maternity units, or homebirth, at some stage of our career. We were aware that this would mean making decisions on our own and providing care when all was normal, as well as providing care when situations became abnormal or an emergency arose.

My time as a midwife in a small unit was prior to the 1990 legislative change that enabled midwives to provide care to women without the involvement of a doctor. Hence, all the women who birthed at the small maternity unit were booked under the care of GPs. Women were encouraged to attend the small unit for at least three antenatal visits in order to meet the midwives and feel familiar with the environment. Some GPs expected the midwife to undertake all assessments as part of providing labour care, while other GPs attended women routinely throughout their labour. The GP might or might not have been present at the birth depending on a variety of factors.

It must be acknowledged that it was dependent upon the viewpoint of the GP concerned as to whether or not primigravidae were 'allowed' to birth at the small unit. Some doctors had a policy that first time mothers had to birth at a large hospital. This probably arose from a directive from Bonham² (1982), that high-risk women should not be confined in a small maternity unit. According to Bonham, high risk women included, "All primigravidae, women aged 30 or over, those with a medical complication, a history of obstetric complications or of stillbirth or of neonatal death, any complication developing in the current pregnancy" (p. 2). He regretted that most confinements were supervised by family doctors within "smaller maternity facilities some of which merely provided

² Professor Bonham was the Chair of the University of Auckland postgraduate School of Obstetrics and Gynaecology, based at National Womens hospital from 1964-1988. He also headed the Maternity Services committee of the Health Department which over two decades monopolised maternity policy and favoured channelling births into a few high-tech base hospitals (Coney, 1988).

aggregated domiciliary confinement” (p. 1). Bonham’s memorandum undoubtedly discouraged the use of small maternity units and Rosenblatt and Reinken (1984) reported that during 1982, approximately one third of all women who lived closest to a small unit had their babies in large obstetric hospitals.

In general, midwives working in the small unit supported primigravidae and women without complications to birth in that setting. There was one occasion, however when I recall having been afraid of the potential outcome. The woman was having her second baby and the shoulders were impacted. I later discovered that the woman had had shoulder dystocia with her first baby, but that this had not been documented. I asked the other midwife to ensure that the GP had responded to my earlier call as I anticipated needing additional assistance with resuscitation of the baby. After several manoeuvres the baby was born much to the relief of all in attendance. The GP arrived around fifteen minutes after the birth, and by that time the baby had been resuscitated and had recovered well. Midwives were expected to manage problems competently, and most of the GPs generally had a respectful attitude towards midwives’ abilities.

While midwives did manage several emergency situations each year, this work was generally unnoticed. Patterson (2000) described rural midwifery as requiring skilled and experienced practitioners, yet the work of these midwives is often invisible. Patterson noted that while some maternity units are so called general practitioner maternity units, it is the midwife who makes the majority of decisions and manages the labour, or initiates transfer. In many instances it is the midwife, who had to manage a haemorrhage or neonatal asphyxia with perhaps only a nurse on duty to assist her,

My experience of practising in a small maternity unit has increased my midwifery wisdom, yet until undertaking this research, I had not articulated why this is so. On reflection, the small maternity unit was often considered quiet in contrast to the large obstetric hospital. Yet in the quietness, I learnt to spend time with women and to care for women throughout their childbirth experience. Hunt (Hunt & Symonds, 1995) similarly explained that she learnt the art of midwifery doing night duty in a small maternity unit, unsupported by medical staff. There she

learnt about physiological birth and discovered the skill of being a midwife 'with' women.

Research and Midwifery Practice

Extensive searching of the literature was undertaken to establish if research existed concerning intrapartum care provided by independent midwives in different settings. The majority of studies reported outcomes between different settings, and incidentally included data concerning midwifery practice. Outcomes with respect to safety in different contexts are discussed in chapter two. Studies that explore midwifery practice in Australia, Britain and New Zealand are discussed to provide a background for this present study.

Research conducted within New Zealand has provided information concerning independent midwifery practice. Moloney (1992) used critical social science methodology and interviewed five midwives employed in a large hospital. Moloney described conflict internally between hospital-employed midwives and externally between independent and hospital-employed midwives. Moloney stated, "Overt aggression is displayed toward independent midwives who are viewed by the policy of the institution to be inferior for not possessing the technical knowledge and skills to be on an epidural register" (p. 113). She surmised that technology fosters technical knowledge and creates elitism as opposed to liberating midwives.

Critique of Moloney's (1992) thesis raises some issues that could be further explored. Independent midwifery was in its infancy so to speak when Moloney conducted her study, and Auckland hospital policies deterred independent midwives from caring for particular women. Independent midwives needed time to gain access to the epidural register and to meet the requirements of local policy. Hospital employed midwives were expected to enforce the various policies, and as a result tension between hospital and independent midwives was rife. Moloney's five participants had been qualified for only eighteen months and were working in the culture of a tertiary obstetric hospital. They felt that their philosophy of

midwifery from their training was not supported and this also resulted in conflict between them and senior midwives in the hospital.

Fleming (1995) used feminist methodology to explore the concept of partnership, power and politics between independent midwives and their clients. As part of her study, Fleming deliberately sought opinions concerning the relationship between independent and hospital midwives after hearing derogatory comments throughout New Zealand and after reading Moloney's (1992) study. She found that the independent midwives acted as advocates for their clients. However often this advocacy resulted in a polarisation of ideologies held by the independent midwife and the hospital midwives. Lesley, an independent midwife participant in Fleming's study commented:

A hospital system is a very hierarchical system. It has a trickle down effect and regardless of what we have to say practice is still limited by the fact that there are endless power structures and you have to survive within that power structure (p. 142).

Power structures emerged as an important theme in Fleming's (1995) and Moloney's (1992) study. Hotchin (1996) who also used feminist methodology, explored independent midwives' use of unorthodox therapies. Unorthodox therapies were used mostly in homebirths, as homebirth was also viewed as unorthodox. In contrast, the hospital was perceived as being orthodox, hence midwives working there restricted or restrained in the use of unorthodox therapies. Griffith's (1996) study supports Fleming's (1995) and Hotchin's (1996) findings that the setting influences midwifery practice.

Griffith (1996) used (feminist) standpoint theory to consider the beliefs, practices, conditions and constraints that construct midwifery practice in Australia. Griffith argued that while there is awareness that midwifery is practised differently in different contexts, there is not awareness of the extent to which birth and midwifery practice is a social construction. She commented that in Australia, "this balance of power rests with the medical discourse and the ideologies of technology and patriarchy" (p. 366). Griffith categorised different maternity contexts according to the degree of medicalisation. Large teaching hospitals were

classified as overtly medicalised and the way of practising appropriately was defined by protocols. The midwifery discourse was at least as influential as the medical discourse in birth centres where there was sufficient flexibility to negotiate medically defined parameters of safety and protocols.

According to Griffith (1996), midwives practising in large teaching hospitals were restricted by the overtly medicalised context with a scientific and mechanically orientated medical text. She was unsure however, where to categorise independent midwifery practice that takes place within an institution. She recognised the expectation by the institution that independent midwives work within the protocols, however whether they did or did not follow protocols was not open to public scrutiny.

Hunt and Symonds (1995) conducted an ethnographic study to explore the social meaning of midwifery and birth as it happens in many British maternity hospitals in 1989. Findings include the notion that the masculine profession of medicine dominates the hospital practice of midwifery. "This is an everyday lived experience for midwives. Independence and autonomy may have a strong ideological influence on midwifery, but in everyday practice they have to be constantly redefined" (p. 37). According to the authors, the antagonisms present between midwives and others stem from the contradictions of the ideological and the work context. Hunt and Symonds found that midwives enjoyed the freedom of night duty where they were undisturbed by doctors, and the pressure to use medical interventions. The midwives who participated in their study were all hospital-employed midwives and this might have limited their ability to work autonomously of medical staff and protocols.

Pairman (1998b) used feminist methodology to research the midwife/woman relationship in New Zealand and found that there are commonalities in what each brings to the partnership relationship. Taking time and sharing power and control were important to the development of the relationship where the midwife develops a "professional friendship" as part of the partnership (p. 193). One of Pairman's participants called 'Heather' described the difference between being an independent practitioner and previously working in a base hospital. Heather

described the restrictive 'one hour second stage' of labour in a base hospital. If this timeframe was exceeded "you would get a hard time from doctors and often other more, so called senior midwives" (p. 73).

Further to comments about restricted timeframes, Pairman (1998b) surmised from another participant's narrative that, "even as an independent practitioner making use of the hospital facilities, she is conscious of the influence of hospital protocols on practice and the strength it takes to reject these" (p. 71). One might ask how does the culture of a hospital exert so much influence upon the way independent midwives practise? Pairman described a positive outcome of midwives "relearning the normal" (p. 71) through questioning routines and imposed protocols within the hospital setting. Participants in Pairman's study also favoured their "freedom to practise" (p. 72) as autonomous independent midwives.

Challenges for Independent Midwives

As Pairman (1998b) indicated, independent midwives reflect a different way of working with women and practising normal childbirth. None the less, the history of independent midwifery in New Zealand has been fraught with opposition from sectors of society. Change often involves gains and losses and inevitably some bitterness remains. Baird, an Obstetrician, (McLoughlin, 1993) expressed his personal view that independent midwives were not independent as they relied on hospital staff, hospital facilities, and were totally dependent upon the state for their income. Their heavy dependence was said to be causing division and stress at the hospital. In Baird's opinion, independent midwives used hospital midwives to cover for them when they got out of their depth, which he thought was often. Donley (1989) commented that Baird had warned fellow obstetricians that the three greatest threats to modern obstetrics were: consumerism, feminism and midwives. It would be fair to suggest that some obstetricians resented midwifery autonomy and were deliberately outspoken against independent midwives.

On the contrary, other obstetricians such as Enkin (Stuart, 1994) commented that New Zealand was ahead of the world in recognising the value of midwifery as an autonomous profession, and that midwives were the best-trained professionals to

deal with 85% of women who experience normal childbirth. Enkin commented, "One hopes the tension between midwifery and obstetricians will settle down" (p. 13) as primary care midwifery is reliant upon obstetric backup.

Dissent around issues such as maternity payment and changes to the way midwives practised created tension between self-employed and hospital-employed midwives. Tensions between 'Know your midwife' or team scheme midwives and hospital-employed shift midwives occurred in other countries, long before independent midwifery was established in New Zealand. Flint, Poulengaris and Grant (1989) reported favourable outcome statistics from a study in England of four midwives who provided continuity of care. The authors remarked that while these four midwives were very supportive of one another, their independence created problems in working relationships with other personnel. The authors advised that such difficulties should be taken into account when other schemes were planned, indicating that the relationship difficulties must have been significant.

Returning to the New Zealand context, O'Connor (1994) reported that some hospitals allowed employed midwives to also work independently, while Health Waikato had forbidden midwives to practise independently. If hospital employed midwives were found to be practising independently (self employed) they could expect to be disciplined. Midwives from Kenepuru hospital had also reported that they had been advised to stop independent practice. O'Connor was concerned that such threats from hospital managers would escalate conflict between self-employed midwives and hospital-employed midwives to the detriment of the women.

Butler (1994) acknowledged that although midwifery autonomy had received accolades, the changes had brought confusion about the interface between hospital and independent midwives in the practice arena, as well as causing retention and recruitment difficulties for hospitals. Experienced midwives were opting for independent practice as opposed to remaining in hospital employment. From my personal observation, the loss of experienced midwives from busy labour wards results in increased tension between hospital and independent midwives.

Structure Of Thesis

Chapter 2: Literature Review

This chapter provides a critical overview of the literature in order to place the research study within a context of existing knowledge.

Chapter 3: Research Design and Method

In this chapter a description of the study using Van Manen's (1990) method of hermeneutic interpretation is provided. The design and conduct of the study are discussed with particular attention to ethics, data collection, data analysis and rigour.

Chapter 4: Real midwifery

Data within the context of this chapter relate to what midwives describe as practising 'real midwifery'. Sub-themes include the notion of practising more autonomously, having time, giving time, and managing options.

Chapter 5: Carrying the Can

Carrying the can is the other theme from the data where midwives describe the sole responsibility of providing care in a small maternity unit. Sub-themes include the notions of being solely responsible, making risky or reasoned decisions and being judged.

Chapter 6: Discussion of the data, Conclusion and Implications for practice

This chapter pulls together the meaning from the two data chapters and addresses the research question and its aims by showing the differences between providing intrapartum care in small maternity units compared with a large hospital. Implications for practice, education and research are presented in relation to the findings from this study.

Summary

The orientation to this study has introduced the research question and the aims of the study, and overviewed the method. The study is designed to uncover the differences between providing intrapartum care in a small unit compared with a large hospital. The serious under-utilisation of small maternity units was used as a justification for the study. The context of the study was explained, and the number of small maternity facilities available within the greater Auckland area, separate to the facilities of large obstetric hospitals was recognised.

Terminology relating to maternity facilities was explained. An historical overview was given of midwifery in New Zealand and of independent midwifery practice. My background experience was discussed, and any biases arising as a result are further acknowledged during discussion of the research method in Chapter three. Pertinent studies that might assist the reader to orientate to this study were discussed, as were some of the challenges for independent midwives. Challenges in the relationships between independent and hospital-employed midwives were described as this provides background understanding to lingering tensions between midwives. Finally an overview of the structure of the thesis was provided.

Chapter 2: Literature Review

Introduction

The literature review serves to place the research study within a context of existing knowledge that has relevance to this particular study (Rountree and Laing, 1996). In this instance the present study concerns the experience of midwives providing intrapartum care within small and large hospitals. During preparation of the research proposal, literature was searched to provide background information and to find out if such a study had been undertaken before. Justification for the study included the fact that few studies addressed the experience of midwives providing intrapartum care, and the significant under-utilisation of small maternity units and over-crowding of large obstetric hospitals. Most of the literature located focussed on the outcomes of childbirth in various maternity facilities, as opposed to the midwifery care during the intrapartum process.

In keeping with the underpinnings of hermeneutics, Van Manen (1990) advised that it is sound practice to attempt to address the meaning of one's own data first, before turning to the literature. According to Van Manen, "If one examines existing human science texts at the outset then it may be more difficult to suspend one's interpretive understanding" (p. 76). In line with this, narratives from participants in this study were analysed for themes and meaning prior to the reading of literature related to themes that emerged from the data. This is to ensure that my interpretation comes from the data of participants, as opposed to what other authors have written on the topic.

Once data analysis was completed, literature was searched by electronic searching, manual searching from reference lists and through access to Joan Donley's (author of *Save the Midwife/Birthrites*, 1986/1998) personal library. Electronic searching was employed using numerous different key words and phrases for different purposes. For example small maternity unit was searched under a variety of key words including birthing centre, rural maternity hospital,

cottage hospital, general practitioner unit, and level one hospital. Databases were accessed through CINAHL, Ebsco, Medline, Proquest Medical Library, PsycInfo, Webspirs, and Wilson Social Sciences. During the course of this study, on-line resources have become increasingly sophisticated and more readily available. Searches ranged from 10-50 years back, depending on whether historical material was being located or whether current aspects of midwifery practice were being sought.

As stated in chapter one, Griffith (1996) showed that the context or setting has an influence upon practice. Of relevance to this study are the contexts of small maternity units and large obstetric hospitals, hence themes concerning the maternity context, practitioners and models of care are critiqued. Firstly, the history of small maternity units in New Zealand is described followed by studies concerning the safety of small maternity units. The influences upon midwives' and women's use of small maternity units are outlined, and the trend toward large obstetric hospitals is detailed. The midwifery and medical models of care are discussed including use of technology and interventions in childbirth.

History Of Small Maternity Units

Small maternity hospitals where available, provide a 'half way house' between the options of homebirth and giving birth in a large obstetric hospital equipped with caesarean section facilities. Mein Smith (1986) asserted that most New Zealand women in 1920 gave birth at home, while "approximately 35% of deliveries had occurred in hospitals" (p. 62). She commented that the transition from midwife care to doctor care had definitely taken place in New Zealand by 1924, abetted by insurance to cover the medical fee for birth. "This change to the doctor preceded the transition from domiciliary midwifery to hospitalised childbirth, which occurred between 1920 and 1930" (p. 16). By 1930, 68% of New Zealand women who gave birth did so in hospital. Mein Smith commented that New Zealand women experienced medical care during childbirth many years before this became common in other countries.

The change from midwife care to doctor preceded the change from home to hospital birth, and one might assume that the increase in hospital births was promoted by doctors. Opposition to small maternity hospitals can be traced back to the 1920s when Jellett, a former obstetrician of Ireland's Rotunda hospital, favoured the abolition of New Zealand's 200 private maternity hospitals. Some of these private hospitals, including the prestigious Kelvin hospital in Auckland, had been plagued by puerperal sepsis (Mein Smith, 1986). Jellett believed that these hospitals should be replaced by large teaching hospitals in order to improve the training of medical students and midwives, and to provide a more economical and efficient maternity service.

On the other hand, Paget (employed by the Department of Health) opposed Jellett and advocated that small maternity units were the most sensible option for the small and scattered nature of the New Zealand population. Paget favoured homebirth for low risk women as this was cost effective, and he envisaged that small hospitals could manage women with complications (Mein Smith, 1986).

Despite differences in opinion, Paget and Jellett united to eliminate the threat of puerperal sepsis that had given New Zealand the second highest maternal mortality rate in the developed world in 1920. Through Health Department initiatives, the mixing of obstetric women and general cases was discontinued and the Department introduced antiseptics through the use of Dettol. By 1932 New Zealand had earned worldwide acclaim for producing the lowest death rate from puerperal sepsis among eight countries which used identical methods for compiling maternal mortality statistics. However, the New Zealand statistics did not include Maori women, as only 17% of Maori women had their babies in hospitals in 1938 (Mein Smith, 1986).

The popularity of hospital birth (in small maternity facilities) arose through women being fearful of puerperal sepsis, persuasion by doctors, and the Health Department initiatives toward promoting hospital births with the aim of reducing infection. It is a sad irony that attending a hospital, such as the Kelvin hospital, increased the risk of death from sepsis for some women. Small maternity units further increased in popularity as a result of the passage of the New Zealand

Social Security Act 1937, that provided 14 days of free hospital care following childbirth. Fleming (1996) deduced that a further reduction in homebirths occurred as a result of free hospital confinement, which pleased the medical profession. She wrote, "Small cottage hospitals sprang up throughout the country, providing relatively homelike environments for birthing women, thereby reducing the perceived need for homebirths" (p. 348).

From the success of the Health Department's drive to eliminate puerperal sepsis, the state had established its right to manage and investigate maternity services. The Maternity Services Committee (1976) was one of the many committees to review the provision of maternity care. While small maternity hospitals were described as having "incomplete facilities" (p. 38), advantages were described as a homely atmosphere that fostered good emotional relationships and high rates of breastfeeding. The Maternity Services Committee reported that 27 maternity hospitals existed where a "single handed doctor" (one general practitioner) provided care. The committee opposed single-handed maternity units and recommended that they serve only as maternity aftercare units. The report also recommended the closure of an additional 15 small maternity hospitals that existed with general patient beds, in view of the risk of infection.

The Maternity Services Committee (1976) also recorded concern about the standards of care. The report stated, "Some doctors were frankly hopelessly inexperienced, some being straight from medical school and others from alien cultures abroad" (p. 52). With regard to the role of the midwife the committee stated:

The responsibilities of the midwife, particularly in a small hospital without resident medical staff can be very considerable, either when she feels that she has a patient with an abnormality or in terms of deciding how far she can allow matters to proceed without seeking consultation with the doctor, who may be very busy in his surgery or on his rounds (p. 54).

In acknowledging the considerable responsibilities of a midwife, the Maternity Services Committee (1976) authors indicated subservience from midwives with

reluctance to call a doctor who might be busy elsewhere. When analysing this report, admittedly a quarter of a century after it was published, judgements are apparent concerning the ethnicity of general practitioners and regarding the age of the midwives who worked in small maternity units. A discourse analysis might find that the language used in the report was congruent with values held by the members of the committee at that time in history. Ten of the fourteen board members were medical doctors and four were midwives.

From their investigation, the Maternity Services Committee (1976) recommended closure of 42 or half of the smaller obstetric units in New Zealand, partly on the assumption that hospitals with fewer than a hundred deliveries annually were unsafe. Rosenblatt, Reinken and Shoemack (1985) estimated that approximately a quarter of births in New Zealand occurred in small general practitioner maternity hospitals at that time. However 33 rural maternity units, most being the only hospital in that rural community, were closed between 1970-1984. Donley (1986) commented that by 1984 in the greater Auckland area, "only five small hospitals remained" (p. 111). Rosenblatt et al. added that The Maternity Services Committee Board of Health report was responsible for regionalisation of maternity services, with a belief that availability of technology meant greater safety in childbirth. Large hospitals were necessary also for the future training of doctors.

Regionalisation of maternity services began in the 1970s, and by 1980 most maternity units were part of a formal regionalised perinatal care system (Rosenblatt, Reinken & Shoemark, 1985). That is to say that small cottage hospitals in rural and urban areas were closed and centralisation of maternity care was organised into large hospitals.

The Health Funding Authority (1999) published the number of births in 'primary maternity hospitals' during 1997. These ranged from only three births in Ranfurly and the Chatham Islands maternity units, to the highest rate of 418 births at Kenepuru maternity unit. The authors indicated that from the time of data collection to publication of the Health Funding Authority report, two more of the small maternity units had been closed.

New Zealand is not unique concerning closure of small maternity facilities. Campbell (1997) recalled that small units were similarly closed in the United Kingdom on the grounds that they were less cost effective than large centralised consultant obstetric hospitals. However the little evidence available, mostly from the 1970s, tends to point to the opposite conclusion. Despite this evidence, the United Kingdom along with countries throughout the developed world have moved toward increasing the concentration of births into consultant-led hospitals over the past 50 years.

Walsh (2000a) reported that midwives and consumers lamented the closure of the many isolated general practitioner units in England during the 1980s. Walsh said these units were closed under the smokescreen of safety and economics, whereas the real reason was control of childbirth by obstetricians. Curtin (1999) reported a small increase in births occurring in freestanding birthing centres in the United States of America, possibly due to the lower cost of confinement compared with large hospital care.

Returning to the New Zealand context, Larkin (1985) wrote of action taken by Auckland consumers and midwives to save small maternity units from closure. Midwives initiated new ways of working in these units in an effort to avert closures. O'Leary and Bilton (1993) commenced a hospital based midwifery team scheme at the Papakura maternity unit aimed at increasing births there. They commented, "While the three level 0 units in South Auckland have survived 'round one', there is still considerable anxiety about their continued existence" (p. 20). Hendry (1995) established a 'Continuity of Care Midwives' scheme at the Burwood birthing unit at Burwood hospital, Christchurch. This resulted in an increased number of women choosing to birth at the unit and an increase in Maori women using the unit. Transfer rates to the base hospital remained at around 8-12%.

Safety of Small Maternity Units

Small maternity units have been closed throughout New Zealand and in the United Kingdom on the grounds that they are unsafe for labour and birth, and/or that small maternity units are not economically viable. In discussing the safety of small maternity units, Rosenblatt et al. (1985) undertook a landmark study within the New Zealand context. Additional studies are presented later in this section concerning maternal and neonatal outcomes and the economics of small maternity units. Sociological studies have also contributed to the literature concerning safety of childbirth, and as such, are discussed.

Findings from the Rosenblatt et al. (1985) study are particularly significant in showing the safety of small maternity units in New Zealand. Data were obtained from the National Health Statistics Centre of New Zealand concerning all births, birth weight, perinatal deaths, and the location of births, over a three-year period. These authors found that babies of normal birth weight born in small maternity hospitals had a lower perinatal mortality rate than normal birth weight infants born in larger obstetric hospitals. Rosenblatt et al. (1985) concluded that "The significantly lower perinatal mortality rates of normal-weight infants in level 1 hospitals by comparison with level 2 and 3 facilities may indicate that low-risk mothers fare better in low technology environments" (p. 431).

The favourable statistics in New Zealand's small maternity units were further explained by Rosenblatt et al. (1985) who commented that New Zealand's maternity care is more tightly organised and uniform. High-risk patients are identified and sent to referral centres before delivery. "General practitioners and midwives are responsible for most normal deliveries, and most maternity hospitals have no specialist coverage" (p. 431). In this context, Rosenblatt et al. confirmed that obstetrics is safe in small hospitals. The authors did not support plans to close small maternity units on the assumption that those with less than 100 deliveries annually were unsafe.

Fleming (1996) noted that the Rosenblatt et al. (1994) report was never put into general circulation as it contradicted the intentions of the New Zealand

Postgraduate School of Obstetrics and Gynaecology. Donley (1986) also objected to the report being embargoed by the Health Department and wrote, "This is monstrous, as the report's findings challenge many of the assumptions behind the strategic plan" (p. 114). The report did not support centralisation of maternity services into large hospitals, hence the government did not release it.

A number of other studies internationally, supported the continuation of small maternity units. Taylor, Edgar, Taylor and Neal (1980) conducted a comparative study in West Berkshire, England concerning safety between general practitioner units and a consultant unit. The authors found no difference in maternal or infant morbidity or mortality in the different settings. The authors noted that the cost of services in general practitioner maternity units was half that in the consultant unit, and restricting confinements to a consultant unit could not be supported.

At a similar time Ashford (1978) examined regional statistics from England and Wales concerning perinatal mortality for selected years between 1963-1973. He compared the outcome in consultant units, general practitioner units, and in home confinements. "The overall perinatal mortality rate was substantially higher in the consultant units than in the general practitioner units, which in turn was the same as for home deliveries" (p. 29). Even when allowance was made for low birth weight infants, mortality remained higher for infants above one and a half kilograms born in the consultant units. However the author did state that this might be representative of the case-mix attending consultant units. Ashford noted a paradox with general practitioner units providing a less intensive form of institutional care, but they cost almost twice as much per delivery compared to a large hospital. From an economic perspective, Ashford recommended closing general practitioner units and expanding domiciliary services.

In response to Ashford's viewpoint, Huntingford (1978) reviewed trends in obstetrics, and recalled that the Cranbrook committee (United Kingdom) had recommended in 1959 that small units be established to reduce domiciliary confinement. The committee had also recommended that general practitioner maternity beds were "best situated within, or very close to, consultant maternity hospitals" (p. 232). By 1970, the majority of women in England were delivered in

consultant beds, indicating that obstetricians had gained control over where women birthed. Huntingford concluded that the closure of small units due to cost, instigates other costs, including the loss of a personal local service, and resentment caused by the removal of choice.

American authors have also been active in researching the safety and cost of birthing units compared with large obstetric hospitals. Feldman and Hurst (1987) matched two groups of low risk women in New York. One group birthed in a freestanding birth centre while the other gave birth in a tertiary care teaching hospital. Women in the birth centre tended to have longer first and second stages of labour, yet there was no difference in neonatal outcomes. Women in the tertiary hospital were significantly more likely to have amniotomy, use of intravenous infusion, anaesthesia and analgesia, episiotomy and forceps. Feldman and Hurst concluded that evidence is mounting, that out-of-hospital birth centres offer an alternative as safe as large hospital settings. Secondly, the birth centre alternative or small unit provides safety with less intervention, and possibly less cost.

Sangala, Dunster, Bohin and Osborne (1990) undertook a large prospective study in England, where 14,415 births occurring in a consultant unit, isolated general practitioner units and integrated general practitioner units were analysed. The authors found that perinatal mortality rates due to asphyxia were more common in the isolated general practitioner units (1.5/1000) than in the consultant unit (0.6/1000). However, the authors collated statistics according to the initial booking venue, as opposed to the actual birth venue. Women who had an intra uterine death prior to labour, were deemed to be part of the statistics of the isolated unit, if that had been their original booking. The findings showed that "there was an excess of fetal deaths during labour among babies delivered in the isolated general practitioner units, suggesting that intrapartum care in these units was partly at fault" (p. 301). The authors concluded, "As skilled anaesthetic and paediatric services can be quickly available only in the consultant unit it could be said that all deliveries should take place in that unit, with transfer back to the isolated units for care shortly after delivery" (p. 301). The authors also recommended that all women were seen by an obstetrician during pregnancy to conduct risk scoring.

These statistics are in contrast to the Rosenblatt et al. (1985) findings, and Campbell (1997) issued a cautionary note advising readers to question the statistical analysis from the Sangala et al. (1990) study. Campbell did not elaborate on faults within the statistical analysis. However as mentioned previously, fetal deaths that occurred antenatally were attributed to the small units' statistics if that had been the venue chosen at booking. Pertaining to statistical analysis, Tew (1990), a medical researcher, revealed that published statistical data had been deliberately misinterpreted in the United Kingdom from 1958-1970. Data were collected concerning every birth, live and still, that occurred in Britain in one single week of each year. The 1958 study collected information for the following three months about every stillbirth and neonatal death. Tew stated that an impartial observer could clearly see that the perinatal mortality rate was higher in hospitals, yet this fact was distorted in the report. The experts claimed, "The family home is the most dangerous place for birth" (p. 29). Obstetricians throughout the world used the false interpretation of these statistics to influence the future development of the maternity service.

A study conducted by Hundley et al. (1994) compared outcomes between women who birthed in a midwife led unit with no doctor involvement and women who birthed in a consultant unit. Women considered low risk at booking were randomised to birth in each facility and 2,844 women agreed to participate. Women allocated to the midwife unit were less likely to have continuous electronic fetal monitoring, and tended to use natural methods for pain relief. There was no significant difference in outcomes between the groups except that women in the consultant unit had more interventions. The authors surmised that the lower rate of intervention in the midwife unit points to this being the most effective option for women at low risk. However, the authors cautioned that the high rate of transfer for primigravidae indicated that antenatal risk scoring is unable to determine who will remain at low risk during labour.

A number of obstetricians have favoured 'risk scoring' of women with a belief that an obstetrician should advise the most appropriate venue for labour and birth (Morrison, Carter, McNamara & Cheang, 1980; Knox, Sadler, Pattison, Mantell &

Mullins, 1993; Walker, 1995). O' Driscoll and Meagher (1986) similarly believed that the obstetric consultant should involve himself with the "larger number of perfectly normal women who had hitherto been overlooked at consultant level because they suffered from no organic disease" (p. 3). He believed that ironically, most of the problems arise in the women who are considered to be 'normal'. Despite such claims, Tucker et al. (1996), in a multi-centre randomised controlled trial, showed that routine specialist visits for women initially at low risk of pregnancy complications offer little or no benefit concerning safety.

A further large study on birth centre outcomes was undertaken in Stockholm. Waldenstrom and Nilsson (1997) reported that 1860 women were randomised to either birth centre care or to standard care. All care took place on the same premises of a major hospital, although electronic fetal monitoring, pharmacological pain relief, induction and augmentation of labour were not available in the birth centre ward. Midwives attended women in the birth centre and they made their own decisions about transfer according to established guidelines. Within the standard care ward, midwives provided labour care, but an obstetrician was usually on hand. Women at the birth centre had slightly longer labours and less medical intervention than the women in standard care. There was no statistical difference in infant health and maternal health between the two groups.

Rooks, Weatherby and Ernst (1992) conducted a prospective study of 11,814 women admitted for labour and delivery to 84 freestanding birth centres in the United States of America. The transfer rate of women, usually for prolonged labour was 12%. Birth centres used few invasive, uncomfortable or restrictive procedures and had fewer caesarean sections. The authors concluded that birth centres offer a safe and acceptable confinement for selected pregnant women. This study has reviewed the largest number of women who have given birth in units away from consultant hospitals and found that outcomes are satisfactory.

Goer (1995) concurred with the previous two studies and stated, "Birth centre studies uniformly report outcomes equivalent or superior to those of comparable women giving birth in the hospital" (p. 320). Campbell, Macfarlane, Hempsall

and Hatchard (1999) conducted a prospective cohort study of low-risk women who booked at Bournemouth, a midwife led unit, and the consultant led unit at Poole. Women who booked at Bournemouth were more likely to use a water bath during labour, whereas women booked to deliver at Poole had higher rates of induction, augmentation, pethidine and epidurals. The authors concluded, along with other studies, that there were no differences in outcomes between the two units, however there were significant differences in practice.

Differences in practice appear to be related to the different maternity settings. Campbell et al. (1999) stated, "It is not so much who provides the care during labour but the philosophy underpinning that care and the context in which it is provided" (p. 190). In other words, if the philosophy of the unit supports natural childbirth, general practitioners and midwives working there are more likely to practise normal childbirth. Alternatively, if the context is highly medicalised, practitioners tend to adopt a philosophy of medicalised practice and use interventions during labour.

Tew (1986) analysed outcomes between home, unattached general practitioner units and consultant hospital obstetric units, and found that obstetric interventions intrapartum, did not reduce the perinatal mortality rate. Tew commented that it was extremely unfortunate that the improvement in perinatal mortality rate, that was bound to follow the improvement in health status, should have coincided with the expansion of obstetric intervention. Too many doctors incorrectly assumed a cause and effect, and the assumption has remained. Wagner (1994) lamented the demise of small maternity hospitals and noted, "The trend to hospital birth has been accompanied by a trend to close maternity units in small hospitals with the justification that larger hospitals, where obstetricians and technology are in place, are safer" (p. 14). Wagner stated that numerous studies, as shown by this literature review, do not support this claim.

Some sociologists have paid particular attention to childbirth and shown concern regarding interpretations of safety. Annandale (1988) conducted a study using both quantitative and qualitative methods to study the structure of birth in a birthing centre in America. Her study included 18 months of observation, repeated

focus group interviews and content analysis of 900 women's records over a five-year period. Obstetricians did not see women unless a risk factor arose, however Annandale commented that midwives and obstetricians disagreed about what constituted a risk factor. Midwives tended to disagree with post-term inductions and also the use of interventions after twelve hours of rupture of membranes. Annandale found that birth centre midwives adopted strategies to maintain the 'normal' such as encouraging women to stay at home until active labour was well established. This strategy reduced the likelihood of transfer to a large hospital for perceived prolonged labour.

This section has provided findings for and against births occurring in small maternity units. Some of the units studied were 'free-standing' units while others were attached to large obstetric hospitals. Rooks et al. (1992) and Waldenstrom and Nilsson (1997) conducted large trials and concluded that birth is safe in small maternity facilities. This confirms the findings from Rosenblatt et al. (1985) that New Zealand women fare better in low technology birth environments. The purpose of the following discussion of the literature is to analyse why small maternity units are or are not utilised.

Use of Small Maternity Units

Midwives seem to be free to choose whether or not to practise in the setting of the small maternity unit. The literature suggests that midwives frequently determine the place of birth and that there is an inverse relationship between years of experience and willingness to practise in a small unit. Women's use of small maternity units is influenced by attitudes to childbirth and a preference for homelike surroundings. Influences upon midwives' and women's use of small maternity units are discussed.

Midwives' Use of Small Maternity Units

Since the amendment to the New Zealand Nurses Act (1990) midwives have been able to offer women a number of options during the birthing process. Hedwig and Fleming (1995) stated, "Autonomous midwifery practice permits midwives to attend births at home, in birthing units or in hospitals" (p. 217). Gulbransen,

Hilton, McKay and Cox (1997) similarly commented, "The optimal maternity system will include home, birthing centre, and hospital, with those responsible working in partnership and cooperation for the prime benefit of mother and child" (p. 89). Hendry (1996) noted that midwives who work in small community hospitals are able to offer women continuity of care, and have been doing so for many years. Continuity of care is possible with fewer births occurring in small units, in comparison with large obstetric hospitals.

Independent midwives are able to provide intrapartum care to women in small maternity units, provided that a unit exists in their district. However, a number of authors found that a midwife frequently determines the place of birth according to her own beliefs. Levy (1999) found that the personal opinions and attitudes of the midwife influenced the facilitating of informed choice for women. Information is provided within the context of the midwife's bias. Jabaaij and Meijer (1996) confirmed that midwives in favour of women birthing at home, did indeed attend more home births; or if they were comfortable with 'low tech environments' they were likely to use small maternity units. The midwives had a strong influence upon the place where birth occurred.

Woodley (2000) wrote about her concern that Papakura (South Auckland) maternity unit was under-used for intrapartum care. Woodley questioned, "the social, economic and emotional costs of directing women to an inappropriate place of birth based on so called women's-choice" (p. 3). She implied that midwives influence women as to where they should give birth, and all too frequently the recommendation is for women to go to a large obstetric hospital. Axe (2000) and Stuart (2000) have suggested that interventions commonly used in large obstetric hospitals might contribute adversely to the woman's emotional well-being. Woodley's comments also remind midwives to consider the effect of the environment of birth on women's health. A high technology, medicalised birth environment is frequently a less satisfying environment for women than the setting of a small maternity unit. This alone should be an incentive for midwives to offer women the choice of giving birth in a small maternity unit.

Page (1995a) referred to the 1993 report 'Changing Childbirth' published in Britain that gave women the right to make choices about their care, including the place of birth. Choice over the location of birth is an important issue for many women, and may affect women's subsequent psychological well-being (Creasy, 1997; Walker, Hall & Thomas, 1995). These authors suggest that women want the choice to birth in small maternity units, and it is important for women's physical and psychological well-being that an opportunity is given for those without obstetric problems, to labour and birth in this setting.

With further regard to choice, Steele (1995) noted that midwives should provide women with researched evidence to assist decision-making concerning the place of birth, while Guilliland and Pairman (1994) emphasised the need for the midwife to follow the woman wherever she chose to give birth. Griffith (1996) commented that it is not for midwives to tell women how and where they should birth, and midwives need to support women to make an informed choice.

Symon (1998) surveyed midwives through a questionnaire as part of his doctorate study. Midwives who were not already working in a midwifery run unit, were asked if they would be happy to do so, taking full responsibility for a woman's care. Replies were received from 1,522 midwives. The majority of midwives (76%) stated they would happily do so, and 24% said they would not. Midwives with more than 20 years of experience, and those working in units with 2000-2999 deliveries per year were least likely to say 'yes'. Reasons for not wanting to work in a midwifery run unit included, preference for consultant cover and full facilities, not having enough experience (although most of these midwives had 20 or more years experience!), not having enough confidence, fear of complications, and fear of litigation. Symon reported the following comments from a midwife participant:

I strongly believe that these units are an excellent means by which midwives (particularly junior ones) can develop their true midwifery skills and practice - working in an obstetric or consultant unit should be seen as a different type of practice altogether. Many of today's midwives do not seem to know the difference or care for that matter (p. 45).

Graham (1997) indicated that it might be a certain type of midwife who prefers to work in settings away from the dominance of obstetricians:

It is intuitively obvious that systems of care which give the practitioner more independence in decision making, a homely environment in which to work, continuity of involvement with women, and a focus on normality and natural childbirth will attract particular individuals (p. 396).

The statements above suggest that 'true' midwifery skills develop when a midwife practises in small maternity units, whereas a different type of practice is apparent in a consultant obstetric unit. Graham concluded that more independence and a focus on normality might be more enjoyable for some midwives.

As stated previously, independent midwifery enables midwives to provide intrapartum care in a variety of settings. It seems likely that the midwives' personal beliefs and length of time practising in a large hospital, (the more years of experience in a large hospital were inversely related to a desire to practise in a small maternity unit), might influence their choice of venue for provision of intrapartum care.

Women's Use Of Small Maternity Units

This sub-theme explores the factors that influence women's use of small maternity units. Lazarus (1997) suggested that the feminist movement has urged women to make choices and to control their own lives, including the childbirth experience. Lazarus said, "Women's decisions are influenced by their acceptance of or ambivalence toward ever-increasing use of advanced technology" (p. 150). Rejection of interventions during childbirth will encourage women to birth in alternative settings, whereas a desire for epidural analgesia or caesarean birth will influence women to utilise large obstetric hospitals. The following discussion includes reasons for women selecting to use low-technology small maternity units and reasons for women rejecting them.

The following studies have examined the environment of birth, and women's experiences of birth in particular settings. Walker et al. (1995) used in-depth

focussed interviews to elucidate the experience of women receiving care in a midwife led unit, anonymously located in Britain. These authors found that having choice over the location of birth emerged as such an important issue that they recommended this be examined further in the future. The relaxed atmosphere and friendliness of midwives drew much comment from clients in this study. Proctor (1998) conducted focus group interviews with women and midwives in Yorkshire, England. She discovered that women want locally provided maternity care, and homelike surroundings that conveyed that their experience was normal and that they were not ill. While homelike surroundings are valued, the hospital environment is perceived as being safe and as having less risk than a home birth, therefore women frequently submit to a hospital environment for intrapartum care (Berg, Lundgren, Hermansson & Wahlberg, 1996; Bluff & Holloway, 1994; Machin and Scamell, 1997; Ogden, Shaw & Zander, 1998).

Daly-Peoples (1977) commented on the use of small maternity units at a time when a number of these faced closure. She agreed that many New Zealand women feel safer in a hospital and that in some circumstances homebirth might not be a viable option. She said, "For these women, smaller local hospitals can offer safe, convenient and comfortable maternity services without the impersonal routine of large institutions" (p. 24). She regretted the fact that small hospitals have been closed on economic grounds. Yet it is not the women who refuse to use these small hospitals, it is the doctors who will not attend birth unless they have the elaborate 'back-up' services provided by base hospitals. One may ask if this complaint could also be directed against some midwives, who currently do not offer women the choice of giving birth in a small maternity unit.

Use of birth centres and small maternity units is frequently associated with natural birth. Waldenstrom, Nilsson and Winbladh (1997) claimed that the very nature of birth centres encourages natural childbirth, limiting the use of medication and technology during labour. Waldenstrom (1998) concluded from a descriptive study undertaken in Stockholm that women enjoyed "parental participation in decisions, responsibility, freedom and individualised care" (p. 212) in small maternity units. Annandale (1988) revealed that from her study in the United States of America, a third of the women initially chose a birth centre, as they had

no insurance. However, as pregnancy progressed the commitment to a natural ideology grew, and the commitment to birthing in a birth centre was cemented. Bennetts and Lubic (1982) described a freestanding birth centre in the United States of America as a 'maxi-home' and admitted that these were established in response to discontent with hospital birth. However they had not been supported by the American College of Obstetricians or paediatricians. Women and midwives using low technology birthing settings may endure opposition from the medical fraternity.

Women from England and Australia also wanted the opportunity to use a birth centre as opposed to a large hospital. Campbell et al. (1999) when reporting on the Bournemouth study, (previously referred to with regard to positive outcomes for women who gave birth in the midwife led unit) acknowledged that widespread public consultation rejected the centralising of all births into a consultant hospital and that hence the Bournemouth midwifery led unit was built and established. Rowley, Hensley, Brinsmead and Wlodarczyk (1995) cited two Australian ministerial reviews that recommended increasing the number of birth centres in each state. The homelike surrounds of small maternity units combined with the safety of a hospital, appeal to a certain number of women.

The previous authors emphasised the importance of women's choice regarding the venue for birth, women's expectations of safety, and some women's desire for natural childbirth in a small maternity unit. In contrast, LoCicero (1993) reviewed reports on the interactions between obstetricians and women in labour, and found that women are more likely to submit to authority. She found that gender and psychosocial development contributed to women's acceptance of interventions during labour, that women have a tendency to trust the experts and that epidural analgesia enables a woman to maintain feminine stereotypes such as quietness. LoCicero argued that birth in high technology hospitals is perpetuated by gender and psychosocial factors.

Trend Toward Large Obstetric Hospitals

As stated previously, childbirth shifted in the early 1920s from home to maternity units where women hoped to avoid the peril of puerperal sepsis. Papps and Olssen (1997) stated, "Medical control was consolidated in 1935 when the Labour government took power and made hospitalisation under the medical profession a key plank of its welfare policies" (p. 98). This resulted in the eventual demise of small private and public maternity units that were replaced by large obstetric hospitals suitable for teaching medical students, such as National Women's hospital, built in Auckland in 1946. McLoughlin (1993) agreed that from the 1950s, birth was shifted out of cottage hospitals, which had replaced homebirth, into large high-tech obstetric hospitals. The cycle from homebirth to birth in small local maternity units, to birth in large obstetric hospitals, occurred within a thirty to forty year timeframe in New Zealand. A scientific systems approach was applied to the New Zealand maternity service that advocated centralisation of hospital services and streamlined organisation.

Other influences also contributed to the development of large obstetric hospitals. Most middle class women's organizations supported the process of medicalisation and helped Doris Gordon lobby for a professorship in obstetrics. Doris Gordon advocated twilight sleep, an anaesthetic used during childbirth from the 1920s in New Zealand. She had personal experience of this medication with all of her four children and touted its benefits to women (Donley, 1986). Papps and Olssen (1997) remark that the use of drugs required a change in the scale and type of hospitals, from small to large. In the present day, epidural analgesia gives women the opportunity to be pain-free and conscious while interventions occur, and many women elect this option of childbirth (Jowitt, 2000).

Of particular relevance to New Zealand's change to large hospitals, is the effect upon Maori women. Donley (1986) noted that hospitals were alien to Maori and that the routine performance of vaginal examinations, often by male doctors, was a particularly traumatic experience. Mikaere (2000) reflected that the state, through hospitals, assumed control over Maori childbirth alienating women from their whanau. She also noted that internal examinations were a complete

denigration of tapu and that “the absence of karakia must have been extremely difficult for many of the women” (p. 14).

Whiteside (1982), a member of the Maori Women’s Welfare League, questioned the practices at large obstetric hospitals where patients’ privacy, cultural values and confidentiality were ignored. She challenged the routine use of ultrasound scanning and fetal heart monitoring that was used so liberally on women and babies. Whiteside expressed her anger at the large hospital saying, “We are treated like lifeless carcasses on a freezing works chain, then if we object we are labelled anti-hospital or Maori activists” (p. 37).

Rama and Taiatini (1993) and Timutimu (1992) commented that independent midwifery has offered significant changes for Maori, with Maori midwives forming collectives and offering women choice concerning place of birth and an acknowledgement of cultural customs. Rimene, Hassan and Broughton (1999) challenged maternity services to offer an environment that is conducive to wahine Maori and their whanau. Perhaps the small maternity setting with a friendly, home like ambience might be less alienating and suit the needs of Maori women, as opposed to the busy crowded environment of large obstetric hospitals.

Large obstetric hospitals and centralisation of maternity services occurred as a result of medical control over childbirth, modernity and the desire for painless, safe childbirth. Women were encouraged to use effective analgesia that was only available in the setting of large hospitals. The literature acknowledges that Maori women have experienced alienation of traditional customary values and trauma through been confined in large hospitals. Independent midwifery schemes that were established to offer Maori women choice concerning place of birth and a culturally safe experience were noted. The different maternity settings seem to foster different philosophies of practice. This will be reviewed in the following section through an exploration of the medical and midwifery models.

Medical Versus Midwifery Model of Care

This section aims to describe the medical and midwifery models of care and the intersections between the two models. The models of care are important as they influence the type of care that is offered to women and their families during the childbirth experience. Discussion of models serves the purpose of “accentuating differences” (Rooks, 1999b, p. 370), whereas the reality is that differences may be relative and dependent upon context, practitioner and women.

Medical Model

It is not within the scope of this literature review to detail the history of obstetrics and science, but to provide an overview of how obstetrics and obstetricians have dominated the provision of facilities and practices for birth, and the model of care under which many or most practise. Griffith (1996) stated adamantly that the context of a large hospital reproduces the medicalised model and manages women giving birth, as well as managing the midwives working in this environment.

Historically it would appear that with a rise in scientific methods there was a similar rise in hospitalisation and interference during childbirth (Donley, 1995; Fleming, 1995; Hewison, 1993; Katz Rothman, 1991; Papps & Olssen, 1997; Sakala, 1988). These authors informed readers that increased use of technology during childbirth is supported by the medical model and is believed to be associated with lower maternal and infant mortality. Medical technology is associated with large hospitals and in turn is associated with safety in childbirth. Timeframes of labour are redefined in the medical model and medical intervention is used to shorten labour.

Obstetrics developed from within medicine for the purpose of dealing with the pathologies of pregnancy and childbirth (Bryar, 1995; Rooks, 1999b). The medical model’s focus is on the pathological potential of pregnancy and birth with an underlying belief that women’s bodies are imperfect and liable to require assistance during birth. Most obstetricians would see themselves as having the authority and expertise to be the key decision-maker for a woman in order to achieve the safest outcome for her baby/babies. Hunt and Symonds (1995) and

Fleming (1998a) considered that obstetrics normalised technology and childbirth, and that this became acceptable to many women and midwives. The medical model of childbirth is predominant and most women give birth in large hospitals with access to pain relief. Consequently, the majority of midwives provide care in large obstetric hospitals with a medicalised philosophy of practice.

Fox and Worts (1999) and Tew (1986) concluded that the medical model defines childbirth as hazardous, and that routine interventions are imposed upon an essentially natural process. Obstetricians who work within a medical model aim to impress upon women the conviction that technology is superior to nature. Fox and Worts maintained that women choosing to access help with pain, such as epidural analgesia, "can be understood as rational in a society in which pharmaceutical and technological intervention is accessible and commonly accepted" (p. 337). Tew (1985) observed that obstetricians believe that birth is safer if it takes place in a consultant obstetric hospital equipped with the instruments of high technology, as opposed to a place not so equipped - a general practitioner maternity unit or the home.

Reiger (1999) similarly described the medical model as having an underlying assumption that no birth was normal except in retrospect. The body as a machine, and especially women's bodies, were liable to faulty functioning. "Hence the acute care, high-tech hospital setting was portrayed as the only environment able to cope with breakdown" (p. 395) and thus the only environment in which childbirth could safely occur (Papps and Olssen, 1997).

Midwifery Model

In contrast to the medical model, the midwifery model of childbirth derives from a view that childbirth is a normal part of women's lives and a belief that women's bodies are well designed for birth (Rooks, 1999b). Midwives are expected to be guardians and experts in normal childbirth or uncomplicated pregnancy, and to avoid unnecessary obstetric interventions such as electronic monitoring of the fetus and epidural analgesia. The midwifery model also acknowledges that the pregnant woman, as an active participant, has the right to make decisions about her experience (Guilliland & Pairman, 1994; NZCoM, 1993).

Pairman (1998c) explained how the new professional relationship between the woman and the midwife challenges the dominant medical model of childbirth. The midwife and the woman work together in partnership which integrates the notions of 'being equal', 'involving the family', 'building trust', 'taking time' and 'sharing power and control' (p. 6). The notion of partnership has been critiqued and challenged within midwifery. Skinner (1999) advised that partnership might require a homogeneous population of women who are willing and able to be partners. She described the risk to the midwife if the plan for care is outside the medical paradigm, and something 'goes wrong'. With hindsight and pressure, "The family moves paradigms often rejecting the validity of any partnership agreement" (p. 16). This places a midwife practising within a non-medicalised paradigm at risk of criticism when unfortunate events occur.

Additional critique was undertaken by Benn (1999), who agreed that midwives might be vulnerable to or fearful of litigation if things go wrong, but said this should not negate the possibility of partnership as defined by Guilliland and Pairman (1994). Benn remarked that the key is communication between both parties where each recognises their own power and does not attempt to exert it over the other. The location of antenatal visits and the place of labour and birth require communication with the woman and her family. The midwifery model encompasses working with women, as opposed to telling women what will be done.

Page (2000) expressed the midwifery model as meeting the needs of women and their families, resulting in a difference in power relations, attitude and approach. Callaghan (1996) viewed the midwifery model as espousing concepts such as continuity of care, shared responsibility for childbirth between the midwife and the woman, and in contrast to the medical model, rejecting time limits.

To assist in the development of a holistic approach in midwifery education Carter (1994) suggested that midwifery training should include experience in smaller obstetric units. The midwife needs to learn to work alongside women through their childbirth experience, and the small maternity setting enables this

development. Student midwives are likely to gain different experiences if they work with an independent midwife who practises outside large hospitals. Griffith (1996) suggested that the non-medicalised context of birthing centres provides greater flexibility than a large hospital where an independent midwife might be constrained by an overtly medicalised context.

The midwifery model encourages practitioners to enable normal childbirth and to respect the woman and her partner as active participants. Communication, choice and continuity of care are important factors that enhance the midwifery model of partnership. Time limits are not imposed upon the woman in labour and the midwifery model demands emotional energy, possibly from the midwife and the woman. The midwifery model of care is relationship and time intensive as explained by Rooks (1999b) who stated, "Midwives use their own physical and emotional energy to encourage, support, and comfort women during birth; the medical management model, in contrast, tends to substitute more use of medical technology [in preference to] more use of professional time" (p. 372). There is now evidence that suggests that low intervention care, supported by the midwifery model, is appropriate and safe for most women during childbirth (Rooks, 1999a). In many instances the medical model of care has been adopted and this model dominates some hospitals.

Adoption Of The Medical Model

Reference has been made previously to the notion that the context of practice influences the philosophy of practice. This section explores the literature that refers to the practice of hospital-employed midwives. There is a dearth of literature concerning the relationship, if any, between the independent midwives' philosophy of practice and the context in which they practise.

Griffith's (1996) findings that the midwifery discourse was dominant in birth centres, as opposed to the medical discourse that dominated midwifery practice in teaching or city obstetric hospitals were cited in chapter one. According to Griffith, "Midwifery is conceptualised and practised differently in different contexts" (p. 366).

Fleming (1996) similarly found that most midwives in larger hospitals practise within a medical model of childbirth, because the institutions are fragmented into pre and postnatal wards and labour and delivery suites. Kirkham (2000) described the behaviour of labouring women and midwives in different settings. She found there was common ground between the home setting and GP maternity units. In comparison, the behaviour of women and midwives was very different in the consultant hospital. She articulated the difference as being a contrast between "day and night" (p. 228). Kirkham also concluded that midwives are unable to work in partnership with women, when the constraints of the setting, such as large consultant hospitals, disempower midwives.

Abel & Kearns (1991) viewed the midwife as a compromising practitioner and stated, "The midwife is the health care professional whose role potentially mediates the experience of giving birth and the formal medical system" (p. 826). The question remains however, whether midwives are able to provide a midwifery model of care within a medicalised birth setting. Katz Rothman (1991) suggested not and stated, "As the nurse-midwives have shown me, it is working outside of medical settings that makes demedicalisation possible" (p. 284). This is to say that the setting is so pervasive, that the ideology within the setting dictates accepted practice.

According to Kirkham (1997), "Modern midwifery in Britain was very much defined by the more powerful profession of medicine and there is clear evidence that midwives internalised the values of that profession" (p. 193). Midwifery has accepted the language and values of obstetrics and this has obscured the difference between supporting women to birth and using medical interventions. Kirkham believes that midwives have learnt much from the increasing body of obstetric knowledge. However, the traditional knowledge of midwifery has been muted or lost in this process of scientific dominance. Davis (1994) supported the fact that midwifery has become dominated by the medical model with the introduction of state-of-the-art technology and has resulted in a reduction of the art of the manual and observational skills of the midwife.

Differences in practice between the medical and midwifery models were described by Oakley et al. (1995) who undertook a descriptive study of 1181 women assigned either to midwifery or to obstetrician care. The authors examined clinical notes and responses from four questionnaires given to women. They found that midwives provided more hands-on, lower-level technology care while women in the obstetrician group were much more likely to have care based on state-of-the-art medical technology. The authors also noted that there is enough evidence that the professional groups put into practice two different models of care, where almost three quarters of women in the obstetrician group experienced continuous electronic fetal monitoring, compared to a third of the women receiving midwife-led care.

In summary, the constraints of a maternity setting can disempower midwives. Katz Rothman (1991) considered that midwives have to work outside of medical settings in order to practise in a midwifery model. There are gaps in the literature regarding independent midwives and whether the context affects their partnership relationship or their philosophy of practice. Further discussion of the context of practice is provided with regard to use of technology.

‘High Technology’ Versus ‘Low Technology’ Settings

This section briefly explores the relationship of technology and midwifery practice. Tew (1985) claimed, “The maternity policy in England has been based on hospitalisation for birth which was achieved only by unjustifiable propaganda which persuaded nearly everyone, medical and lay, that it was highly dangerous and irresponsible for mothers to give birth anywhere else” (p. 24). This policy has directed research to ever more sophisticated technology and directed the education of obstetricians, general practitioners and midwives to master technology, as opposed to learning the skills of low technology midwifery.

Nurse-midwives in America (within highly technical settings) are spending increasingly more time on equipment as opposed to giving labour support (Rooks, 1999b). Gagnon and Waghorn (1996) found that most women in the large hospital required technical expertise such as epidural analgesia, intravenous infusions,

catheterisation, continuous electronic fetal monitoring and oxytocin. The authors stated, "Widespread use of technology, however, appears to encourage more emphasis on technical expertise and much less on supportive care expertise" (p. 5).

Some studies have shown that midwives reject the use of technology when given the opportunity to do so. Waldenstrom and Turnbull (1998) undertook a systematic review of alternative models of maternity care characterised by continuity of midwifery care. The review included a total of 9148 women in seven trials over an eight-year period across five industrialised countries. Benefits to women who received continuity of midwifery care were shown to be reduction in labour interventions with less electronic fetal monitoring, less pharmacological pain relief (epidural analgesia), and less invasive procedures. Women in the alternative models of care groups (continuity of midwifery care) had longer duration of labour, yet they universally had increased levels of satisfaction.

Summary

The literature review initially outlined the historical development of small maternity units within New Zealand. Evidence was provided that small maternity units replaced homebirth, and subsequently small units were closed in preference to large obstetric hospitals. The main reasons for closure of small units were claims that large hospitals were safer, and more cost effective. A number of studies were presented to refute such claims, in particular, the Rosenblatt et al. (1985) study, that showed the safety of small maternity units in the New Zealand context, a large study by Waldenstrom and Nilsson (1997) in Stockholm, and Rooks et al. (1992) with regard to data from the United States of America.

Use of small maternity units by midwives and women was discussed to provide a background understanding as to why small maternity units might be under-utilised. The literature points to the fact that midwives working in large hospital settings become accustomed to that way of practice and may be reluctant to practise in a setting without back up emergency facilities on site. Similarly, women have been conditioned to believe that large hospitals are a safer

environment for birth, and that the lure of pain relief, in particular epidural analgesia, attracts some women to labour in large obstetric hospitals.

Differences in the medical and midwifery paradigms were discussed with the midwifery model of care emphasising working in partnership with women and their families. The notion that medicalised-midwifery care is prevalent in large hospital settings, whereas midwifery model care is more likely to occur in small maternity units was explained. High technology birth is fostered in large hospitals where there is high technology equipment, such as fetal monitoring, epidural analgesia, syntocinon infusion pumps, and ready access to specialists. In contrast, midwives and women generally accept the small maternity units as a place for natural birth.

There is a dearth of literature concerning the context of independent midwives' practise, possibly due to the relatively small numbers of self-employed midwives internationally, and the recent establishment of independent midwifery in New Zealand. This literature review points to the fact that intrapartum midwifery care is influenced by the maternity context, although the evidence relates mostly to hospital-employed midwives. It appears to be unknown as to whether independent midwifery practice differs in different contexts. In the following chapter the research design and the method of the present study are presented. The purpose of the study is to explore the experience of independent midwives practising in different settings.

Chapter 3: Research Design and Method

Introduction

In this chapter an explanation of the research design, and the method used for the present study are elaborated. A qualitative study was designed and conducted using Van Manen's (1990) research method. The philosophical underpinnings of Van Manen's human science are described with reference to thematic analysis, and hermeneutics. The research method, which includes approval from the relevant ethics committees, recruitment, and the process of informed consent is discussed. The process of interviewing, the conduct of thematic analysis, and the approach to uncovering the meaning of the data are explained, as these are integral parts of the study. Rigour is addressed in relation to the trustworthiness of the study. This will be illustrated by showing the steps used to analyse the data to uncover themes, and the means of gaining feedback on data analysis.

Research Design

The research question posed was: How is the provision of intrapartum care by independent midwives different in a small maternity unit as compared with a large obstetric hospital? As stated previously, it became apparent that few authors had referred to the experience of midwives who had provided labour care in different settings. Research tended to focus on the outcome statistics of various maternity settings, generally through quantitative studies.

A qualitative study that employed Van Manen's (1990) method of hermeneutic thematic analysis was designed and deemed appropriate to answer the research question. Robertson (1999) commented that when a researcher is attempting to understand or gain insight into human experience, hermeneutic phenomenological research is appropriate and Van Manen (1990) provides a recognisable approach, or a way to conduct research in this manner. Van Manen described the purpose of thematic analysis as the needfulness to make sense of the data, a process of discovery, and the means to get at the notion. Van Manen warned researchers not to confuse hermeneutic analysis with well-known techniques of content analysis.

Content analysis specifies beforehand what it wants to know from a text, whereas a phenomenological hermeneutic analysis searches for the meaning in the text. It is discovery oriented.

The intention of this study is to answer the research question by describing the differences experienced by independent midwives who provide intrapartum care in both small and large maternity settings. Van Manen refers back to Heidegger's philosophy of 'being in the world'. The researcher asks questions to encourage participants to remain close to the experience and to give examples of how they lived the experience, such as "What is this experience like?" The question posed to the participants was, "Please tell me what it is like to provide intrapartum care to women both in a small maternity unit, and a large obstetric hospital".

Philosophical Underpinnings

Van Manen (1990) used the terms phenomenology, human science and hermeneutics interchangeably. He described hermeneutic phenomenology as "descriptive (phenomenological) methodology because it wants to be attentive to how things appear, it wants to let things speak for themselves; it is an interpretive (hermeneutic) methodology because it claims that there are no such things as uninterpreted phenomena" (p. 180). Phenomenological research is generally associated with uncovering a phenomenon (Crotty, 1996; Smythe, 1997) while hermeneutics is about discovering the meaning of experiences, or according to Van Manen, "hermeneutics describes how one interprets the 'texts' of life" (p. 4).

The term hermeneutics relates back to the seventeenth century in the context of biblical interpretation. Hermeneutics assumes an affinity of some kind between the text and reader, and this commonality provides a basis for the interpretation that is to emerge. Intentions and meanings are often hidden in the text and the authors themselves may be unaware of these. Hermeneutic inquiry has the potential to uncover such meanings (Crotty, 1998). Van Manen's (1990) research method was influenced by the "hermeneutic phenomenological tradition as found in Germany (from about 1900 to 1965) and in the Netherlands from about (1945 to 1970)" (p. 2). Van Manen frequently refers to Heidegger and described his

hermeneutic understanding as the power to grasp one's own possibilities for being in the world in certain ways.

Martin Heidegger, a student of the phenomenologist Husserl, was a scholar in hermeneutics, who diverged from the thinking of his teacher. Heidegger did not think it was possible to put aside or 'bracket' one's previous understandings. Koch (1995) advised that Heidegger's two essential notions, "historicality of understanding, and the hermeneutic circle, should be understood" by the researcher (p. 831). Kaelin (1989) noted that Heidegger did not actually refer to "a circle" of understanding, (Ricoeur used this term), but referred to a relatedness backward and forward with the act of inquiry pointing "in one direction to its beginning and in the other to its completion" (p. 24). 'Historicality of understanding' refers to pre-understandings that will be discussed following an explanation of the hermeneutic circle and existentials.

Hermeneutic Circle

Walters (1994) explained that, "The hermeneutic circle has become a metaphor to describe the process of moving between the part and the whole during the interpretation process" (p. 138). The hermeneutic circle reflects that a researcher comes with an average understanding of what we are asking about, to a full comprehension of its meaning, where the process seems to be circular. The understanding we begin with is only implicit, and the understanding produced by the inquiry is fully explicit (Kaelin, 1989). The researcher moves back and forth between an overall interpretation of the text and significant parts of the text.

Koch (1995) noted that within this interpretation is the researcher's background of previous understanding which Heidegger called 'fore-conception', in which we grasp something in advance and can never free ourselves from its influence. Crotty (1996) explained the hermeneutic circle as a means of achieving understanding. To understand something, one needs to begin with ideas and have pre-understanding of the notion. The understanding turns out to be a development of what was already understood, with an enriched understanding that further illuminates one's starting point.

Van Manen (1990) reflects the intentions of the hermeneutic circle and stated that interpretation of lived experience has a methodological feature of relating the “particular to the universal, part to the whole, episode to totality” (p. 36). Koch and Harrington (1998) advised that getting into the hermeneutic circle properly relies on each person’s background where neither participant’s text nor the researcher can assume a privileged position in interpretation. Participants tell stories with their pre-understandings, and the researcher’s background brings an understanding that compares new information to something we already know.

Koch (1995) advised that understanding is not the result of a correct procedure; rather it is found in the hermeneutic circle where the researcher’s understanding is modified by re-examining the parts and the whole. Heidegger described insightful interpretation as occurring when the crucial features of self-understanding are brought to light (Guignon, 1997). Self-understanding for Heidegger referred to knowing one’s way around the world, or a particular subject matter. Interpretation reflects meaningful human existence in the world.

While the hermeneutic circle is recognised as being essential to hermeneutics, the application of hermeneutics to research is contested. Leonard (1989) remarked that the goals of hermeneutics are to understand everyday skills, practices and experiences, to find commonalities in meanings, and to reveal embodied experiences through exemplars. Crotty (1996) disagrees with hermeneutics being depicted as being about everyday experiences, and argues that Heidegger’s hermeneutics is about ‘being’ or ‘Dasein’ the ‘being-there’, and he used ‘spatiality’ and ‘temporality’ to provide an understanding of being in the natural world in relation to space and time. These ‘existentials’ were used to replace the categories of traditional metaphysics that Heidegger doubted as being relevant to ontology.

Heidegger (1927/1962) wrote that the “being can be covered up so extensively that it becomes forgotten and no question arises about it or about its meaning” (p. 59). Heidegger used existentials as structures of ‘being’ that make human existence and behaviour possible. Yet, Heidegger rejected the term ‘existentialist’ and maintained that he was an ontologist concerned with the study of ‘being’.

Heidegger was concerned primarily with Dasein and used existentials which are structures in the existence of Dasein (Crotty, 1996; Kaelin, 1989). Existentials are a useful framework for analysis and for structuring reflection.

Existentials or Lifeworld Themes

Van Manen (1990) described themes that pervade the lifeworld of all human beings; they are fundamental lifeworld themes. These four themes are particularly helpful as a guide for reflection in the research process and have been used to assist analysis in this study. Van Manen suggested, so as not to confuse these themes with themes of human phenomena, they are called 'existentials' defined by Heidegger. 'Lived body' describes how one is always bodily in the world. In our bodily appearance we both reveal something about ourselves and we always conceal something at the same time. How we respond in our bodily context is dependent upon the response of our 'being' to that particular situation.

'Lived space' was described as the space where one finds oneself, and how this may affect how one feels. According to Van Manen (1990), "There are cultural and social conventions associated with space that give the experience of space a certain qualitative dimension" (p. 103). Lived space may also be associated with 'lived distance' where the objective distance may not be the 'felt distance' between two places. Bollnow (1960) described the experience of lived distance as dependent on how accessible the other space was perceived to be, as to whether it seemed nearby, or a long distance away.

'Lived time' is described as subjective time as opposed to clock time and is closely related to the existential of lived space. Lived time may also be the being of a person in the world at that particular time, such as a midwife who now wants to provide labour care in a low technology setting. 'Past time' travels with one, to shape what a practitioner brings with her to her everyday practice.

'Lived other' is the lived relation one maintains with others, and one forms a view of the 'other'. Heidegger (1927/1962) described the 'other' as being those people whom one relates to, or one is associated with; those people called 'others'. For the most part, one does not distinguish oneself from the 'other'. Being in the

world is being in a world shared with others. In other words, being with others, shapes the being. However, the 'being' can be taken away. An example might be my experience as a practising midwife. If I am with others who indicate a respect for my assessments, my being is one of relating with confidence and assuredness. On the other hand the 'others' or 'they' can shrink that confidence by doubting or questioning my practice.

Pre-understandings

As stated previously, in contrast to Husserl (the founder of phenomenology), Heidegger advised that pre-understandings could not be bracketed or put to one side. According to Van Manen (1990),

We try to come to terms with our assumptions, not in order to forget them again, but rather to hold them deliberately at bay and even to turn this knowledge against itself, as it were, thereby exposing its shallow or concealing character (p. 47).

Walters (1994) and Leonard (1989) explained that hermeneutic interpretation presupposes some prior understanding, and the researcher interprets something from their own lived experience from 'being-in-the-world'. Van Manen, influenced by Heideggerean hermeneutics, therefore cautioned researchers that the questions each researcher brings to interpret the data, are from the background of their understanding.

As stated in chapter one, I came to this study with many years of midwifery experience in large hospitals and a small portion of my career in a rural maternity unit. My memories of working in the large hospital were the busyness, the unexpected problems that occurred, and the camaraderie with other midwives. I have worked as a Charge Midwife and I recall days when there were more women than beds available, and insufficient staff to cope with the number of women in the unit. At times a transfer from a homebirth or a small maternity unit added additional pressure to the already over-stretched resources.

While working as a midwife teacher with students in different clinical settings, I became aware that each of these different settings was providing equally good learning experience. Being a teacher had perceived advantages and disadvantages

with respect to undertaking this study. I felt that midwives might talk freely and openly about the maternity settings, as I was employed independently of the maternity structures. On the other hand, I wondered if the independent midwives might be reticent in telling me stories, as they might fear a critical response from a teacher. According to Koch (1994),

Our situatedness as interpreters, our own historicity, do not constitute an obstacle. Prejudices are the conditions by which we encounter the world as we experience something. We take value positions with us into the research process. These values, rather than getting in the way of research, make research meaningful (p. 977).

My 'situatedness' as a researcher carries values from my personal and midwifery experience. The purpose of acknowledging these values is to recognise that values can prejudice the process of understanding meaning. My personal assumptions particular to this research study were shared with students and supervisors at Massey University in June 1999, prior to application for ethics approval.

These values included that I assumed that midwives who were confident with homebirth were more likely to provide intrapartum care in a small maternity unit. My first experience of attending a homebirth occurred after I had worked in a small maternity unit. I recall the joy of seeing the woman, husband and children in their own surroundings. I also felt comfortable with attending a homebirth as it reminded me of being on night duty in the small maternity unit. I have not had children hence I do not have personal experience of birth in any particular setting. As a researcher, therefore I cannot relate to a particular setting as being ideal from my experience. My experience is only from a midwife's view, of being in a particular setting with women and their families.

While discussing my potential research question, an independent midwife told me that recent cases of litigation deterred her from offering women intrapartum care in a small maternity unit. I therefore expected that litigious issues might arise during interviews, as there had been a lot of recent media attention (Legat, 1997; Pearse, 1998; Wagner, 1995) concerning cases where birth had gone wrong. I also

assumed that negative attitudes from obstetricians, or problems associated with transferring women might also discourage independent midwives from providing intrapartum care in small units. I did not know any obstetricians who attended births in small maternity units and I presumed that they might be unsupportive towards independent midwives providing labour care in these units.

Although I have personal midwifery experience, I remain acutely aware that it is the participants in this study who have lived, and continue to live the experience of providing labour care as independent midwives. It is their voices that need to be heard, not mine. Van Manen (1990) stated, "We gather other people's experiences because they allow us to become more experienced ourselves" (p. 62). Being a midwife therefore is essential to the notion of gathering and interpreting the midwifery experience within the context of this study.

Acknowledging pre-understandings reflects understanding of part of the hermeneutic circle and reflects an integral part of the research design. My 'being' a midwife enables the collection, analysis and interpretation of data as described in the following sections.

Research Method

In this section, the steps used to carry out this qualitative study in line with Van Manen's (1990) research method are detailed. Approval from ethics committees, and ethical considerations are discussed. Recruitment, gaining informed consent, anonymity and confidentiality are also detailed. Concerns for participants, and concerns of the researcher associated with this study are shared. An overview of participants in this study is restricted to generic information in order to protect the identity of participants. Processes of data collection, analysis and rigour are also explained in detail.

Ethical Considerations

Ethics approval was gained from both the Massey University Human Ethics Committee and the Auckland Ethics Committees, in September 1999. While it

was not a requirement to obtain approval from the Auckland Ethics Committees, I chose to do so in view of the research topic. The study asked participants to describe the experience of providing labour care in both small and large maternity hospitals. I was aware that this research might raise concerns about midwifery practice, or about the culture of specific environments. Another concern was a possible backlash against researching this very topic. Some maternity practitioners have definite viewpoints as to whether a small or a large hospital is the safer environment for birth. Van Manen (1990) indicated that research might have effects upon institutions through an increased awareness of experiences that may change or challenge practice. As the research was based around maternity settings in the Auckland region, it seemed important to have approval from the Auckland Health Ethics Committees.

Recruitment

The midwifery community is relatively small in New Zealand, therefore there was concern that participants be recruited without coercion. Ethics approval had been sought to access midwives through the NZCoM website, the telephone directory and by identifying midwifery clinic signs within the geographical area where small maternity units existed. Non-probability purposive sampling was used to recruit independent midwives who have lived the experience (Baker, Wuest & Stern, 1992; LoBiondo-Wood & Haber, 1998) of providing intrapartum care, in both a small maternity unit and a large obstetric hospital.

At the time of recruitment the NZCoM website was newly established and had only six midwives listed for the entire region. The telephone directory was also restrictive in that few midwives were listed within the same geographical area as small maternity units. I had assumed that midwives who lived near small maternity units, within the Auckland region, were more likely to practise in these units.

Two midwife managers had provided letters of support for this study as part of the ethics application. I approached them for a list of names of all the independent midwives who attended births in the small units. A total of 14 names of independent midwives was received. Information sheets were subsequently sent to

13 midwives, inviting them to return their name and telephone contact if they were interested in participating in the research. An address was not found for one midwife, hence her letter was kept in reserve for a future mailing recruitment if required.

Information sheets were generally sent to the independent midwives' antenatal clinics or homes, as this was considered a private mailing address. Seven participants replied within two weeks of the initial mailing, and a further three replies arrived within five weeks of the information sheets being posted. The realisation that independent midwives were interested in participating in the study was encouraging and exciting.

Consent

Each participant signed a consent form prior to the interview, and questions were invited. I reiterated their right to refuse to answer questions and to stop the audiotape at any time. The right to delete parts of the transcript and the right to withdraw from the study were also discussed. I took care to explain that withdrawal from the study was possible prior to the return of the transcript, that is to say, the timeframe was chosen to precede a time when I would have already begun interpreting the data. This information was reiterated in the covering letter attached to the return of each participant's transcript.

Anonymity and Confidentiality

Participating midwives were each invited to meet me at a private venue to ensure that other midwives did not witness a research interview in action. Anonymity (when desired) was assured by the use of a pseudonym on the transcript and in the thesis. Confidentiality has been maintained by not revealing the identity of any of the participants. However, it is evident that some participating midwives have talked to each other and disclosed the fact that they are participants in the study.

Names of hospitals where the midwives practised are substituted with the terms a 'small maternity unit' or a 'large obstetric hospital'. The names of midwifery and medical colleagues mentioned in data extracts have been replaced with a generic name, [midwife] or an [obstetrician]. Names of clients were similarly deleted

from any text and replaced with the term 'a woman'. The requirements of the Privacy Act (1993) have been adhered to with respect to information about clients that was shared with me during the course of the interview. Within one data chapter, sensitive incidents are included, but without reference to a pseudonym to further protect participating midwives' identities.

Confidentiality was maintained during my day-to-day personal and professional life. Work colleagues were sometimes aware of my interview schedule, but were not privy to who was being interviewed. On one occasion outside of work, a friend offered to post the mail in my hand. I was about to hand over the envelopes to her when I realised that she might recognise the names of midwives and link them to my research study, hence I withdrew from her offer. Care was also taken with regard to storage of data. Audiotapes and field notes were labelled with a pseudonym, or the participant's name according to their preference, and kept in a locked filing cabinet separate from consent forms. Audio tapes and field notes will either be destroyed ten years after the completion of this thesis, or returned to the midwife as requested on the consent form.

Concern for Participants

Benefits from participating in the study included the opportunity to talk about practice, which all midwife participants appeared to enjoy. All participants will be offered a copy of the data chapters upon completion of this thesis. Time and cost for the participants were minimised by my offering to travel to participants and to take only one and a half to two hours of their time. I generally took some fruit or cookies to show appreciation to the midwife for giving her time. In all instances I spent additional time with the midwife to chat about the study, or to hear other stories of her practice that she did not wish to have audiotaped.

According to Van Manen (1990) the researcher has "a certain moral obligation to his or her participants that should prevent a sheer exploitative situation" (p. 98). My role as a researcher was to create a conversation similar to that which occurs in a friendship, to listen attentively to the participant's experience, and to show respect for the participant. The opportunity for reflection appeared to be welcomed by participants. The recall of difficult situations did evoke memories of

distress for one midwife, however she assured me that she had a good support network for debriefing. I telephoned the midwife the next day and she confirmed that she felt no further distress. I also telephoned my supervisor to inform her of my contact with the participant. Two midwives informed me prior to audiotaping, that they had had a difficult case a short time before and did not wish to discuss it during the interview. Both midwives were assured that this was entirely acceptable and were encouraged to talk about other experiences. One of the midwives shared the recent experience after the audiotape was stopped; the other midwife explained her distress without providing details of the incident.

Concerns of the Researcher

During the time of data collection, I continued my employment and this involved working with students in a large hospital delivery unit. On one occasion I found myself saying to a woman who was known to have a small baby, "Do you really want this pethidine? A very small amount does go through to your baby". As I said this, I knew a participant's story had influenced me. I journalled this experience in order to reflect fully upon the implications of being a researcher and practitioner-teacher simultaneously. I do not believe that there was any conflict in my roles. However I had gained an awareness of approaching pain management from a different perspective as a result of listening to a participant.

I frequently felt exhausted after interviews and was acutely aware of the difficulties some of the independent midwives experience through their practice. On two occasions I needed to contact my supervisor about incidents that independent midwives had experienced, in order for me to debrief my sorrow. This debriefing was helpful as the midwifery skills, plus the research skills of my supervisor, enabled resolution of my concerns.

Participants

All ten participants who had responded to the information sheet were interviewed. Each participant had provided labour care to women in both small and large maternity hospitals within the previous two years. The stipulation of having practised within the previous two years was included to provide currency to the

research findings. All participants were practising midwifery within the Auckland region and had been qualified for at least three or more years.

Participants were on call during the period of interview as this is the nature of independent midwifery practice. I advised the participants to allow two hours of interview time to accommodate unpredictable interruptions. Only two participants needed interview times rescheduled due to work commitments. I offered one midwife the option of withdrawing from participation after our third appointment was cancelled as she appeared to be extremely busy. She insisted however that she was willing to be interviewed, and our fourth appointment was successful.

Participants have chosen whether to use their name or a pseudonym. Participants were invited to consider this prior to being interviewed, and each midwife made her own choice concerning the name/pseudonym to be used. I am conscious that some of the pseudonyms are identical to the names of other independent midwives who were not participants in this study. I did not influence participants concerning their choice of name and I would like to disclaim on behalf of participants and myself any mistaken identity through this process. I think it is important that the data are seen to be data that might be universal to any midwife practitioner. Most of the data extracts are attributed to participants as they have indicated this to be their preference, and they are keen to see their contribution to this study.

Data Collection

Prior to each interview, Van Manen's (1990) section on data collection was re-read to remind me of the manner in which interviews should be conducted, in order to ascertain the experience being studied. Seven of the interviews consisted of 90 minutes of audiotaped time, and the other three interviews were between 50-90 minutes. Interviews began with participants being asked how long they had been practising midwifery and how they had come to use small maternity units as a place to provide labour care. If the midwife did not continue talking spontaneously, I would ask, "Please tell me about a woman for whom you provided labour care in a small unit or at the large hospital". My role was to listen attentively and encourage further description of notions raised during the context of the interview.

According to Van Manen (1990), "human sciences strives for precision and exactness by aiming for interpretive descriptions that exact fullness and completeness of detail, and that explore to a degree of perfection the fundamental nature of the notion being addressed in the text" (p. 17). That is to say, data were collected by asking participants to give illuminating detail of events, feelings, thoughts and actions related to providing intrapartum care in both small and large hospital settings.

During early interviews I was fascinated to hear stories of homebirth or postnatal incidents and felt it would be rude to interrupt participants. Van Manen (1990) warned, "One needs to be oriented to one's question or notion in such a strong manner that one does not get easily carried away with interviews that go everywhere and nowhere" (p. 67). When transcripts were returned from the typist, I had to read the transcript with a 'Van Manen eye' and ask myself if I had remained orientated to my research question that explored the differences between providing intrapartum care in small maternity units, as compared with a large obstetric hospital.

After the third interview, I addressed this concern by asking participants if anything was on their mind that might affect their interview before we began audiotaping. Strategies such as reiterating the research question prior to turning on tape recorders helped to keep the participant focussed on the provision of labour care within small and large hospital settings. Only one interview was conducted per participant and this yielded between 30-45 pages of transcribed data.

The decision to undertake one interview only was made with consideration for the participants' time, and the fact that all participants felt they had disclosed what they wanted to share with me prior to the completion of the interview. The participants checked their transcripts thoroughly and most added further description when needed. The final two interviews provided further original stories. However I was aware that the notions being related, were notions similar to those described by previous participants.

Data Analysis

A practice interview was undertaken and transcribed by myself. An efficient typist (who had signed a confidentiality agreement) transcribed interviews thereafter. Field notes were recorded immediately after each interview to note non-verbal cues (such as the midwives 'touching wood' for luck) and to record the main points from the interview. Listening to the tape provided an opportunity to place exclamation marks, to fill in words that were not understood by the typist, and to generally enjoy listening to the participant's stories in a relaxed manner. Frequently parts of the tape were replayed up to five times to capture what the participant had said in order not to miss any of their story. Listening to the tape also provided an opportunity for reflecting upon inappropriate interruptions, or alternatively, inadequate prompting.

Once I had filled in omissions and corrected the transcript, three copies were made. One copy was returned to the participant with a covering letter inviting her to amend any part of the transcript or delete aspects she did not want to have included in the thesis or any publication arising from it. During this research, no participant deleted any aspect of the transcript. Several participants commented that they trusted my use of their data. My supervisor also received a copy of each transcript and I retained a copy.

My process of writing included journalling after each participant interview, writing notes while listening to the audiotape, 'memoing' on the typed transcript (Lofland & Lofland, 1995; Tolich & Davidson, 1999) and then organising data into themes. According to Van Manen (1990), "grasping and formulating a thematic understanding is not a rule-bound process but a free act of 'seeing' meaning" (p. 79). Annells (1996) also commented that an interpretive paradigm of inquiry is gaining in popularity, "although the research process varies, as there is no apparently dominant list of procedures for the research process" (p. 712). That is to say, the researcher must personally establish a means of interpreting and reporting the data gathered.

Van Manen's (1990) "wholistic reading approach" and the "selective reading approach" (p. 93) guided analysis. The wholistic approach involves reading the

text as a whole in order to capture the fundamental meaning or main significance of the text. The selective reading approach recommends reading a transcript several times in order to note phrases that seem to be essential to or revealing about the experience being described. Particular phrases were underlined and highlighted with notes written in the margin expanding upon the meaning of the phrase. Sandelowski (1995) emphasised the need to be familiar with the data and to get a sense of each individual interview before comparisons were made across interviews.

Other authors on qualitative research were read to assist with the process of formulating themes. Tolich and Davidson (1999) assure the researcher that preliminary themes are precisely that, and one may place a tentative title upon revelations, with awareness that it is likely to be refined many times. Initial stories and quotations were frequently discarded for data that reflected more accurately the notion being described. Similarly, sufficient data from the participant's narratives were required to show the reader what the experience was really like. Hence some data extracts are lengthy. The process of data analysis was a process of trial and error. I found the most successful method was keeping transcripts complete and writing extensive notes down the margins, and highlighting 'zingers' (Tolich & Davidson) or phrases that seemed revealing about the experience being described (Van Manen, 1990).

A sense of preliminary themes came to me on an occasion when all ten transcripts were read one after the other. The highlighted aspects of transcripts showed phrases that had similar meanings, and a sense of preliminary themes were developed. The next step involved grouping similar and contrasting data together, and re-writing an interpretation of each participant's data. Through this process, the data analysis chapters began, overgrew, and were constantly pruned and refined to uncover the meaning of the data. Initial themes were replaced with descriptions that more accurately reflected the meaning of the data. An example of refinement was the theme, 'being solely responsible' which was initially called, 'being alone'. The process of re-reading and re-writing assisted my interpretation and a deeper meaning was uncovered that encompassed much more than the notion of 'being alone'. The research process involves writing and rewriting. This

requires a high level of reflection and patience to tune into the lived experience under study.

The process of data analysis occurs within the hermeneutic circle, where I came to the data analysis with pre-understandings and moved to a deeper understanding through examining specific parts of participants' texts and the whole text. The process of writing and rewriting assisted me to see new meanings within specific parts that in turn modified the overall meaning. Moving between the parts and the whole of the data constantly enriches the meaning of one's previous experience, and leads to a richer understanding of the text (Walters, 1994).

Presentation of themes and use of the data

In the following two chapters, themes are presented, and extracts from participants' narratives supporting the themes are included. The data chapters are called 'real midwifery' and 'carrying the can'. A discussion chapter follows the two data chapters, and provides further analysis of the narratives in relation to Van Manen's (1990) existentials of 'lived body', 'lived time', 'lived space' and 'lived other'. A key to the data excerpts is as follows:

- Participant's speech is indented and italicised
- Underlining of some of the participant's words indicates their verbal emphasis
- Participant's chosen pseudonym is provided at the end of each data extract
- Page numbers occurring at the end of each participant's narrative (in the data chapters) refer to each participant's original transcript
- Page numbers, attributed to participants' data in the discussion chapter, refer to the page on which the full quotation may be located in this document
- (Mary, pp. 1/11) Indicates for example, that excerpts were taken from Mary's original transcript, pages one and 11
- [] Signifies comments to clarify an abbreviated word, or is used when a name is replaced with a generic name to maintain confidentiality
- ... Edited material

- All the independent midwives interviewed are women, hence 'she' and 'her' are used
- Frequently, the 'woman' is referred to without reference to people who support her. This does not negate the fact that in most circumstances women are supported by significant others such as partners, husbands, family and friends.

Rigour

Credibility of research is enhanced when researchers describe and interpret their experiences as researchers (Koch, 1994). My interpretation is coloured by my practice as a relatively cautious midwife, with more years of experience in a large hospital than in the homebirth or small maternity unit setting. While analysing the data, I was mindful of the inter-relationships that exist between midwifery colleagues, and the tensions between some practitioners in different settings. All these factors needed to be considered as influencing my interpretation of the data.

Interpretation belongs to the researcher, yet a test of the accuracy of the interpretation occurs through feedback. Feedback on preliminary themes and my interpretation of the data was received from my supervisor, a midwife academic, from two of the participants, and from an audience attending the year 2000 New Zealand College of Midwives conference. Koch (1994) said that consulting with participants and asking them to comment on the researcher's analysis establishes credibility. Van Manen (1990) similarly advised "Themes may become objects of reflection in follow-up hermeneutic conversations in which both the researcher and the interviewee collaborate" (p. 99).

Initially I had opted not to share my interpretation with participants prior to publication, because of the time involved for the participants. However, I had particular concern that two midwives who had chosen not to use a pseudonym might be readily identified. It seemed especially important that both these midwives concurred with my interpretation of their stories prior to publication, and also that they had the option to reconsider a pseudonym. An opportunity was therefore given for both midwives to read draft chapters that revealed their stories with my interpretation. Both willingly agreed and one participant responded with

excitement as she read her data extracts and then the interpretation. She exclaimed, "That's exactly it; that's what it is!" The other participant suggested minor changes that enhanced my analysis, and she provided further written description to elucidate the meaning of her stories.

Feedback was also received from midwives who attended my presentation at the New Zealand College of Midwives conference in Cambridge, New Zealand, September 2000. A midwife who is undertaking a doctorate study, agreed with the themes presented. She said that preliminary analysis from focus group interviews with independent midwives (in a different region in New Zealand) has identified at least two of the same themes I have identified. A midwife practising in a small maternity unit said that my interpretation had put into words exactly how she felt about practising in that setting.

Van Manen (1990) said, "A phenomenological description is always one interpretation, and no single interpretation of human experience will ever exhaust the possibility of yet another complementary, or even potentially richer or deeper description" (p. 31). Interpretation is therefore the interpretation of the data as understood at that time. Undoubtedly the meaning of the data might be interpreted in a different manner in the future, just as my interpretation has evolved and developed over the time of writing this thesis.

Koch and Harrington (1998) concluded that a research project is plausible when the work is engaging, "and has an internal logic achieved by detailing each interpretive, reflective turn of its makers" (p. 889). Each interpretive turn has been illustrated through the process of refining my interview technique, journalling after interviews, making notes on transcripts, grouping stories of participants into preliminary themes, refining themes and analysis simultaneously, and ensuring credibility through participant, supervisor and external feedback.

Summary

Details of the design and method employed are an essential aspect of a research study. The philosophical underpinnings of this qualitative research are Van

Manen's (1990) method of hermeneutic interpretation, an understanding of the hermeneutic circle and lifeworld existentials. Pre-understandings that travel as part of me were explained and interpreted. Approval from ethics committees and attention to ethical conduct throughout this study were described. Recruitment of participants was done through purposive sampling of midwives who were known to provide care in both small and large maternity hospitals. In-depth interviews were used as the way to obtain data about the experience of independent midwives providing intrapartum care.

Writing memos on the transcript and highlighting essential statements initiated interpretation of the data. Stories were grouped into similar and contrasting examples related to a theme, and an interpretation was written beneath each narrative. It is difficult to say how the interpretation crystallised, except that each feedback, each re-reading, and each re-writing seemed to show something new. An overview of the data chapters with an explanation of symbols used was provided to ensure that the writer and readers have a shared understanding. Finally the questions of rigour and credibility were addressed with reference to authors such as Koch (1994), Koch & Harrington (1998), and Van Manen (1990) who advised the researcher to make the trail explicit when conducting research.

Van Manen's (1990) research method, and the philosophical underpinning of Heidegger's hermeneutics, guided the formation of the research question, the interview process and the interpretation of data. The design of the study achieved the aims of addressing the research question of how the provision of intrapartum care is different in a small maternity unit, as compared with a large obstetric hospital. The following two chapters reveal the themes identified from the analysis of data.

Chapter 4: Real midwifery

Introduction

The purpose of the two data chapters, this one and the next, is to illustrate how the context or setting affects the practitioner and her practice. This chapter introduces selected verbatim data from the independent midwives which support the theme and sub-themes identified. All the midwife participants provided labour care in both small and large maternity settings and comparisons arose spontaneously during interviews. I have already acknowledged that the literature suggests that the context or setting has an affect on midwifery practice.

There was unanimous preference by the participants for providing labour care at small maternity units, and the midwives describe practising in this setting as 'real midwifery'. 'Real midwifery' is seen as doing 'normal' midwifery and attending to women, as opposed to attending to machines. The midwives indicated that they felt affirmed by practising midwifery in this way. This theme comprises several sub-themes that further explicate the notion of 'real midwifery'. The sub-themes include: 'practising more autonomously'; themes related to the meaning of time named: 'having time'; and 'giving time'; and themes of 'tolerating noise' and 'managing options'.

The notion of real midwifery is introduced by the following account:

At [the small maternity unit] it's like real midwifery in a way, because you're not interfering. Don't get me wrong, the technology has got its place. I can go from being at [the large hospital] one day and having a woman on everything, [using a syntocinon infusion and epidural pump] to the next day, at the small unit, and the woman is squatting in the corner, or whatever, and it's totally different. ... When you are using the synto and the epidural, a lot of it's taken away from the woman and, in a lot of respects, probably taken away from you a little bit as well. ... I think with real midwifery, a lot of it is not doing, in a way letting it happen, being there, but you're still there and you still want to make

sure that things are happening as they should. ... And I think real midwifery can be not being that overpowering person there. ... I don't know what it is, real midwifery. I don't know (laughs) (Elizabeth, pp. 26-27).

For Elizabeth “real midwifery” means not interfering, “not doing”, yet the midwife is watching and monitoring the “happening” or unfolding of the labour. Elizabeth acknowledges the place of technology; however, she feels that technology displaces the woman and the midwife, and dominates the process of birth. Real midwifery may be “just being there” often in the background, with the midwife using her skills in a non-obtrusive manner.

Mary says that midwifery skills only develop when midwives are unshackled from the technology of birth:

And, when I was [overseas], I just did midwifery thrown in with everything else, and you learned a lot about emergencies and that kind of situation but nothing about real midwifery. It was emergency stuff. I developed a lot of midwifery only, when I was working in midwifery run units and doing home births. Before that I didn't actually like it. ... I think you'll probably find that, if you look at midwives, the more confident they get in their own practice, the more likely they are to deliver in the small hospital. I think, if you looked at anybody's careers in independent midwifery, you'd find that. There might be some that wouldn't deliver in the small hospital, but then they have never moved from the high tech mentality, and they've never really become midwives in the true sense of the word (Mary, pp. 1/11).

Being in a high technology setting or focussing on emergencies is thought to hinder midwives from practising in a way that Mary describes as “real midwifery”. Mary indicates that midwives need confidence to work in small maternity units, yet confidence can only develop when midwives move out of the “high tech mentality” of large hospitals. Perhaps it is reliance on one's own skills, as opposed to reliance on technology that gives confidence. Mary feels that midwives preoccupied with technology fail to become midwives in the true sense of the word.

Grace describes the midwifery skills required when providing labour care in the small maternity unit:

You've actually got to use the skills, and some of those are skills that grow as you go along, but a lot of them are gut feelings and perhaps just listening to, really listening to what the women are saying, and adjusting your thoughts and practices to what the needs of the women are. That's a huge shift to working in a big hospital where you've got machines and technicians and other medical personnel that might be, not actually interfering, well I guess it is interfering with that basic in-built knowledge that you've got. You turn off, I'm sure you switch off at [the large obstetric hospital] because you're too busy, too busy watching all those other things instead of listening to the women (Grace, p. 2).

Grace is mindful of using “gut feelings” and really listening to women in the small maternity unit. These skills grow with practice, but will only develop when the midwife takes time to be with women. This contrasts with midwifery practice in a large hospital where machines and technicians interfere with midwifery skills. Grace indicates that the midwife may “turn off” or “switch off” to the woman, almost simultaneously with switching on the machines.

Joyce experiences less satisfaction when she is not using her midwifery skills:

I feel like I'm sitting there [at the large obstetric hospital] just watching a machine and not really using midwifery skills. So I don't come away from that kind of birth feeling quite so good. I try and say to myself that, O.K. the baby's healthy and the mother's healthy, so it's a good outcome, but it doesn't usually feel quite so victorious as coming away from a birth where the woman pushed the baby out and felt really exhilarated at the end of it (Joyce, p. 22).

“Watching a machine” at the large obstetric hospital does not feel congruent with “really using midwifery skills”. Joyce tries to justify the use of machines when necessary, however it does not feel “quite so victorious”; not quite the victory, the enlivened feeling as when the woman births without intervention. When the woman

feels powerful through giving birth, and feels she has directed her own experience, the midwife also feels affirmed (Guilliland & Pairman, 1994; Rosser & Anderson, 1998).

Bronnie describes watching machines as perhaps less challenging than providing labour care in a small maternity unit:

Sometimes people apologise that they have to go through to [the large obstetric hospital], that you have to do all this work with monitors and things like that. I actually find that part of midwifery at [the large obstetric hospital] almost easier, because it's all black and white, and the woman's lying there with her epidural and you're watching machines. Whereas this way, when I'm at [the small unit] it's more hands on. You know, it's sort of like watching and waiting, and I think it's more enjoyable, but I think [to say] it is more stressful is probably too strong a word. It can be more emotionally draining perhaps, that you are getting it right from reading it, and that you have to have confidence in women's bodies, if it's normal, just to let it flow (Bronnie, p. 11).

Providing care in the large obstetric hospital is described as “almost easier because it's all black and white”. “Black and white” has meanings of clarity and showing the obvious, such as black writing on white paper (Partridge, 1963). Doing midwifery care without machines seems to take more energy as the midwife tries “to read” what is not obvious, to work through the grey areas, to ensure all is right. This requires a midwife who has confidence, and a belief in the normal course of events of labour, alongside the confidence in her own knowledge and skills to “read it right”.

Using one's own skills is also apparent in the next reflection by Cluain Meala:

[At the large obstetric hospital] it's almost like you have all this equipment, but you actually don't need it. You need your eyes and your hands more than any equipment. That will tell you more than any monitors. [In the large hospital] you're actually thinking more in the high risk, more technical side, using all the instrumentation you have, or all the equipment you have, or the technology, whatever it is, rather than using your own ideas or what you're seeing yourself. You're thinking

differently while you don't have time to sort of look at the woman
(Cluain Meala, pp. 4/12).

Cluain Meala proposes that technology takes the midwife away from using her own assessment skills or, as Sutton (1996) indicated, the midwife sacrifices assessment skills for the technology of obstetrics. There appears to be a paradox in that technology is purported to make birth “safer” for women, yet all the midwives said that using technology appears to take midwifery care away from the woman, and thus might make it less safe. Sutton (1996) and Hodnett (1996) postulated that technology has changed the role of the midwife from being woman centred to technology centred. The midwives interviewed indicated that ‘real midwifery’ means working without technology, using skills of being with the woman, having confidence in their knowledge and skills, listening to women, watching and waiting, and using all their senses. One may ask the question, “What prevents ‘real midwifery’ from happening at the large hospital”? Midwives said that the use of machines distracts from ‘real midwifery’, yet perhaps it is a wider issue of the medical model prevailing in large hospitals, with a focus on protocols and fetocentric care (Sandelowski, 2000), that precludes ‘real midwifery’ practice. There appears to be a number of situations in which midwives feel constrained in the large obstetric hospital and this will be further explored through the sub-theme of practising more autonomously.

Practising More Autonomously

The ability to be able to practise more autonomously is rated highly by independent midwives and this influences their preference toward providing labour care in small maternity units. Midwives referred to ‘them’ or ‘they’ who seemed to interfere with autonomous practice in the large hospital. One may ask, “Who are ‘they’”? As described in chapter three, Heidegger (1927/1962) said that our ‘being’ is affected by the ‘other’ and what ‘they’ might say. ‘They’ seem to be nameless faces that are not defined. It would have been impolite for the researcher to press this issue with participants. The independent midwives seem to practise at the large hospital in accordance with what ‘they’ expect.

...I do rupture membranes but I don't feel pressured into doing it. I'm probably better off than a lot of the younger midwives who may be pressured to do so. You've got to do a CTG³ [at the large obstetric hospital]. They like you to do a 20-minute CTG. Completely unnecessary in the majority of cases. You see I have a suspicion that they leave me alone. They might well comment on what I do afterwards or what I don't do, as the case may be. I don't feel compelled to give ecbolics like I used to, and I don't (Mary, p. 14).

Mary suspects she is "left alone" but 'they' may talk about what she does or does not do. She admits to doing cardiotocographs through feeling compelled to do so, although research would support the futility of this in normal labour (Enkin et al., 2000). There is concern that younger midwives may feel compelled to do all the interventionist procedures expected at the large hospital. Perhaps younger midwives have not developed confidence to practise in a way according to their philosophy.

Kirsty speaks of a feeling of relaxation at the small maternity unit:

But certainly, looking after women in those [small maternity] units, there is this expectation of going with the flow and the normal. Nobody's knocking on my door or asking if there are any problems. Women are treated as normal, therefore there isn't the intervention automatically, and there isn't CTGs as soon as you walk in the door. There are no routines and, as an autonomous practitioner, I do what I feel is appropriate at the time without having to really discuss it with anybody (Kirsty, p. 2).

Kirsty feels more autonomous at the small maternity unit with nobody knocking on the door and asking questions as to what she is doing; such surveillance might annoy independent midwives. The preference is for the small maternity setting where human interference and technological interference is less apparent. Intervention at the large

³ CTG refers to a cardiotocograph. This is a machine that electronically records and prints the fetal heart rate pattern and maternal uterine contractions.

hospital is illustrated by the protocol of a routine cardiotocograph for each woman on admission.

Elizabeth relates her experience of beginning to use small units:

I really enjoyed it at the beginning [at the small maternity unit]. It was like - now I can do what I want to do here. There were no CTGs. And, in fact, sometimes you feel like a bit of a rebel as well. ... maybe I felt that I could push my wings out a little bit more or whatever. But I think then I learnt, well you can do that but you've still also got your priority, you've still got to not put anyone at risk in doing that, and it's finding that balance there. ... I now find myself going into [the large obstetric hospital] and not routinely doing what I class as [large hospital] stuff, which I was [doing] in the early days of independent practice. I would still routinely do those things, like the routine half an hour CTG at [the large obstetric hospital], even though I don't do it at [the small maternity unit]. And I started questioning myself, "Well, is it just a routine? Why am I doing it? Is it just a routine? Is it the place that's dictating to me?" So I guess now it's just finding what I find, so that I can dictate to myself (Elizabeth, p. 4).

Elizabeth expresses the joy of beginning to provide labour care in a small maternity unit. She describes "pushing her wings out", as if to test her own ability, as a bird tests itself prior to launching into flight. She feels a sense of autonomy and thinks of herself as a "rebel" by not abiding by protocols such as the routine cardiotocograph on admission. Use of technology is frequently associated with claims of safety (Tew, 1990), hence not using technology might be associated with a resistance or rebellion and therefore lack of safety.

One may ask how the practice of, for example, questioning whether or not to do a cardiotocograph develops. It may be possible that working in a setting without cardiotocographs prompts an independent midwife to reassess the need for such technology. On the other hand, perhaps it is related to experience as an independent midwife, where a time arrives when the midwife questions the routine practices of an institution. Garcia and Garforth (1989) stressed the importance of midwives being

able to use personal judgement when providing labour care, as opposed to following formal policies, and Walsh (2000b) commented that the clinical freedom to practise as one wishes is more possible in a birthing unit.

Having Time

It would appear that being able to practise 'real midwifery' entails the notion of 'having time'. A recurrent theme was the sense of not having time at the large obstetric hospital compared to having ample time at the small maternity unit. The importance of time within a large hospital dates back to Friedman's (1954) study of one hundred primigravidae at term. Women were examined (either rectally or vaginally) half hourly, hourly, or usually bihourly depending on the progress of their labour. Friedman said, "There were 29 spontaneous, 64 prophylactic low forceps and 4 mid-forceps deliveries. ... The one caesarean was performed because of arrested progress after prolonged trial of labour" (p. 1569).

Friedman (1954) claimed to have redefined labour in terms of setting time limits and demonstrating what may be expected of a normal labour. His study does not address the fact that only 29% of the women had a spontaneous birth; this cannot be representative of normal labour. The partogram used in labour has been developed from Friedman's 'curve' and his study has influenced policies of 'active management of labour' where a woman's cervix is expected to dilate at a rate of half to one centimetre per hour (Sweet & Tiran, 1997). Active management of labour has been modified over the years and has come to dictate what is considered to be an acceptable length of time for a woman to be in labour, and also the rate of progress during labour (Annandale, 1988; Walsh, 2000b).

The modern obstetric hospital has a high level of technology to hurry things on if there is any deviation from so-called acceptable progress of labour (Leap & Hunter, 1993). This includes protocols such as artificial rupture of membranes and the use of syntocinon augmentation if the woman's labour is not progressing at the rate of one centimetre per hour (Enkin et al., 2000).

Rosemary reflects upon the sense of a timeframe in large hospitals:

Whereas, when you go into a big base hospital, it is based on a policy of mass production, if you like, where it is important to have the woman come in, have her delivered and have her out again. ... It was quite revolting to have to treat people so aggressively in the system, all because it wasn't better for their outcomes or whatever their birthing experience was going to be; it was going to be better for the hospital. That is the difference between working in a major base hospital, and working in a smaller country hospital; you don't have that heavier focus of sort of shunting these women along on a conveyor belt and getting the job done as quickly as possible. (Rosemary, p. 2).

Rosemary likens the large base hospital to a factory saying that women are "shunted along on a conveyer belt" because of the pressure of time. Davis Floyd (1992) and Walsh (2000b) wrote of an 'assembly line production' adopted by modern obstetrics. Hunt and Symonds (1995) confirmed that the analogy of hospital births, to a factory assembly line, was almost a cliché of discontentment from consumers and midwives in the 1980s. For Rosemary, this type of midwifery practice is too aggressive, too hostile to the normal process of labour, and against her philosophy of allowing women to labour in their own time. At the small maternity unit, Rosemary describes a sense of having time; therefore women can labour in their own time, in contrast to having their labour hurried along.

Mary provides an unusual example of providing care to a woman in labour during a busy time at the large obstetric hospital:

...there isn't the sense of urgency [in the small maternity unit] which you get when you go into the big base hospital. There's always a sense of urgency [at the large hospital] because so many people are coming and going. At [the small maternity unit] to a greater extent, you can allow the woman to labour at her own pace. I probably would be one of the few people who actually transferred a woman from a base hospital to a small unit for delivery. Like the example would be, say, in the base hospital, with a perfectly normal Gravida 2, who was labouring quietly but well, but I was taking up a room and too much time, and people kept coming and saying to me - "Is she going to deliver soon? Is she going to

deliver soon? Have you ruptured her membranes?" I didn't want to do any of that and it got on my nerves.

I went to the woman and said, "Look how about we move to [the small maternity unit] now?" So I went and rang [the small maternity unit] and said, "I know this is an unusual request, but can I take a woman over there for delivery? I'm at [the large obstetric hospital]." They said, "Yes, of course you can," (laughter) so we went to [the small maternity unit] and delivered in her own time and had a lovely normal delivery. ... So I think that probably will illustrate the difference. The difference is when you get to the small units, O.K. you take your safety parameters with you, but you're not pressured, and the mother is not pressured because, if you're pressured, it rubs off on the mother (Mary, pp. 2-3).

Mary did not intervene to reduce the length of time the woman was in labour and when they transferred to the small maternity unit, she was able to birth "in her own time". This example is unusual as women may be transferred in to a large hospital during labour, but almost never transferred out until after the birth. It could have been embarrassing if this woman had required transfer back into the large hospital because of unforeseen problems. Mary's actions show courage and a determination to allow this woman to labour in her own time.

The following accounts all illustrate a notion of 'having time' at the small unit in comparison to 'not having time' at the large hospital:

But what I find in a bigger hospital, you feel you're rushed a bit more, especially if it's busy, that's the thing. You find [they want to know] if your mum is going to deliver at a certain time, as "We need the bed"; you're to get her up and out. If it is a busy day when you're in [the large obstetric hospital], you often have that on your mind. That shouldn't be, but that's the way it is. It's not the policy; there's no space (Cluain Meala, p. 10).

...once the baby is delivered, there's some urgency at [the large hospital] to get the room cleaned and the woman moved on. So I enjoy

the leisurely pace at [the small unit] to be able to take time to get the baby fed and maybe give the baby a nice relaxation bath, and give the family time, whereas, at [the large hospital] I feel they need the room and so we have to rush a little bit, so that perhaps interferes with the experience for the family (Joyce, p. 11).

But I think the difference between [a small maternity unit] and [the large obstetric hospital] is, at [the large obstetric hospital] once you get in there you feel like you've got a timeframe to get out of the unit, whereas a multip, she could come in to [the small maternity unit] and then might go down the street for lunch or something ... you don't want to interfere, you don't want to rush things. They go away and do their business, down the street or to a relative, their name is on the room, there's no timeframe (Bronnie, p. 26).

When a place is small you can only have small numbers, therefore you haven't got the same busyness ... I suppose people are people and not numbers, and there's an expectation of the normal ... what I like about the small hospitals is, if you've got a first time mum there isn't the same feeling as there would be in a base hospital that you have to be clock watching. So this first time mum that I'm thinking of recently, she did have a long labour [in the small unit]. If you take it from onset of regular contractions, she had a 20-hour labour... It's a balance between the woman feeling relaxed in the satellite and maybe using the bath and knowing that she is coping, to going to the base hospital where we've got to use active management of labour (Kirsty, pp. 2/4/20).

When the midwives practise in the small maternity units they are able to allow leeway, freedom, the sense of not rushing and not interfering. At the large obstetric hospital there seems to be a timer monitoring the midwife and the woman from the time of entrance. The timer prescribes when the woman should have her baby and be out of that room. Cluain Meala says that the time pressure was determined by the lack of space and was not imposed by policy. In contrast, Kirsty says "You have to be clock watching" and the expectation is that the midwife uses the active management of labour protocol at the large hospital. Katz Rothman (1983) highlighted the

relationship between time and space where the tempo of individual births is matched to the limitations of space and staff of the institution. In other words Katz Rothman believed that a policy such as active management of labour, and the available space at the hospital are related.

Elizabeth speaks of how time may affect the relationships with others:

It's not like a hospital at the [small maternity unit]. On the whole, the staff that are there are pleased to see you, and I don't want to sound bad against [the large obstetric hospital], but it's a different mind game. They are so busy that they've got to get them in. There are people that can be waiting for beds. It's a different pressure on them at [the large obstetric hospital] than it is at [the small maternity unit]. I just feel a little bit freer at [the small maternity unit]. It's like being at a home birth in a way really, not quite, but in a way it can be. It's that sort of feeling that you get there, that I get if I'm at a home birth. I do feel different, and I can't explain it (Elizabeth, p. 24).

Perhaps having time, as in the small maternity units, creates a culture that welcomes independent midwives to that setting. Elizabeth describes the feeling of freedom at the small unit as similar to the feeling of being at a homebirth. On the other hand, the large hospital is described as a “mind game” where the allocation of beds is a constant juggle and the staff constantly appear busy.

The notion of ‘having time’ provides a comparison of a small maternity unit that may have days without births with a large obstetric hospital that would never have a day without several births. ‘Having time’ may be associated with adequate space, fewer women, fewer personnel and a sense of not having to follow a timeframe intervention such as active management of labour. However a tension does prevail, in that small hospitals are not as popular as they could be, and if the small units became busy, the notion of ‘having time’ might disappear. Closely associated with the notion of ‘having time’ is the perception of ‘giving time’, where the midwife enables the woman to labour and birth in her own time.

Giving Time

The notion of 'giving time' refers to midwifery practice where midwives are able to allow time for women to settle into the small maternity unit. In contrast, midwives feel a need to examine women soon after arrival at the large hospital to confirm labour. Hunt and Symonds (1995) observed from their ethnographic study that midwives undertook a vaginal examination on each woman admitted to a large hospital. This ensured that the woman was in established labour and "would not 'block' a labour ward bed" (p.96) that might be required for women arriving in advanced labour. 'Giving time' in the following examples describes the experience of midwives being able to assess women in a watchful patient manner.

Joyce explains how she prefers not to undertake vaginal examinations unless requested to do so by the woman; however this is dependent upon the setting:

So I guess in a situation where I was pretty sure of the presentation and the engagement, if the woman had come in and she was obviously contracting really well and hadn't been in labour too long, ... and had a good fetal heart, I wouldn't examine her right away, unless she was really keen to know what dilatation she was. Maybe 3 or 4 hours later, if I didn't feel that she was making the progress I expected, I would ask her if she wanted to know. It would probably be about a third of the labours I go to, I don't do an internal examination when I arrive. At the large obstetric hospital I probably would feel more that I would need to do everything by the book (Laughs). I suppose the feeling [is] that it is more medical over there (Joyce, p. 13).

Joyce explores the factors that inform her decision-making as to whether or not to do a vaginal examination. However, there is a more automatic tendency to do a vaginal examination at the large hospital as Joyce speaks of a need to do "everything by the book". This might mean obeying protocols or abiding by textbook type recommendations for labour care such as performing vaginal examinations at regular intervals (Annandale, 1988; Warren, 1999).

Nettie contends that a vaginal examination at the large obstetric hospital becomes a major focus:

Well, I don't always do VEs [vaginal examinations] on arrival. It depends on the situation. If you've got women that you can see are obviously progressing and doing well, and when I say obviously, is it ever obvious? I give women time to settle in and [labour] either declares itself or, sometimes women want to know how far on they are. ...[a vaginal examination] is just one part of the whole picture. I think probably when you're practising in [the large obstetric hospital], it becomes the major part of the picture because it's something concrete. You can say, "She's this or she's that". It's such a concrete thing, but I'm saying it's not that accurate necessarily... On two occasions it has happened [where] ... a specialist has examined [each woman] and said, "Oh no, 6cms [dilated], you need an epidural". The epidural just gets in and then they're ready to push. I really hate that, because I feel like we could have hung in there a bit longer (Nettie, pp. 7/9).

Nettie emphasises the need to give women time to settle in to the hospital environment as the labour may change in pattern when the woman first enters the hospital. She views a vaginal assessment, as one part of the picture of a woman's labour, whereas practitioners at the large obstetric hospital, seem to consider this as being the most accurate aspect. Nettie has experienced occasions of providing midwifery care, when a specialist has ordered an epidural based on the woman's cervical dilatation, and in both cases the woman gave birth quickly (in contrast to the specialist's expectations) without really needing an epidural.

Gould (2000) and Stuart (2000) agree that vaginal assessments should not become the sole focus of assessments and the midwife should be adept at recognising descent of the head by abdominal palpation and have confidence in practice wisdom to make an assessment of the progress of labour. Duff (1998) encouraged midwives to record the observed changes in women during labour that form part of the midwife's assessment of progress of labour. The changes in the woman's behaviour should be documented alongside any abdominal and vaginal assessments. Enkin et al., (2000) indicate that the vaginal assessment is the most reliable measure of the progress of labour. This

reflects a medicalised paradigm of childbirth where something that is measurable is considered accurate at predicting progress of labour and estimated time of delivery.

Rosemary relates expectations that influence her practice:

When a person first comes in [to the small maternity unit], I will often just sit there and watch them for a couple of hours. I don't always do a VE. Sometimes women will request to have a vaginal examination just to reassure them that they are actually in established labour. I'll probably do a vaginal examination then, but, if they don't request one, then I'll just sit and wait and watch for a couple of hours. ...

At [the large obstetric hospital], the expectation is once the woman arrives, again if it's a primip, I feel pressured into doing a vaginal examination to make sure that she's actually in established labour, because sometimes a first time mum it's not always clear from their behaviour. Sometimes you have to wait a little bit longer to see those changes. You might have to sit around for 4 or 5 hours before you actually see definite progressive changes in her behaviour. When you're going into [the large obstetric hospital] that is managed on a bed status, where they want these women in, delivered, and bed available again, you don't have that time. You don't have the time to just sit around and wait and see what happens (Rosemary, pp. 33-34).

In the small maternity unit Rosemary is able to give a woman several hours of time, preferring to watch and wait. Sakala (1993) acknowledged that midwives preferred watchfulness and patience as a means of assessment. However, at the large hospital, Rosemary is expected to examine the woman immediately to confirm the diagnosis of labour that then justifies the midwife and the woman's presence in the large hospital.

In contrast to the previous midwives, Elizabeth describes her assessment pattern as not differing in relation to place of practice:

I still do vaginal examinations. I probably don't do as many as I would have done. I find that women like to know when they come in what dilatation they are. So usually within an hour or two of women coming

in, unless I think that they really are not too far away, I normally check [do a vaginal examination] then to see how they are ... You use your intuition, you know the progress, what's going to happen with the pains and what they are feeling. Not routinely doing a VE every three hours or whatever. You know how the pattern's going to go, and most times you don't need to check again because they want to push. ... I feel I'm confident enough to put my case not to do any more vaginal examinations at [the large obstetric hospital]. In saying that, if I feel that a woman needs one I'm not going to not do one (Elizabeth, pp. 23/24).

Elizabeth adopts a pragmatic approach concerning vaginal examinations explaining that the women generally like to know their dilatation. Elizabeth also, probably likes to have this information. She speaks of confidence to be able to "put her case," but the very need to put one's case suggests that not undertaking routine vaginal assessments is against the expected practice in the large obstetric hospital. The culture of a large obstetric hospital, models a rate of 1cm per hour progress of labour and requires midwives to attain these rates of dilatation for women in their care, from the time of admission to birth (Sakala, 1993).

Midwives felt able to give women time in a small maternity unit, without necessarily knowing the dilatation of the cervix, whereas most of the midwives felt a need to examine women on admission to the large obstetric hospital. If a midwife wishes to occupy a labour room at the large hospital, it would seem that she is obliged to perform a vaginal assessment. The following sub-theme discussed the notion of noise and midwives' response to noise.

Tolerating Noise

Unexpectedly, each of the independent midwives talked about noise, and whether or not noise during labour was tolerable. The sub-theme of 'tolerating noise' is used to incorporate narratives from midwives, concerning how much noise is acceptable from labouring women. Midwives articulated the difference between

acceptable noise levels in the small unit as compared with the large obstetric hospital.

The following accounts suggest that midwives resort to the use of epidural analgesia to control noise from women:

... when you're at [the large obstetric hospital], the expectation is that when things get too hard to handle, we get an epidural in. The pressure is on, subtle pressure. You can feel that your woman is making all this noise in there, "What's going on?" ... Whereas, in [the small maternity unit] people are making the noise that they want to make and, if the whole ward is hearing them, then the whole ward is supporting them (Rosemary, p. 17).

Even epidurals, they're there. You use them. The woman's making a noise. Nobody wants women to make a noise, "Can't you either give her some pethidine or give her an epidural?" They're the kind of things that irritate you (Mary, p. 28).

Mary describes the irritation she feels when pain relief is suggested to her as a means of silencing the woman. When the woman is making a lot of noise and "things get too hard to handle" possibly for the midwife and the woman, the midwife is expected to organise insertion of an epidural. There appears to be pressure upon the midwife to relieve the woman's pain, as opposed to increasing midwifery support to assist the woman to cope. In contrast, in the small unit, noise is acknowledged as an indication that the woman in labour needs more intensive midwifery support.

Kirsty relates differences in managing pain in different settings:

Well, it's a bit different [managing pain] in a large hospital because, for one thing, the noise level is different, and I don't mean necessarily from the outside in but, if we're in a room and my woman is noisy, then I can expect knocks on the door - "Have you got a problem?" And O.K. that doesn't happen very much in early labour as opposed to advanced labour. But I certainly feel that noise is power. If somebody gets really

heightened in their voice, I don't necessarily think it's a problem but I'm aware that, in institutions they might think it's a problem, and there is also the feeling that other people might be upset by noise levels.

... I'm thinking, I've got to try and modify this situation to suit everybody, but it goes against my gut instincts. I'm actually doing something to keep the administration happy as opposed to what's best for the woman and the baby. However, I am aware that if there are, particularly, other first time mums in the unit in early labour, the noise levels will be a bit distressing. However, I discuss with my women that, when they go into the unit, there will be noise levels and not to think of them as something terrible (Kirsty, pp. 19-20).

Kirsty speaks of “knocks at the door” when excessive noise is being emitted from the room. This signals a message that if a midwife is in control, the woman is quiet. Achieving a “quiet woman” might require the use of sedation or epidural analgesia. Kirsty admits to being annoyed that she feels obliged to practise in a manner that is against her “gut instincts”.

Joyce also recalls pressure to subdue noise levels:

I think probably, if I have somebody who is quite noisy during labour at [the large obstetric hospital], I feel a bit more pressure to do something about the pain. Rather than, if I was at [a small maternity unit], I wouldn't worry so much because you've got lots of space, you can close the doors for the delivery, and I don't really worry about noise in labour if people are feeling better about making noise, and the staff there are O.K. about it. I think, at [the large obstetric hospital], there might be the subtle pressure of, “Why don't you do something about that poor woman? She sounds like she's in a lot of pain” (Joyce, p. 22).

Bronnie reinforces the ready availability of epidurals at the large obstetric hospital:

... the women are not allowed to make a noise at [the large obstetric hospital]. ... I don't care if a woman ... uses the worst language when

she has a contraction and needs to beat the wall down, that's fine. It's what she's doing in between contractions, how I really assess it. The only time you really hear a lot of people making a noise at [the large obstetric hospital] are in transition, pushing, or when the anaesthetist is a bit late with the epidural. It's acceptable then. I think it's an unspoken rule. It's a feeling. [An example] was a woman who had had a previous section. It was her third baby, she was from Romania, and she does make a lot of noise, and the Charge Midwife said, "Are you all right?" sort of thing. And it's off putting for the woman because it makes her feel like she can't do that [make noise]. At [the small maternity unit] I don't think that anybody worries too much about noise (Bronnie, pp.20-21).

Nettie illustrates the need to give women the freedom to make noise:

... you're letting women feel free about using noise. You might have a woman who doesn't want to be touched but is really noisy. And just letting them know that's fine, that that noise is O.K. There are more things imposed on you in [the large obstetric hospital], I think it's probably worse. I've heard a midwife say, "My woman does get noisy", because you're feeling that they're judging you on the noise of your woman. The epidurals are there, so they are probably used more readily. I think it does change; it could affect your practice (Nettie, pp. 13/39).

These midwives speak of "subtle pressure", "an unspoken rule", and "things imposed on you" that indicate a lesser tolerance for noise. It is possible that the large hospital imposes a noise limit upon the midwives and the midwives in turn impose pain relief or an epidural upon women. There is an inference that "good" midwives do not have noisy women during labour. The prevalence of epidural analgesia has possibly served to produce a culture where noise control occurs.

McKay and Roberts (1990) conducted a grounded theory study concerning the meaning of maternal sounds during the second stage of labour. They commented "The hospital culture holds strong norms about what is and is not appropriate

behaviour for those who work in it or come to it for its services” (p. 268). The authors suggested that maternal behaviour, including the suppression of noise, is shaped to conform to these core institutional beliefs, often with the help of medication. McKay and Robert’s research substantiate comments from midwives in the present study, indicating that if the woman is making a noise, the midwife feels a need to give her something for the pain. To illustrate other means of managing pain, the next sub-theme discusses how midwives manage options available, apart from using epidural analgesia.

Managing Options

When midwives narrated their experience of providing labour care, strategies used to manage women’s pain formed part of their stories. The differences between what midwives did in the small unit as compared with the large hospital became apparent. Epidural analgesia was not an option in any of the small maternity units used by the midwives, therefore the midwife concentrated on other options. Midwives acknowledged that their options for managing pain differed according to the culture of the setting.

Elizabeth explains how she manages without an epidural when it is not an option:

I think we use the bath more at [the small maternity unit] ... I knew [this woman] was going to do it, and she was about 8cm and she was begging for me to take her to [the large obstetric hospital] and give her an epidural, and that was hard. I don’t know what I would’ve done if she’d been at [the large obstetric hospital], because my gut feeling is that when they’ve reached that stage, then you can get them through it. She laughed about it afterwards with me because she said, “You had selective hearing” (laughter). “Too right” I said. “I wasn’t going to take you in an ambulance, you would’ve delivered in the ambulance.” I think what I’ve found, ... if for whatever reason you can’t [get an epidural] because you’re at [a small maternity unit], or even when I’ve been in the same situation at [the large obstetric hospital]. ... If the anaesthetist is busy, they normally get to fully within that time that you’ve waited for the anaesthetist to come down. That tends to happen.

... It's not an option, because it's not an option. And the woman knows it's not an option. That's the only time I've been asked for an epidural out there [in the small maternity unit] was with this one, who ended up, as I knew she would, getting on and managing without it (Elizabeth, pp. 20/22).

"It's not an option because it is not an option" might teach a midwife to employ other strategies and to manage without using an epidural. Fullerton, Hollenbach and Wingard (1996) support the notion that midwives explore other options when an epidural is not on hand. Elizabeth's illustration also shows that a midwife has to believe that women will manage without resorting to epidural analgesia.

Cluain Meala agreed that there is pressure to use epidurals:

Basically what you utilise is all the normal things at [the small maternity unit], like the showers, and also different positions, hands and knees, squatting, sitting on the toilet, putting the head down and rocking, and all those sorts of things. ... Maybe I think more before using epidurals at [the large hospital]. I don't advertise the fact. ... I don't dwell on the fact that there's something right there we can use for the mother, but I know it's in the background if I need it. Unless there is a problem, I actually don't dwell on giving an epidural, I actually go for the other options. I go for being with the woman, going through the contractions with her, talking her through them, and you actually don't even think of pain relief unless, of course, the mum requires it. And of course that's her choice. Or if you feel it's necessary. But you don't focus on pain relief as much when you are an independent midwife. I actually have the time; the big difference to me is knowing the woman and having the time [to care for a woman during labour] (Cluain Meala, pp. 25-26).

Cluain Meala said she thinks differently about using epidurals now, and for her the change is mostly related to practising as an independent midwife, in that she knows the woman and has time to be with her supporting her during labour.

Hydrotherapy in the forms of a tub, whirlpool bath and high stream showers are being used a lot more in North America and Europe (Hodnett, 1996; Simkin, 1995). Grace describes trying to negotiate an option of using a birthing pool at the large obstetric hospital:

[A woman] said to me the other day could we organise the birthing pool, she would like to use the birthing pool. ... The large obstetric hospital hasn't got a birthing pool. It has got a bath, but it is not the same. I did ring [a midwife] and was told, "No, the policy is that if they want to use a birthing pool, the woman needs to be in a small unit". ... the woman just would like to use it as her pain relief. ... If that's what she feels that she would like to do, surely we shouldn't be denying this option. ... She doesn't want to use pethidine and she wants to be able to get away without the gas (Grace, pp. 14/17).

The following example shows a lack of basic resources at the large obstetric hospital:

I'll tell you what really brassed me off though at [the large obstetric hospital]. We were put in a little dingy room right down the end and we went to put her in the shower and there was no hot water, it was only trickling out. She was shivering in there; there wasn't enough water. So that let me down, I felt really let down with that. So then I got her rocking, rolling, leaning over and doing movement, but I know the water would've made a huge difference, the hot water, but it wasn't there (Nettie p. 26).

Kirsty discussed some of her strategies other than epidural analgesia:

Well, a lot of it is done prior to labour, as to convincing people that this is something they can cope with, so you could say the education factor. I use hot packs on their back or on their suprapubic area. ... So water, massage, and yes I do sometimes use homeopathy, things like arnica chiefly, bach flowers and rescue remedy. ... If an obstetrician, who's a bit below God, has suggested an epidural, you can't actually discuss anything after that (laughs). ... I probably still don't use pethidine any more in a base hospital but I would like to

have more baths in the base unit. I do use the shower, but it's not quite the same, although it has its uses (Kirsty, pp. 7/11).

Grace feels that the issue of a birthing pool is a choice women should be offered regardless of the setting where labour care is occurring. Simkin (1995) commented that baths and showers are palliative in labour and hospitals were remiss if they do not install tubs and showers in their birthing rooms. Perhaps a pool is not viewed as appropriate within a medicalised hospital setting. Nettie experienced a “dingy room” that lacked adequate shower facilities. Kirsty laments that the obstetrician has the power to suggest an epidural at the large hospital and this undermines her suggestions of using other options.

Rosemary sums up the differences between the two settings for her when managing pain:

You do manage [the women] a lot differently. I think the support that you give a woman at one of these smaller units is more intensive. You know that if the woman has that support all the way through her labour, she is going to cope a little bit better, and you probably use mobilisation a lot more. You go for a walk in the garden - you can't do that at [the large obstetric hospital]. You can't hop in a pool at [the large obstetric hospital], and you probably wouldn't try a lot of the floor positions. Sometimes what I will do is squeeze the top of the hipbones, all those sorts of other manoeuvres that you wouldn't always do at [the large obstetric hospital], because you are in a different environment (Rosemary, pp. 16-17).

Rosemary used “intensive support” to assist the woman to cope as well as options such as mobilisation, use of the pool, trying different positions and applying some manoeuvres such as pressure on the hipbones. Increasing support is known to decrease interventions during labour (Hodnett, 1996; Rooks et al., 1989; Walsh, 2000b). Rosemary indicates that she does not feel comfortable to use some manoeuvres in the large hospital because the environment is different. The medicalised culture seems to restrict Rosemary's freedom to use some of the alternative options for managing pain.

The options employed for managing pain seem to depend on the setting. For example, if hydrotherapy, which is popular, (Hodnett, 1996), is not available in the large hospital, this limits choice. The medicalised culture of the large hospital seems to discourage the use of some of the non-pharmacological alternatives for managing pain. Finally, the notion of an independent midwife having the time to be with women during labour could be an important factor in using other options.

Summary

This chapter illustrates the differences between providing intrapartum care in a small maternity unit as compared with a large obstetric hospital. The context of practice, such as small maternity units, enables midwives to practise more autonomously, to be less bound by time and timeframes and to allow women the freedom of making noise. Methods of managing pain include natural methods and the use of hydrotherapy.

‘Real midwifery’ captures the experience of midwives working without using technology, the notion of ‘not doing’ yet using their knowledge and skills, being there for women, listening to women, and using all their senses. Practising more autonomously was illustrated with descriptions of the midwife feeling free to practise as she wanted, as opposed to following the medicalised protocols at the large hospital.

Mary provided an example of transferring a labouring woman out of the large hospital in response to suggestions that she was taking up too much time and space. This example provides an understanding of how difficult it is for the midwife to feel a sense of freedom at a busy, large hospital. The notion of ‘giving time’ described by midwives who used skills of watching and waiting to assess women’s labour at the small units, as opposed to performing routine vaginal assessments. Examining women at prescribed times is associated with active management of labour, or the assumption that all women should progress at a preset rate, from admission to the hospital until the birth of the baby.

Midwives spoke of the differences in the way noise is and is not tolerated between the two settings. It seemed that at the large hospital noise is not tolerated, therefore midwives are encouraged to use an epidural or other analgesia in order to quell noise. Finally, the sub-theme of managing options revealed two important points. When epidural analgesia is not available, midwives and women frequently seem to manage without it. Secondly, all the midwives state that access to hydrotherapy is an important means of relieving labour pain.

The theme of 'real midwifery' uncovers the differences in intrapartum midwifery practice between two settings. In the present study the context of practice seems to be so pervasive, as claimed by Griffith (1996), that it permeates the practice of independent, self-employed midwives. The following chapter provides examples from selected data, of how midwives experience the sense of 'carrying the can' when they choose to provide intrapartum care to women in small maternity units.

Chapter 5: Carrying the Can

Introduction

The previous chapter, 'real midwifery', showed the differences between providing intrapartum care in the two settings. While participants' data have been divided between the previous chapter and this chapter, there are commonalities between themes in each of the chapters and such intersections have made the separation of data a difficult decision. During the course of interviews the independent midwives talked of challenging situations when they had concern for either mother or baby. Recall of emergency situations was often associated with a range of emotions, alongside the immense responsibility when providing care in the small maternity units. The notion of 'carrying the can' comes to the foreground when independent midwives experience a challenging situation, or 'others' challenge their practice. Sub-themes of 'carrying the can' include: being solely responsible, making reasoned or risky decisions, and the experience of being judged.

The meanings of 'carry the can' are multiple and context dependent. Wood (1969/1979) defined to 'carry the can' as to "place oneself, or be placed, in a position where one may incur blame, censure or a penalty" (p. 53). Grant and Devlin (1999) defined to 'carry the can' succinctly as "to accept the responsibility" (p. 37). According to Longman Idioms Dictionary (1998) to 'carry the can' is to accept responsibility for something that has gone wrong.

Smythe's (1998) thesis, 'Being safe in childbirth' contained data from a general practitioner who said "... I'm the one still carrying the can, if something different is happening from what I've actually ordered, and that worries me" (p. 206). The doctor was referring to a woman who had been induced, and he indicated that the responsibility for the woman's care remained with him. He expressed his worry when a midwife had not followed the plan for care that he had asked for. Thus 'carrying the can' referred to a responsibility so great that it was a worrying responsibility.

The use of the phrase 'carrying the can' in this chapter is about accepting full responsibility and being answerable for what might happen during the course of providing care. 'Carrying the can' is a metaphor used for a sometimes-overwhelming sense of responsibility, or as one participant said, "the buck stops with you". Examples will focus upon occasions when the independent midwives had sole responsibility, and events when responsibility was held by the obstetric team at the large hospital in order to show that the concern of 'carrying the can' never leaves the midwife.

Being Solely Responsible

There appears to be a sense of being solely responsible when the independent midwife is providing labour care in the small maternity unit. Perhaps the responsibility is different from practising in the large obstetric hospital because in the small maternity unit, the midwife has a sense of being alone and being a long way from emergency services. There is also the constant need to anticipate, to foresee a need to transfer. However, intertwined within this theme is a confident belief by each midwife that she is skilful and that the outcome will generally be satisfactory. The following accounts refer to occurrences in the small maternity units.

Joyce introduces the notion of 'carrying the can' with the following account:

We had a primip who was in second stage and past the point of being able to be transferred because the head was on view, and we suddenly got very thick fresh meconium, and it was 5 in the morning ... Well it's quite frightening. Luckily, the woman's mother realised that the baby was in distress because we did have fetal heart dips as well as meconium, and she said to her daughter, "You've really got to push very hard", and that had an amazing effect on her, and she did. She actually pushed her baby out face to pubes and very quickly. I suppose because the distress had only been very short lived, that the baby wasn't affected by it, and he cried right away and didn't have any problem. But you go through in your mind, situations where

maybe the baby isn't going to get out very quickly and it's past the time when it's safe to move. It is quite lonely because you think well, I've got another midwife here but maybe she's got no more experience than me, so really I'm going to carry the can if there is any problem. So you do live with that but I think you balance that by believing that, in most cases, the outcome is going to be good (Joyce, p. 19).

On reflection, Joyce ponders how the baby's well being might have been IF the baby had not been born so quickly, and if the woman had not pushed so effectively. Joyce speaks of it being "past the time when it's safe to move". Moving may mean that the baby is born en route in the ambulance, and that is less satisfactory than being in the small maternity unit where, although facilities are limited, resuscitation equipment is available. Joyce admits to feeling "quite lonely" during a frightening event, where she perhaps acknowledges that her own skills and those of the other midwives may not be sufficient to deal with a severely compromised baby. There is no on site paediatrician, as at the large obstetric hospital. Joyce describes this reality with, "I'm going to carry the can if there is a problem". She might be criticised for having a primipara with an occipito-posterior baby that late in the labour declared meconium liquor and fetal dips, in the small maternity unit. The risk of a poor outcome is balanced with a belief that in most cases, as in this case "the outcome is going to be good".

Elizabeth provides an example of providing labour care in the small maternity unit where she, similarly, is left wondering, "What if?"

I knew the delivery was imminent or was going to happen in a few minutes, and I listened again and I heard [the fetal heart] really really "boom" [low heart beat, only just there]. I remember thinking, "Bugger! This baby needs to come out now really". The next push and it came out and it didn't need resuscitation or anything. It was pretty flat but it didn't need to be taken away. ... there was a true knot in the cord. I thought afterwards, if she'd been a primip she wouldn't have pushed it out that quick. It's funny, because when I heard that [fetal heart] I thought, "That heart's going to stop". I just felt that. I normally think,

"Well it's so low down, I'm probably not hearing it", but I knew that I was. I think now, if that had been a primip and I'd got that feeling, I don't know what we would've done out there (Elizabeth, p. 6).

The fetal heart is heard at a low rate and Elizabeth recalls thinking, "Bugger"; an exclamation associated with things going wrong. Fortunately, the baby was born shortly afterwards, yet Elizabeth is left wondering and reflecting about what might have happened. What if it had been the woman's first baby when it would have taken longer to push the baby out? What would Elizabeth have done "out there" if the baby needed to be born immediately? Elizabeth knows that there is nothing she could do if a fetal heart stopped unexpectedly at the small maternity unit. The descriptor used for the small maternity unit "out there" is of a place in the distance, a long way from help. The lack of control over an event, such as a true knot in the cord, and the possible demise of a baby, is a worrying thought.

Bronnie relates an incident that illustrates the notion of time during a stressful event. There is a sense of time passing slowly and the accompanying feeling of being solely responsible:

... sometimes the fetal heart goes down in the second stage. I had one that I did an episiotomy in the end, and I rang [for external assistance] for resus. We actually had the baby out before they got there, and the baby had an Apgar of about 10, of course (laughter). It was horrible; it was a really quite slow brady [slow heart rate]. It would come up; it seems like a long time of course at that stage, but it was taking longer and longer to come up.

When I actually put the local in, she said it numbed her and took the pressure away to push, so it was like that real begging, "Come on come on," and the husband was there. You feel very alone, and you just feel so responsible, very heavy. I'd probably say you feel really heavy. I think you just, well my knees go weak. But you just sort of have to get on with it. It was quite funny, I was talking to someone the other day, "It must be bad for you. You must be knocking your adrenals off". All the time you get these big adrenaline rushes, you

can't fly away. You have to stand there and fight it or take on the challenge. I think you just do it and you just know that you've got to do the best you can (Bronnie, pp. 15-16).

Bronnie relates a vivid memory of time passing by with a fetal heart rate taking an increasingly longer time to return to the correct rate. Time seems to drag as each time after a contraction, the fetal heart appears to take longer and longer to increase in rate. Bronnie's sense of heaviness is akin to carrying a heavy can, containing all the responsibility of safe practice. The responsibility rests on her shoulders, which makes her feel weak at the knees. Bronnie speaks of the need to stand and take on the challenge like a matador who must stand to be able to fight, as opposed to one who may flee with fright. The stress of these situations causes surges of adrenaline and Bronnie jokes that "It must be bad for you", knowing that indeed, stress-related adrenaline over a long period of time may cause ill health (Mackin & Sinclair, 1998).

Kirsty emphasises the responsibility that the midwife feels together with the feeling of being alone:

I've had one major flat baby, I did have a second midwife in the room, and I cut the cord and went straight to the resus [room]. In the satellite hospital, that's not in the same room, so you have to move rooms. And the second midwife, instead of staying with the woman, came with me to assist. Fortunately, there was a third midwife in the unit and I got her to stay with the woman because the placenta wasn't born, and so she dealt with that side of things, but it was traumatic for the woman that I rushed out of the room. Unfortunately the baby didn't decide to breathe on its own, although [the] baby became pink very quickly, and that was a real difficult situation. ...

I phoned [the large obstetric hospital], as one was under the impression that you could talk to paediatricians, and it wasn't very helpful ... And so at that point, it was very distressing and I felt like I might as well be in the desert as being in the satellite. I'm bagging the baby, and I just carry on bagging, whilst my brain is working

overtime ... my adrenaline is obviously working overtime at this point (Kirsty, pp. 15-16).

Kirsty speaks of the good fortune that there were sufficient midwives available in order for someone to remain with the woman, while another midwife assisted her with resuscitation of the baby. The response from the team at the large hospital was not helpful and Kirsty's feeling of "being in the desert" reflects aloneness, being solely responsible and possibly a sense of fear associated with the distance from help. "Being in the desert" is akin to being in a place where feelings of isolation, remoteness, and vulnerability are brought to the fore through recall of this particular situation. The small maternity unit feels like a lonely far away place, like a "satellite" on the outer perimeter of the Earth, unconnected to the resources that were required for this baby.

Grace articulates humility and relief in respect to emergency scenarios:

... you're forever being humbled, you can never be complacent, and you're always wondering; every delivery you wonder. You breathe a sigh of relief and say a prayer that you're being watched over again, and we've had a nice normal delivery again.

We had one last week where ... the [baby's] cord had been round the neck tight, ... so we actually quickly clamped and cut the cord and I took it over to the resus table. And it did just stay stunned like that, although the pink was coming, but it just wouldn't take that initial breath. And then it's all happening. This woman was having a bit of a bleed; it was a big baby, ... Within three minutes [the baby] was breathing fine, but I tell you what, it was a long three minutes and of course the parents of the baby were saying, "Is it all right? Is it all right?"

I knew that baby was O.K., but it took me back to another situation ... a lovely normal delivery, Apgars were fine, everything was fine, but in an hour, the temperature was still a bit low. ... I'd rung the paediatrician and said that I was concerned. I said that everything

seemed to be O.K. the colour was O.K., we'd had a couple of feeds, and no colour change or anything, but I couldn't get this temperature up. ... Blood glucoses were fine. I actually stayed on longer. One of the other midwives was there, an experienced midwife ... between us we were watching, and I said to her "Well perhaps we'll just keep half hourly recordings", and I documented everything.

And I got a ring early in the morning to say the glucose had been fine half an hour earlier, and then she'd gone back in with the mother and the baby had actually died. ... There was absolutely nothing that we could've done, and I mean we found that out afterwards, but that didn't help at the time. The baby [baby's condition] was actually incompatible with life; we found out from the post-mortem. But that's the first time I think, in all the years, ... I think in all that time, that I actually felt that we were so far away. ... I always feel that I'm so busy watching out for something not going how I think it should be and so, therefore, I maybe act on it a bit over-cautiously because I know the distance we are. I haven't been in that situation in labour. There's always a first time though, heavens (Touches wood for luck). That has been my first really traumatic experience (Grace, edited from pp. 21-26).

Perhaps Grace is influenced from her past experience in that she expresses a sense of relief when all has gone well. One may ask if this sense of relief is a phenomenon associated with being solely responsible in a small maternity unit. The first incident described how the "happening" was all around Grace and she was required to co-ordinate the management of both mother and baby, to arrest the woman's bleeding and resuscitate the baby. The notion of time passing slowly is expressed when Grace says, "It was a long three minutes" until the baby was breathing on his own. The parents' anxiety is recalled and forms part of the stilted time. Describing this incident brought a flashback of another experience.

Grace was concerned for a baby with a lower range temperature and she stayed in the unit to watch this baby, and asked another midwife to continue to watch the

baby closely and take half hourly recordings. Despite this vigilance the baby died several hours later, somewhat unexpectedly. Grace recalls her anxiety during the long wait for the post-mortem result. Even though there was nothing that could have been done wherever the baby was born, Grace felt “so far away”, unsupported, alone and accountable for the outcome. Traumatic instances like this leave Grace watching out for trouble, or something going wrong, and potentially becoming perhaps over-cautious. Being at the large obstetric hospital would not have altered the outcome for this baby; indeed the baby may have been watched more intensely in the small maternity unit.

Rosemary was covering for another midwife’s leave when she encountered the following woman’s experience in the small maternity unit:

... she was a woman of short stature with this big baby and she did well to get to being fully dilated. She managed everything beautifully, no pain relief or anything like that, and the baby just would not advance. We started to get quite a few decels [lowered fetal heart rate] just by listening through the Doppler. She wouldn’t allow us to put the CTG [cardiotocograph] on at all and, at that particular time in her labour, I don’t think we would have been able to get a very good reading. We had to transfer her to [the large obstetric hospital] being fully dilated with a distressed baby. You know that you’re an hour away realistically. ... They like you to have a luer in and all these sorts of things, before you actually get up there. So it’s a matter of putting all of that in, and getting in the ambulance and going like a mad thing. And I know that, even if I’d called upon one of the local GPs [general practitioners] to come in and provide assistance, they wouldn’t have been able to do anything for this lady, as this woman needed to have a section. ...

On the inside you’re quite frightened and quite anxious but, on the outside, you know you’ve got to keep yourself calm, because the woman is going to pick up on your anxiety. ... That’s probably the hardest thing to learn in midwifery is learning to keep yourself calm. You just cope the best you can with the situation that you’ve got, in

the safest way you can and, if the outcome is not good, then we're going to have to cope with that as well, the best way we can. I just trust that nature will sort it, one way or the other; mum's going to be O.K. and baby is going to be O.K. (Rosemary, pp. 26-27).

Rosemary discusses a woman who has laboured well. However, fetal heart rate decelerations necessitated a rapid transfer. Rosemary expresses anxiety about the length of time it takes to reach the large obstetric hospital, despite the implied speed of the ambulance "going like a mad thing". She knew this woman required an emergency caesarean birth and that a general practitioner would be unable to offer any further assistance. There appears to be a tension between the need to hurry and organise the transfer while needing to remain calm in front of the woman. While maintaining a calm exterior, Rosemary admits to her internal anxiety and fear, that the outcome for this woman and baby may not be good, and she is solely responsible for whatever the outcome might be.

Reflecting on one's practice might raise issues that were not previously considered, as illustrated by Cluain Meala:

... I think working in a small unit, ... your senses have to be a lot more acute I suppose. You are solely responsible if something does happen. You have to use your skills to react or interact, whatever the case may be. In [the small maternity unit] even though you have another midwife come in, you actually have to know what to do. You have to know what you have to do then, just right then, like 'A, B, C'. I suppose, you're usually totally aware of that all the time, even though it doesn't come to the fore all the time. I think it's in your subconscious all the time that you have to be ready to go at any time in an emergency. At the big hospital, you can press the button and you might have two or three people there (Cluain Meala, p. 22).

In a small maternity unit, the midwife's senses need to be more acute, more alert and attentive. This could be the midwife's intuitive sense that informs her of a good or bad feeling about each woman and her labour. Again there is an absolute awareness that the independent midwife in the small maternity unit is "solely

responsible” if anything goes wrong. The contrast between hospitals is described by “pressing the button” at the large hospital will bring two or three people to assist while at the small maternity unit, there is likely to be only one midwife available to respond.

Cluain Meala speaks of always being aware, of being ready consciously or subconsciously. Being alert never leaves the midwife. Though it may be in the background, it is always there. “You have to know what to do then, just right then,” suggests an acute sense of time and timing, a sense that the midwife must respond immediately and accept being solely responsible.

The previous accounts of emergency situations suggest that there is a different challenge for midwives practising in small maternity units. The independent midwife accepts being solely responsible in this setting and ‘carries the can’ for the management and outcome of each birth she is involved with. Despite this awesome responsibility the midwives spoke of being calm, being alert, being confident and generally having a belief that the outcome would be all right. Smythe (2000) articulated the qualities of the safe practitioner as: watching and alertness, anticipation, and a concerned mindfulness.

The following incidents also relate to emergency situations, yet these accounts express an acceptance of being in the small maternity unit, whereas previous accounts highlighted the isolation of the small units:

I had a postpartum haemorrhage in [the small maternity unit] the other night, a postpartum haemorrhage of 1000mls. She had intravenous syntocinon and intramuscular syntometrine and I ended up putting up a drip. But I was never, at any stage really worried about her, because I knew the placenta was complete and I knew it was just the uterus that wasn't contracting well. The blood was clotting. You know, all of the observations that you can make that will tell you, is this serious or isn't it, and she was fine. She is fine. I mean I've put her on iron because she will be anaemic I should think, but her blood pressure never wavered, her pulse didn't accelerate, there was nothing [worrying] so she was able to stay there. ... The

haemorrhage happened after the placenta was out, and I'd inspected the placenta and I knew all the placenta and membranes were complete. It was just a uterine contractility thing, the blood had clotted, everything was O.K. Her pulse was O.K. and, regardless of what happened, even if I was going to move that woman, I would've had to put up syntocinon. So you just do what you would do. This is what I mean about the parameters. You don't just wait and see if she has stopped bleeding. She's bled. You know she's bled more than you want her to, so you act then. You don't wait and see (Mary, pp. 15-16).

Mary articulated her diagnosis of poor uterine contractility by describing a complete placenta, normal blood coagulation, and the woman having a stable blood pressure and pulse. "You just do what you would do," signals a confidence in doing and acting without requiring guidance. "You act then. You don't wait and see" recognises what has happened and anticipates what may happen unless timely intervention is initiated.

Tyrrell provided an example that illustrates confidence in her practice, as well as the requirement of thinking ahead:

... my hands never shake when I am doing things, and I just think if there is going to be a problem, we will deal with it. Some problems happen in labour, and you have to deal with them. You always have to be aware in those small places, if you are going to transfer someone, or things are not progressing, the transfer can take like three hours before you actually get the woman seen. You have to take that into consideration, so that is difficult. But no, if you know what could happen, you just think when it happens; I will know what to do (Tyrrell, p. 9).

Tyrrell says her hands never shake, indicating a confidence and competence in her practice, a belief that she will be able to deal with problems at the small maternity unit. In contrast, shaking hands may indicate nervousness, anxiety, pressure, and perhaps a fear of personal failure. A problem is the time it takes to transfer a

woman and then receive consultation at the large hospital. There is a need to anticipate ahead in the small maternity unit and make decisions that allow for the time for transfer, and the time to secure a consultation at the large hospital.

Perhaps there is a paradox in that small maternity units are a place for normal, low intervention midwifery, yet midwives practising in these units need to have a heightened vigil alertness to foresee, in order to arrest or manage problems. The midwife needs to recognise the abnormal and respond immediately, in order to provide safe care, and maintain the reputation of a small unit as a safe place for birth. The difference for a midwife working in the large obstetric hospital is that assistance is closer to hand, perhaps only minutes away. In the small maternity units, it may take one hour or several hours to obtain specialist assistance, therefore the midwife, being solely responsible, needs to be vigilant about being alert to any potential problems.

The independent midwives trustingly shared stories of their vulnerable moments when experiencing emergency type situations. A story from Joyce was used to introduce 'being solely responsible' as the first sub-theme of 'carrying the can'. It would seem appropriate to allow Joyce to speak again, to help other midwives understand the ongoing waning and rising of confidence that affects the practice of an independent midwife:

Like, for instance, if I have someone who has a heavy bleed in the third stage, then I'm a lot less confident in physiological management for a while and I'm a lot quicker to give syntometrine. I may give syntometrine a couple of times unnecessarily in the next dozen births because I've had a fright. So I think I tend to go in cycles really. I get very relaxed and very confident and then I have a fright, and then I become a lot more medical model for a little while, and then I relax again. Overall, I suppose, over the years, I'm a lot more relaxed about birth than I was as a beginning practitioner where I couldn't really see the difference between women who were most likely to be normal and the ones who weren't (Joyce, pp. 14/15).

Joyce indicates that confidence seems to be related to the midwife's recent experiences. She speaks of the cyclical nature of providing care, where there are cycles of feeling relaxed and confident and cycles of practising in a "medical model" after having had a fright. The medical model urges caution and intervention on the assumption that all birth is potentially problematic (Tew, 1985). Joyce says that years of practice have taught her to recognise the women who are likely to have a normal pregnancy and labour, and those that may not. When this pattern of recognition is altered, fear and a loss of confidence may affect a midwife's practice for a while thereafter.

Accounts of emergency situations or the midwife's readiness for problems reflect a conscious or subconscious understanding of what providing care in a small maternity unit demands. The notion of being solely responsible captures the feelings of being accountable, being a long way from help, being humble and grateful for good outcomes, being calm, being alert, being confident to act, and practising with an underlying belief that outcomes will generally be good.

Making Reasoned or Risky Decisions

The following stories have been included after hesitation because there may be criticism directed toward the independent midwives. The participants are therefore not named. Yet, these narratives, while illustrating the nature of 'carrying the can', also show the independent midwives' courage, wisdom, and commitment toward the woman/family. Their decision-making may appear to be reasoned or risky, or both simultaneously. There also appears to be a tension when the independent midwife is worried and concerned, while trying to accommodate the woman's wishes safely.

The first story concerns a woman post term with her second baby. She had a rapid birth with her first baby and required transfer to the large obstetric hospital for a retained placenta. Unfortunately the woman bled heavily while waiting for removal of the retained placenta. The story begins with the midwife's decision-making concerning the second pregnancy that is now overdue:

So what do I do? She lives miles away from the small unit ... we're going to have this rapid labour, and [the woman and her husband] are beside themselves wondering, will they make it to [the small unit], let alone get through to [the large obstetric hospital]. ... Well, she went to 41½ weeks, didn't she, and sat at 5cm. She was getting a bit twitchy, being out there [living a distance away]. ... So 41½ I said, "Well, what are we going to do? ... Chances are they'll look at inducing you". She said, "I don't want to be induced up there".

So I said, "Well, I can break the waters with a sharp fingernail and hope you come into labour, and then I'll have to take the responsibility that, if you don't come into labour, we're inducing anyway". So she said, "Yes, that's what we'll do". She'd been on the evening primrose to see if that would do things, we tried the hot sex, we tried all the natural remedies. Obviously the sex wasn't hot enough, she reckoned (laughter).

And so, 8 o'clock on this night it suited her, her husband was finished work, and her mum was there to baby-sit the 3 year old. I broke the waters, 5cm, lovely thin cervix, head well applied, we were delivered an hour later. Now I also made the conscious decision I wasn't going to do active management [for the third stage] because we had this placental tonic that she was to rub on and take. We had a physiological third stage and we had less than 100 ml loss. So it worked O.K., so I was obviously really lucky.

I don't know how I would've explained myself if things had not gone to plan, and I can tell you I was shaking with that third stage ... I don't know whether I'd do that again. I'd wait for the circumstances with the next one to decide on that. That was a hard decision to sort of make and it was O.K. and the woman was rapt. I could have been, well if things had gone wrong and we had a major problem with that placenta, I don't know how I would have got myself out of [this] because I'd actually done three things that were really wrong. But I felt I'd been an advocate for the woman and that was important. And I didn't think that I was

unsafe, I would have been unsafe if things hadn't gone right. I felt I was safe with what we were doing at the time.

The midwife was under immense pressure to fulfil the woman's request to birth in the small maternity unit, consequently she offered to break the waters "with a sharp fingernail". "A sharp fingernail" means that the midwife could argue that the membranes ruptured accidentally during a vaginal examination, therefore it cannot be deemed a premeditated action. However, the midwife knew the rupture of membranes was deliberate and that she would have to take responsibility if labour did not establish. Thankfully, birth occurred an hour after the rupture of membranes, and physiological management plus a homeopathic remedy were used to manage the third stage of labour.

Being "really lucky" was the midwife's description of the third stage going well and the woman not bleeding excessively. The independent midwife admits to shaking while delivering the placenta. One can imagine the responsibility, fear and concern that could cause "shaking of the knees" as she visualised the woman bleeding and the distance to the large hospital.

While apparently the woman was delighted with the outcome, one senses an ongoing concern from the midwife. There appears to be a tension between making a reasoned decision to meet the family's request, while being professionally responsible from a view of risk assessment. Even though the midwife said, "... it was OK," there is an acknowledgement that the decision-making entailed taking a risk. The midwife's statements, "I don't know how I would have got myself out of [this]" may refer to the worse case scenario of the woman haemorrhaging in a small maternity unit.

The midwife said she did not feel "unsafe" because the decisions made at that particular time had not led to any problems, yet she did say that she had done "things that were really wrong". What is the difference between acting wrongly and acting unsafely? 'Wrong' according to Webster's dictionary (1977) means "not in accordance with an established standard" (p. 2112). The Transitional Health Authority (1997) maternity project outlines referral guidelines. The lead

maternity carer is obliged to recommend a consultation with a specialist for a woman who has had a previous manual removal of an adherent placenta or a large postpartum haemorrhage. In this instance the woman would not agree to attend a specialist, probably because she would have been told to birth at the large hospital.

What about safety? Webster's dictionary (1977) provides multiple meanings for 'safe' including: "free from danger or injury, secure; unharmed; giving protection; taking no risks, prudent, cautious" (p. 1595). The midwife considered she had made a risky decision to induce the woman at the small unit, yet other parameters related to the definition of being safe were met. The woman was given protection from going to the large hospital, she probably felt secure with her midwife, she did not suffer injury and she was unharmed. Guilliland and Pairman (1994) advised that issues of decision-making and responsibility should be worked through by individual negotiation between the woman and the midwife. They issue a caution however, that a midwife cannot abdicate responsibility for her own actions on the grounds that the woman is the ultimate decision-maker. In this account the midwife recalled her anxiety of being accountable and answerable for her actions while meeting the needs of, and being an advocate for the woman and her husband.

The following is another example of decision-making where the midwife tries to meet the needs of a woman:

... the mother was very anxious to get out of [the large obstetric hospital]. She hated being there. I did transfer her to [the small unit] very quickly, it was just on two hours [postpartum] when we moved. ... I followed shortly after the ambulance as it had arrived before I completed my paperwork. When I got to the unit, the staff mentioned that the baby had been quite mucousy when it arrived, and I looked at it and thought, "Gosh it's a bit blue as well". So I took her to the nursery and suctioned more, and it became evident that the baby wasn't very well. Its colour was actually quite pale. I really didn't want to put the mother through the trauma of having to go back to [the large obstetric hospital] with a possibly sick baby. So I did delay a little bit by calling

in a G.P. who had done a lot of paediatrics, to come and have a look at the baby to just confirm with me whether he thought the baby needed to go back.

During that time, I had this awful feeling that maybe I was procrastinating and that the baby was quite sick and, in fact, it was quite sick. It had Strep. B. It did recover very well, but it was very ill, and that was a time when I should've really obeyed that gut feeling to move. Instead I thought, "No I'm not going to stress the mother, she's just got here, she's tired, this is possibly just a mucousy baby and we'll just deal with it here". But my intuition was telling me "No, this is really quite a sick baby, you should move". That was quite a lesson to learn really.

The midwife acted on the woman's wish to transfer out to the small unit immediately after the birth. The midwife recalls arriving at the small unit, assessing the baby, and having an intuitive feeling that the baby was not all right, yet she did not want to refer the baby to the paediatric service because of the woman's dislike of the large obstetric hospital. This influenced the midwife to consult with an experienced general practitioner for a second opinion. During this time, she recalls "an awful feeling", perhaps a gut feeling of foreboding that the baby was quite sick and that she should not procrastinate. The lesson for the midwife from this experience was to prioritise strong intuitive signals above the concern for causing stress to the woman. Reflecting on this experience, the midwife articulated an initial decision that was made with more risk than reason.

Both scenarios describe instances where the midwives' decisions appear to be influenced by the persuasion of the women. In the examples given, each midwife tries to accommodate the woman's wishes, yet remains concerned about their decisions. Cioffi (1998) advised that reflection helps midwives assess what their judgements are based on, and Fleming (1998b) acknowledged that midwives frequently face dilemmas of client wishes contrasting with good practice. It would seem that decision-making involves reason and risk, with the midwife juggling the requests of the woman and her family, with her own professional responsibility.

Ultimately, the midwife is 'carrying the can' and Pearse (1998) from a legal stance, advised midwives "not to be cajoled into situations" and to know the NZCoM (1993) standards for practice and code of ethics. Included in the code of ethics are the following statements: "Midwives have a responsibility to ensure that no action or omission on their part places the woman at risk" and also, "Midwives accept the right of each woman to control her pregnancy and birthing experience" (p. 10). Each of these statements places a demand upon the midwife; she must not place the woman at risk and she must also accept the woman's right to control her experience. Pearse reminds midwives that the process of decision-making is called partnership. Partnership is not enshrined in legislation, but is the foundation for mutual respect between women and midwives.

The following accounts portray midwives advocating intervention at the large hospital, when they considered that decisions made by others were too risky for the women involved:

...she rang up and she said that she'd been contracting on and off for a day and a half, they were getting stronger but the baby had been very quiet over the last day and a half. ... It was her second baby. I said "Well we'll meet at [the small maternity unit], we'll do a CTG and just see if baby is O.K". So she was happy with that. She came in and we did the CTG. The CTG was very flat, there was no variability at all, no reactivity, and we had a baseline of 160. She was 37½ weeks.

We made a decision to consult with [the large obstetric hospital]. It took about half an hour to track down a consultant, and then we had to go back to the registrar, so there was a bit of a delay there. I faxed through the CTG and told them that we were on our way, and it took about another ½ an hour to ¾ an hour to find someone to read the CTG, so we had about a 1½ hour delay actually getting to [the large obstetric hospital].

I was a bit concerned about this baby. We had a high baseline and reduced variability, and I was concerned that, on the CTG, we were

seeing these tightenings happening every two minutes, and really no time for the uterus to relax. The uterus was palpable. There were no obvious signs of abruption there. [The consultant] did an ultrasound, couldn't see any problems, and the breathing movements were there, but still we didn't have a very good CTG. We had had the CTG on now for probably a good couple of hours continuously. There was just a slight amount of increased variability for about two minutes, and then back to this flat trace again and still this tachycardia.

There was a suggestion that we take the CTG off, and this woman goes to the Ward, rests for a couple of hours and then repeat the CTG. Something said to me no, this is not right. We shouldn't do that. We should go and have a section. So I said to the Consultant, "I wasn't happy with her going to the Ward". I said, "They're busy, they're not going to watch this woman as intensely as she needs to be watched, and I'd rather that we actually sorted this problem out". Well we went up to Theatre, did a section, the baby came out in pea green liquor, lumpy, there was lots of congealed blood in there. It came out pink and screaming and then went completely flat, and passed all of this blood stained meconium, and I sent it off for histology. It came back as maternal blood, so that woman was having a concealed abruption, and there was no obvious sign except for the fetal distress.

It was quite frightening because I look back at the different ways I could have handled that situation. It was the fear in the woman's voice on that original telephone conversation that I acted on. If the woman is worried about anything, I will often just bring her in and we'll have a look at the situation and, if everything's fine, she can go home again. ... I think "Thank God I actually brought her in and did a CTG".

The midwife viewed the cardiotocograph as being "very flat" which prompted immediate consultation with the large obstetric hospital. There is a sense of too much time passing while the midwife accessed the system for referral and meanwhile, her concern for the woman and baby increased. The midwife was

thinking that the woman might have a placental abruption despite the lack of “obvious signs”. Once they reached the large obstetric hospital the obstetrician performed an ultrasound scan, was reassured by fetal breathing movements and suggested the woman rested in the ward.

A sense of foreboding seemed to be with the midwife and she used this intuitive feeling to persuade the obstetrician to make a decision to “sort the problem out”. The midwife felt that this woman and baby were at risk and the ward staff were “too busy” to watch them intensely. The midwife reasoned with the obstetrician to perform a caesarean section and this proved to be justified.

“Frightening” was the descriptor used to summarise the midwife’s reflection on this event. The midwife had responded to the woman’s fear and her own feeling that this baby was in strife. Smythe (2000) said the spirit of ‘engaged concern’ entails anticipation and respects the darkness that covers what cannot be seen. The placental abruption was hidden inside the uterus, and was not detectable by the technology of the ultrasound, or the expert knowledge of the obstetrician. The midwife said “Thank God” that she had anticipated something was wrong and had brought the woman to the hospital to assess the situation. Without saying so, the midwife knows that her actions of persuading the obstetrician to do an immediate caesarean section prevented a fatality. This account illustrates that the sense of ‘carrying the can’ never leaves the midwife, even though in this instance the responsibility for care had probably been transferred to the obstetrician. The midwife’s worrying and concerned responsibility coerced the obstetrician to take action.

Another independent midwife speaks of a normal birth at the large obstetric hospital, however the woman had an adherent placenta:

Like, I had a lady a couple of years ago, which makes me realise how ludicrous a base hospital can be sometimes. She had a retained placenta, and the placenta was obviously retained. I took her up to Theatre for a manual removal. She hadn’t bled heavily until then, but she started to bleed before we went to Theatre. I must have waited in Theatre for ¾ hour watching this woman virtually exsanguinate. I kept

saying to them, "she needs to have this done now, she's bleeding, she's getting lower". She ended up needing 3 units of blood and was really quite sick, because they didn't want to open another Theatre. ...

How much does it cost to nearly kill a woman and transfuse her with 3 units of blood? These kind of things are illogical. ... She was at a base hospital, she was a Gravida 3 and she wanted an epidural. I was glad she was there in the long run ... At the time I said - "This is terrible, it's disgraceful, this woman needs to be seen to". They just ignore you. You're a nothing.

In this situation the midwife described watching the woman almost "exsanguinate" or bleed to death during the 45-minute wait for an operating theatre at the large obstetric hospital. The midwife recalled pleading with "them" (perhaps the theatre staff and the obstetric team) to hurry and complete the operation, saying the woman was bleeding and that "she was getting lower". That is to say, the woman might have a falling blood pressure due to excessive blood loss, and she may have shown a lower level of consciousness by becoming drowsy as her oxygen levels decreased. "Getting lower" would indicate to experienced practitioners that this woman might be close to dying unless immediate action is taken to arrest the uterine bleeding.

The midwife questions in an unforgiving manner the morbidity that her client experienced because the waiting time was too long. There seems to be no sense of reason for this unacceptable delay, except the fact that a decision was made not to open another theatre. The large obstetric hospital was not perceived as a safe environment because the delay for this woman was too lengthy. The midwife ends this story on a regretful note recalling that she was ignored and felt unimportant, saying she felt like a "nothing", yet she was trying to advocate for her client in response to a worrying concern.

Perhaps the notion of knowing the woman and the partnership relationship heightens the sense of 'carrying the can' and worrying about the outcome even when the midwife is not solely responsible. The two previous narratives illustrate

the concern of the independent midwives about the decision making of others. Pairman (1998b), from her findings, argued that continuity of care enables the midwife to have a 'knowing' of the woman, and from this knowing, intuition as a type of knowledge can grow.

From the examples above, one has a glimpse of decision-making and the worry these independent midwives experience during the course of providing care in small and large maternity settings. Occasionally an independent midwife may make a decision that entails a risk at the small unit, because the woman refuses to go to the large obstetric hospital. Conversely, examples were provided where the midwife felt the woman was put at risk by decisions made by those at the large hospital. Perhaps this explains why some midwives might prefer to 'take a risk' and continue care in the small maternity unit rather than argue the decisions made by others at the large hospital. The following stories are another sub-theme of 'carrying the can' where independent midwives relate incidents of being judged by their colleagues at the large obstetric hospital.

Being Judged

During interviews, independent midwives gave examples of situations where they perceived judgement predominantly from colleagues who work solely at the large obstetric hospital. Being judged seems to be associated with being 'the other' or being the outsider. Van Manen (1990) said the relations we develop with others help us to form a view of ourselves. Judging may indicate a lack of understanding of the other.

Bronnie talks about a multiparous woman who had an inco-ordinate labour:

I can honestly say I was nervous about the labour because, when things start to deviate from the normal and that ... there is a part of you that [thinks] what's going to happen when I get to [the large obstetric hospital]? Am I going to be told, "You should have come two hours ago". I mean that happens. Or if you ring, "Well does she really need to come?" You're having to cover your back to justify why you've moved and why you haven't moved ... Like it's only on reflection now that it

does have an effect on your judgement of when you're going and when you're not going to [the large obstetric hospital]. It's only on reflection that you realise (Bronnie, pp. 11-12).

Nettie relates an example of transferring a woman to the large obstetric hospital and receiving a cool welcome:

...it was her third baby, she had a really good labour, ... I did an ecbolic for third stage. I just knew [the placenta] was not complete, it was tatty, it was flat, as if some of it had sheered off, it just didn't look right. The woman started to trickle, and the fundus wasn't going down and I knew that she had retained products ... I think the ambulance arrived quite quickly, and we got a line up and had the synto [syntocinon infusion] running, and she went to [the large obstetric hospital]. ... I got told by [a midwife], "Where's your continuity of care?" No understanding at all about secondary services being provided and about secondary care because she couldn't go to Theatre straight away.

It's not like, "Nettie we're absolutely frantic, we haven't got enough staff, I would really appreciate it if you could stay with her". None of that. And some of the midwives would do that. It's what you've just been through, out in this place, coping with this thing, done pretty well, got her stable. She hasn't bled to death or anything. You've managed to maintain her to get her in there safely, and then [you meet a midwife who has] just that real chip on the shoulder towards independent midwives which, as I will say, is getting less and less. I could really almost name who would do it and I can't understand why. I can't see why they need to feel so threatened by us. I think you can forgive those things once or twice because everybody gets harassed and busy, but when it happens time after time from the same source you begin to wonder (Nettie, pp. 19-20).

Both Bronnie and Nettie relate the tension of transferring women to the large hospital. Bronnie describes "covering your back" or protecting herself from

criticism as to whether she had transferred too early or too late. Nettie feels there is a lack of insight from some midwives, as they cannot see what has happened beforehand. The midwives working at the large hospital do not know what the independent midwife has just been through “out there”, and they probably do not care. The independent midwife is the ‘other’, an outsider to the culture of the large, busy obstetric hospital.

The following example concerns a woman who was labouring at a small maternity unit when the independent midwife diagnosed a breech presentation:

...not everyone there [at the large obstetric hospital] is going to be your buddy. One year, I had 8 breeches, and the one that I didn't pick, she came into labour ... when she stood by the bed, I saw a little bit of meconium. Oh no. I quickly got her into the ambulance, got her to [the large obstetric hospital] and she was nearly ready to push. When the consultant came in, I handed her over but I stayed with her. The midwife said to the consultant “Independent midwife; undiagnosed breech”. I thought “That is sort of the attitude”. I thought, “Well I have got her here really quickly”. As soon as I knew, I had brought her here and I thought that would be the right thing to do, but it is just the rolling of the eyes. I have never forgotten it. Some people are really helpful there, but I would have to say that not everyone is really helpful (Tyrrell, p. 17).

“Not everyone there is going to be your buddy” eloquently describes the feeling of judgement upon transferring a woman with an undiagnosed breech from the small maternity unit to the large hospital. Tyrrell had an extraordinary number of women with breech presentations in that year, possibly around 15% of her caseload, as compared with an average incidence of 5% at National Women's hospital (Stone & Knight, 1999). Tyrrell encountered a midwife who rolled her eyes as she told the consultant, “Independent midwife; undiagnosed breech”. The perceived disapproval and judgement by that midwife has remained with Tyrrell as an attitude of censure of her midwifery practice. On the other hand, Tyrrell did not want to appear too critical and pointed out that some people are really helpful at the large obstetric hospital.

Midwives who practise in the small maternity unit accept the reality that occasions will occur when women need to be transferred. It would seem that transfer to the large hospital entails the possibility of being judged. This judgement may dissuade some midwives from using the small units for intrapartum care.

Mary describes a sense of surveillance, of being watched and judged:

...at a small hospital, they're not constantly hammering you. ... they know the ultimate responsibility is yours. ... At [the large obstetric hospital] you are likely to get them to come up to you and say "The protocol says ...". You're more likely to find that at [the large obstetric hospital]. ... some people look over your shoulder to approve what you have done and some people look over your shoulder to disapprove at what you have done. It depends entirely on the management. It goes right down. Everybody feels it (Mary, pp. 28/29).

Joyce thinks of the small maternity unit as similar to practising in a home environment where there is not a feeling of surveillance:

I think, because you're at [a small maternity unit], you don't feel that you're being watched so much as if you're at [a large obstetric hospital]. So I suppose I wouldn't really follow active management guidelines in terms of time, length of time, the progress and intervening as early as I would at [the large obstetric hospital]. ... I do feel that I can treat women a lot more like they are at home at [a small maternity unit] than at [a large obstetric hospital] (Joyce, pp. 6/9).

Kirsty cites the "Primigravida Protocol for Labour" in respect to the judgement that she may be subjected to if progress of labour is not according to the criteria in the protocol:

I've probably got in my mind in a sense that, if this woman doesn't meet certain criteria, I'm going to be in the shit if I end up at [the large obstetric hospital]. So I'm thinking of what's going to be seen to be done ... because, also this is based on other midwives' experience when

they've had people either at home or in the [small maternity unit] for a long time, that they've been highly criticised later if the woman has needed a lot of intervention. So I suppose that's in the back of my head but it's only in a very small compartment (Kirsty, p. 20).

Mary, Joyce and Kirsty made reference to protocols at the large hospital, in particular the protocol concerning progress of labour. They also describe a sense of greater freedom when practising at the small units as opposed to a feeling of being hammered, being under surveillance, or having expectations placed upon their practice, at the large hospital. During the collation of the examples above, it became apparent that the notion of judgement experienced by independent midwives came predominantly from some midwives who practised solely in the large obstetric hospital.

While the previous examples provide evidence of the notion of being judged, the following example illustrates a time when an independent midwife felt grateful for the support communicated to her by the obstetrician on call:

It was a second baby. She'd had a very quick delivery for a primip and we knew this woman wasn't going to [the large obstetric hospital]. You can say all you like, you can say, "The protocol says you have to deliver at [the large obstetric hospital]". We knew that the reality was, she was going to end up on our doorstep with us having to cope with it. So I just quickly rang [the consultant]. I said, "This is the situation, she's got a haemoglobin of 83 a week ago. I personally took iron [tablets] around to her home, and she's been taking iron for a week, and we were thinking of Active Management [use of syntocinon for delivery of the placenta]. [The consultant] said, "Yes, do that, but give her 10 units IV [syntocinon] and IM Syntometrine", and then he said, "Good luck!"

And you know, I got off that phone and those two words, "Good luck", was like [the consultant] knows about us. We've got that support there if we need it. We're doing the best that we can in the situation we've found ourselves in, but no judging from [the consultant], nothing. It was just, "Good luck". And I've always liked that [consultant] ever since,

because that person on the end of that phone call can make such a difference to the situation that you're in. ... We just want to know they're on our side, they're there with us (Nettie, pp. 18-19).

Nettie explains the reality of a woman "on our doorstep" at the small unit, meaning that some women with risk factors, such as a low haemoglobin, will present in advanced labour at the small maternity unit, ensuring there is no time for transfer to the large hospital. She describes telephoning the obstetrician on call and explaining the predicament she is in. The obstetrician concludes the discussion with wishes of "good luck". Nettie feels supported rather than judged, and that feeling of support has meant that she has liked that obstetrician ever since. She felt the obstetrician was on her side, understanding what it is like practising a distance away from the large hospital.

In the introduction Wood (1969/1979) defined 'carrying the can' as being related to blame, censure or a penalty. The notion of being judged has been illustrated by independent midwives who feel they have to 'cover their backs' when they decide whether or not to transfer women, who encounter a lack of understanding from some midwives at the large obstetric hospital and who feel a sense of surveillance at the large hospital. In comparison, Nettie's final account illustrates how she was 'carrying the can' yet on this occasion, she felt support and understanding (from the consultant) for doing so.

Summary

'Carrying the can' is an expression used by Joyce to explain the reality of providing care in the small maternity unit. Included within this overriding theme is the notion of 'being solely responsible'. Midwives shared vulnerable moments of feeling alone, isolated, fearful and heavy with the burden of responsibility upon them. There is a paradox in that small maternity units seem to be a place for normal midwifery practice and normal birth, yet the midwives have to be extra vigilant to avert or foresee problems. Practising in a low-technology setting means that there is no high-technology backup when things do go wrong. However, all

the independent midwives retain a belief in the possibility of a good outcome, and are aware that foreseeing problems avoids poor outcomes.

'Making reasoned or risky decisions' is included to show the complex influences upon decisions. While some readers may criticise the decisions that midwives have made in the small units, examples are also given where midwives considered that women were placed at risk while in the large hospital. Knowing the woman, and the partnership developed with her, were considered as possible factors that might contribute to a heightened 'worrying responsibility' or a heightened sense of 'carrying the can'.

Finally, the notion of 'being judged' was explored, with independent midwives providing examples of judgement, as opposed to understanding of practice in the small units. The independent midwife feels as if she is the 'other' when she transfers a woman into the busy, large hospital. The 'other' is probably a nuisance for an already busy delivery unit. There is possibly no time for those at the large hospital to appreciate what the independent midwife has endured out in the small unit. Yet, the final example shows a midwife heartened by the consultant who showed understanding for the predicament that she was in. That understanding made all the difference. 'Carrying the can' has uncovered the additional sense of responsibility that independent midwives are aware of, when providing care between two different cultures of the maternity settings.

The following chapter is a discussion of the data presented. The discussion chapter enables the researcher to analyse themes from the data in each chapter and to address the research question.

Chapter 6: Discussion

Introduction

The previous chapters have introduced selected data from participants that illustrate the two main themes of 'real midwifery' and 'carrying the can'. The discussion provides an opportunity to address the research question using the themes from each of the data chapters. Van Manen's (1990) four existentials of 'lived body', 'lived time', 'lived space' and 'lived other' are used as "guides for reflection in the research process" (p. 101). The lived world that midwives experience is explored through the relations of body, time, space and other. To conclude this chapter, implications for practice, research and education are addressed from the findings of this study.

Research Question and Aims

The research question that drove this study is:

How is the provision of intrapartum care by independent midwives different in a small maternity unit as compared with a large obstetric hospital?

In chapter one, Pairman's (1998a) definition of independent midwifery was stated thus, "The critical elements of 'independent practice' therefore, are the midwife's partnership with the woman, autonomy and continuity of care" (p. 7). However, this present study has found that the independent midwives who participated, (and who all provide continuity of care), do practise differently in different contexts, and they regard their practice as being more autonomous in the small maternity units. It seems that the context of practice might be a critical element that influences, or perhaps even determines, the intrapartum practice of some independent midwives.

Midwives describe having the freedom to practise 'real midwifery' in the small maternity units, and this entails the acceptance of 'carrying the can'. The independent midwives expressed the need to have a belief in natural birth alongside a belief in their own skills in order to practise what they call 'real

midwifery'. Practising in the small maternity units enables midwives to do 'real midwifery' by letting the labour 'be'.

This present study also reveals a 'transient tension' or a paradox. In letting the labour 'be' there will be occasions when the labour does not progress, or alternatively, the rare occasions when emergency situations arise. Therefore the midwife's work necessitates being able to foresee problems because of the time and distance factors involved in transferring to the large obstetric hospital. This requires the skills of foresight alongside the confidence and skills to manage emergency situations efficiently without the assistance of an on site obstetrician or paediatrician. The midwife has the autonomy and clinical freedom to practise how she wishes in a small maternity unit. However there is a notion of additional responsibility. These are the key differences between providing intrapartum care in a small maternity unit as compared with a large obstetric hospital.

The aims of the study and the manner in which each aim has been addressed follows:

- To describe the experiences of independent midwives providing intrapartum care in both a small maternity unit and a large obstetric hospital.

Independent midwives described experiences of caring for intrapartum women in both small and large maternity hospitals. The participants' narratives generally illustrate differences in practice between the two settings. In chapter four, the findings reflect the day-to-day practice of caring for women in labour. In chapter five, narratives tend to reflect rare occasions when an emergency occurred, when decision-making was difficult, or when the midwives experienced critical judgement from others.

- To highlight the differences in providing labour care in the different settings.

This study found that some independent midwives are able to practise more autonomously in small maternity units where they are less bound by time and

timeframes, and where women are free to make noise. Prior to undertaking this study, I had not considered the issue of whether or not midwives tolerate women making noise during labour. The findings from the present study suggest a lack of tolerance of noise is associated with use of epidurals, or conversely, the culture of using epidural analgesia means that midwives become unfamiliar with the normal sounds of women in labour. The midwife participants also described using other options to assist with managing pain that might not be employed when practising at the large hospital; where, for example, hydrotherapy is not always available, and where there is a sense that the medicalised culture of the large hospital does not encourage non-pharmacological alternatives for managing pain.

Findings also include the theme of 'carrying the can' where midwives describe the notion of being solely responsible. This entails a sense of being alone and carrying the burden of responsibility while practising outside the mainstream culture of a large obstetric hospital. Midwives practising in small maternity units do not have access to specialists and high technology backup when problems arise. As a result of practising outside the dominant setting, participants from this study experienced judgement when transferring women to the large obstetric hospital.

- To identify issues that influence independent midwives' choice of environment for provision of intrapartum care.

There was unanimous preference for providing labour care at the small maternity units where the midwives have the freedom to practise what they call 'real midwifery'. The midwife participants feel affirmed by practising midwifery in this way, where they use all their midwifery skills, as opposed to using machines. In chapter five, paradoxically, most of the midwives continue to express their agreement with practising in small maternity units despite having experienced emergency situations. The midwives balance the burden of being solely responsible with a belief that in most cases the outcome will be good. They also express their awareness of the necessity of foresight, and their anticipatory response to manage any emergency situations quickly. Van Manen's (1990)

existentials of body, time, space and other are used as a method to assist with explicating the differences and meaning of the midwives' experiences.

The Lived Body: The Midwife in Different Settings

Van Manen (1990) said that 'lived body' refers to the fact that "we are always bodily in the world" (p. 103). How we experience our physical and bodily presence alters according to the context of being in a particular place. During the interviews it was apparent that the independent midwives feel comfortable providing intrapartum care in the small maternity units. There appears to be a belief in natural birth where unnecessary interventions are avoided, and this is sustained through the process of enabling labour and birth to be normal. The midwives enjoy 'real midwifery' where they use themselves, their intuition, their assessment skills, and their experiential knowledge to allow the labour to 'be':

At [the small maternity unit] it's like real midwifery in a way, because you're not interfering... I think with real midwifery, a lot of it is not doing, in a way letting it happen, being there, but you're still there and you still want to make sure things are happening as they should. ... And I think real midwifery can be not being that overpowering person there (Elizabeth, pp. 68-69).

I feel like I'm sitting there [at the large obstetric hospital] just watching a machine and not really using midwifery skills. So I don't come away from that kind of birth feeling quite so good (Joyce, p. 70).

Leap (2000) used the phrase the 'less we do the more we give' to illustrate that midwives' work might be "sitting in the corner of the room in watchful anticipation during labour, but on the whole they were quiet and very non-directive" (p. 2). Leap claimed that this type of practice shifts the power to the woman, as indicated in this present study by Elizabeth, who does not want to be "that overpowering person there", and prefers, as VandeVusse (1997) wrote, to be quietly assistive without taking the main focal position. Leap suggested, "Our expertise as midwives rests in our ability to watch, to listen and to respond to any

given situation with all of our senses” (p. 5). The midwife has the knowledge and skills to know when to act or seek help, or alternatively when to be still and withdraw. Pairman (1998c) and Annandale (1988) also described observation and watchful expectancy as important skills that a midwife requires.

Buus-Frank (1999) indicated that there is a tendency to use technology because it is available rather than because it is necessary. However, the skilled nurse’s [midwife’s] senses provide irreplaceable ongoing assessment. The following participants’ support this view:

You need your eyes and your hands more than any equipment. That will tell you more than any monitors (Cluain Meala, p. 71).

I actually find that part of midwifery at [the large obstetric hospital] almost easier, because it’s all black and white, and the woman’s lying there with her epidural and you’re watching machines. Whereas this way, when I’m at [the small unit] it’s more hands on. You know, it’s sort of like watching and waiting, and I think it is more enjoyable ... It can be more emotionally draining perhaps, that you are getting it right from reading it (Bronnie, p. 71).

The lack of technological interference at small maternity units enables independent midwives to be in touch with their own senses and to use this knowledge when providing intrapartum care. Siddiqui (1999) revealed through her qualitative research that midwives referred to “tuning in” or “keying in” (p. 111) to the labour itself, intuitively knowing if a labour was going right or deviating from the normal, that was quite distinct from technical skills of monitoring. In order to do this ‘keying in,’ midwives need to be in touch with their own being. The ‘being-there’ seems to be different in a small maternity unit where the midwife is more able to use her senses and tune in to the woman.

Participant Bronnie’s statement that “watching and waiting can be more emotionally draining” is echoed by Kirkham (2000) who described the work of the midwife as ‘emotional labour’ where being with a woman conveys to her that her labour is normal and all is well. This ‘emotional labour’ is undervalued in a

culture that values action and measurable skill and where the midwife focusses on monitoring and abnormality. This latter focus is more likely to cause apprehension and panic that is then transmitted to the woman.

A midwife requires additional skills to practise intrapartum care in a small maternity unit. She needs confidence, knowledge and skills to manage any situation that might arise:

... if you look at midwives, the more confident they get in their own practice, the more likely they are to deliver in the small hospital. ... There might be some that wouldn't deliver in the small hospital, but then they have never moved from the high tech mentality, and they've never really become midwives in the true sense of the word (Mary, p. 69).

The difference for a midwife providing intrapartum care in the small maternity unit is that she has to be confident to manage situations without access to specialists and technology. Working without technology means that a midwife has to use different skills. She might be in the background, yet she is always watching the labour to ensure that the woman and baby are well, and that the labour is progressing.

In contrast, the high technology medicalised setting of the large obstetric hospital interferes with the way some midwives want to practise. Findings from this study suggest that the medicalised environment in the large hospital is so pervasive that most midwives conform to practices such as a routine cardiotocograph for all women on admission. When practising in the large obstetric hospital, the midwives frequently feel that their skills are of less value than those of the machines. Using machines emphasises the value of technology and undermines the value of real midwifery skills:

You've got to do a CTG at [the large obstetric hospital]. They like you to do a 20-minute CTG. Completely unnecessary in the majority of cases (Mary, p. 73).

You turn off, I'm sure you switch off at [the large obstetric hospital] because you're too busy, too busy watching all those other things instead of listening to the women (Grace, p. 70).

Some practitioners might question why independent midwives feel obliged to follow protocols at the large obstetric hospital or why some midwives submit to the use of technology for potentially 'low risk' women. Turnbull et al. (1996) found that midwives at the Glasgow Royal Maternity Unit adhered to established practice and used continuous electronic fetal monitoring, despite there being no benefit for a low-risk population. Similarly, when Kaczorowski, Levitt, Hanvey, Avard and Chance (1998) surveyed staff at 523 Canadian maternity hospitals, they found that availability of technology means employment of technology; such as the routine use of intravenous infusions, and continuous electronic fetal monitoring. A midwife participant in Hunt and Symond's (1995) study indicated that it is easier for midwives to comply with the routines such as the artificial rupture of membranes, within a culture where doctors are authoritarian and powerful. According to this participant, "Even the strongest, most assertive and articulate midwives can crumple under that sort of strain" (p. 129). The authority of doctors is so commanding that even the strongest midwives submit to their interventionist routines.

How do the assertions from Turnbull et al. (1996), Kaczorowski et al. (1998) and the midwife participant in Hunt and Symond's (1995) study relate to findings from this present study? Most of the participants in this present study indicate that they feel compelled to do an admission cardiotocograph, that they have a sense of surveillance at the large hospital, and that they fear judgement if a problem arises that requires consultation. On occasions, independent midwives need to consult with an obstetrician, and these consultations might occur more amicably for the midwife and the woman, if the midwife is seen to be conforming to the hospital protocols rather than being 'a rebel'. Perhaps it is the context of a tertiary hospital, with an authoritarian medical culture that dominates the practice of some, or many midwives.

With regard to protocols and a lack of freedom of practice, Lawton and Parker (1999) used focus groups to research opinions and viewpoints concerning protocols and guidelines in the United Kingdom. Five of the six focus groups that comprised midwives and obstetricians indicated their resentment of protocols, and cautioned against the use of protocols that remove flexibility in practice.

Participants in this present study also value their clinical freedom and are able to avoid adherence to protocols by practising at the small maternity units:

Looking after women in those [small maternity] units, there is this expectation of going with the flow and the normal. Nobody's knocking on my door or asking if there are any problems. Women are treated as normal, therefore there isn't the intervention automatically, and there isn't CTGs as soon as you walk in the door. There are no routines and, as an autonomous practitioner, I do what I feel is appropriate at the time without having to really discuss it with anybody (Kirsty, p. 73).

A lack of technology and a difference in ambience is associated with the small maternity unit. The findings from the present study, suggest that midwives compare the freedom in a small maternity unit with that felt at a homebirth:

It's not like a hospital at [the small maternity unit] ... I just feel a little bit freer at [the small maternity unit]. It's like being at a homebirth in a way really, not quite, but in a way it can be (Elizabeth, p. 79).

In contrast, the large obstetric hospital is considered a totally different setting to provide intrapartum care. The level of 'doing' as opposed to 'being' perhaps summarises the difference between the large obstetric hospital and the small maternity units. The need to 'do' is within a culture rich with technological equipment. Other professions including nurses and therapists have also shown concern with the 'being' and use of 'self'. Elliott (1997) surmised that nurses have little faith in the usefulness of 'being' as they are not trained in this, whereas Benner and Wrubel (1989) argued that the clinical judgement embedded in the practice of being with patients, or embodied experience, needs to be taught to

medical and nursing students. Edwards and Bess (1998) and Real (1990) discuss the use of self in therapy and agree that the use of self, of getting alongside a person, is a powerful tool in practice. The midwife participants regarded their bodily connectedness, their intuition, their embodied knowledge and skills as important facets of practising 'real midwifery' in the small maternity units. Their use of 'self' and 'being-there' is different in a small maternity unit as compared with a large obstetric hospital.

Lived Time: The Meaning of Time in Different Settings

The notion of time is context dependent. Time is not clock time. Time is in the experience of the perception of time. Kohl (1965) said, "Time is primordial for Heidegger" (p. 135). Meaning is revealed to us through our personal time, not through an objective, measurable time-concept. When things are going well, a midwife may be oblivious to time. On the other hand, during difficult times, the midwife is acutely aware of time passing. The findings from this study show that the context affects the experience of time and this is illustrated with the following examples.

Being Bound to a Timeframe

The independent midwives referred to a timeframe at the large obstetric hospital where women are required to give birth by a certain time. This means that the midwife is conscious of time ticking by, from admission to the time of birth, and then of the time taken to transfer the woman and baby out of the unit.

That is the difference between working in a major base hospital, and working in a smaller country hospital; you don't have that heavier focus of sort of shunting these women along on a conveyor belt and getting the job done as quickly as possible (Rosemary, p. 76).

There's always a sense of urgency [at the large hospital] because so many people are coming and going. At [the small maternity unit] to a greater extent, you can allow the woman to labour at her own pace (Mary, p. 76).

...once you get in there [large obstetric hospital] you feel like you've got a time frame to get out of the unit (Bronnie, p. 78).

Having a timeframe is related to the busyness of a large hospital, the lack of space, and the culture of expecting women's services to dilate at a minimum rate of one centimetre per hour. The findings suggest that most midwives in this situation become immersed in a culture of abiding by a timeframe, whereas at the small maternity units, the midwives have the luxury of not being bound to clock time. At the small units, the midwife is able to let the woman labour at her own pace, in contrast to labouring according to the protocol at the large hospital, informed by Friedman's (1954) sigmoid curve that redefined a woman's labour into timeframes.

Katz Rothman (1996) drew conclusions from her sociological perspective concerning a labour. In a medicalised paradigm, the diagnosis of labour is made according to shift in location, meaning a shift to the hospital. Enkin et al. (2000) continue to suggest that the most convenient marker of the onset of labour for a woman giving birth in a hospital, is the time when the woman is admitted to the hospital. Once the woman is admitted to hospital, she is given only a limited amount of time to deliver the baby. Sociologists Weitz and Sullivan (1985) found that midwives often lamented not being able to allow women to birth according to each woman's own timetable. According to Fox and Worts (1999), medical professionals in Western society acting on a definition of childbirth as hazardous, intervene in what is essentially a natural process. Thus, when obstetricians who believe that childbirth is hazardous, dominate a particular culture, time constraints are also likely to dominate.

On the contrary, obstetricians do not dominate the culture of the small maternity unit. Midwives are able to practise with flexibility concerning timeframes:

... what I like about the small hospitals is, if you've got a first time mum there isn't the same feeling as there would be in a base hospital that you have to be clock watching. So this first time mum that I'm thinking of recently, she did have a long labour [in the small unit]. If

you take it from onset of regular contractions, she had a 20 hour labour (Kirsty, p. 78).

Lavender and Malcolmson (1999) conducted a descriptive study of midwives working in the labour ward of one large obstetric hospital. The authors found "little consensus concerning the labouring primigravida who has made slow but steady progress for 20 hours in the absence of maternal and fetal distress" (p. 27). The authors found that midwives differed in their rationale and choice as to whether or not to intervene and concluded that different women might require different partograms. The authors also remarked that midwives who had been qualified the longest preferred early intervention, raising the possibility that most of these midwives trained during the height of medicalisation, whereas recently qualified midwives sought not to pathologize maternity care. The present study also reveals occasions when midwives feel vulnerable and when time seems to slow.

Being Vulnerable as Time Slows

The findings from the present study emphasise the notion that midwives do not want to be bound by time and timeframes, and that they enjoy the freedom when practising in the small units. However, this study also acknowledges the times when the midwives feel an extra burden of responsibility, and a sense of vulnerability when providing care at the small units. During emergency situations, subjective time seems to slow down. The following examples portray the feeling of vulnerability during these difficult times:

It was horrible; it was a really quite slow brady [slow heart rate]. It would come up; it seems like a long time of course at that stage, but it was taking longer and longer to come up (Bronnie, p. 96).

And then it's all happening. This woman was having a bit of a bleed; it was a big baby, ... Within three minutes [the baby] was breathing fine, but I tell you what, it was a long three minutes and of course the parents of the baby were saying, "Is it all right? Is it all right?" (Grace, p. 98).

When the fetal heart rate slows or a baby is not breathing, the midwife feels the added responsibility of practising in a small maternity unit away from specialist support. Black (2000) described the delivery of a limp, pale and unresponsive baby as one of the most frightening things that can happen to a midwife. "Midwives who deliver in the community are faced with dealing with such a situation without the backup systems that institutions provide, and require to be skilled in resuscitation of the newborn baby" (p. 258). The difference for the independent midwife practising at the small maternity unit is that though there might be another midwife present to assist with resuscitation, it is unlikely that the other midwife would have any more experience in resuscitation. The reality is that the independent midwife is 'carrying the can' for the outcome:

I think working in a small unit, ... your senses have to be a lot more acute I suppose. You are solely responsible if something does happen. ... In [the small maternity unit] even though you have another midwife come in, you actually have to know what to do. ... At the big hospital, you can press the button and you might have two or three people there (Cluain Meala, p. 101).

Being solely responsible in a small maternity unit means that the midwife needs to manage situations, but she also needs to think ahead and anticipate potential problems as suggested in the following discussion.

Time and Foresight

Heidegger spoke of 'foresight' and 'foreconception' where time is understood as an intention, as an implication of a carer anticipating ahead of time (Kaelin, 1989). Midwives practising in the small maternity units are required to think ahead and to use the notions of 'foresight' and 'foreconception' to recognise the need to intervene ahead of time to avert a potential problem. Midwives working in the large obstetric hospital are already on the spot and do not have to consider the distance and time to access specialist assistance. The small maternity units are located some distance from the large hospital therefore the time to acquire assistance is inextricably linked to the use of foresight:

You always have to be aware in those small places, if you are going to transfer someone, or things are not progressing, the transfer can

take like three hours before you actually get the woman seen (Tyrrell, p. 103).

In non-emergency situations, the midwife has to have the foresight to decide on the 'best time' to transfer a woman in labour from the small unit to the large hospital:

I can honestly say I was nervous about the labour ... there is a part of you that [thinks] what's going to happen when I get to [the large obstetric hospital]? Am I going to be told, "You should have come two hours ago". I mean that happens. Or if you ring, "Well does she really need to come?" (Bronnie, p. 114).

Smith (1998) completed a quantitative study concerning referral of labouring women to consultant hospitals and reported that 27% of doctors and midwives, predominantly from the consultant hospital, felt that transfers were either too early or too late. Practitioners with the benefit of hindsight might render a harsher judgement as to whether or not the transfer of a woman occurred at an appropriate time. Participants in this study indicated the difficulty in judging (foresight) the optimum time to transfer a woman.

Independent midwives who practise only in the large hospital, do not need to concern themselves with the complexities of transferring women in labour, as they are already deemed to be in the 'safest place' from a medical model of childbirth. When receiving a woman who has been transferred, Waldenstrom et al. (1997) advised practitioners in a large hospital to respond seriously, and to respect the decision of a midwife to transfer a woman as a safe decision. They recommend that the consultant unit promptly assess women who have been transferred, and that attention be paid to the history given by the accompanying midwife. The notion of past time relating to previous experiences also seems to influence the midwife and the care she provides.

Past Time

According to Van Manen (1990),

The temporal dimensions of past, present and future constitute the horizons of a person's temporal landscape. Whatever I have encountered in my past now sticks to me as memories, or as (near) forgotten experiences that somehow leave their traces on my being (p. 104).

Van Manen is saying that experiences of time that has past, travel with a person to the present time and ahead toward anticipatory time. Joyce gives an example of her past time affecting her present time:

... if I have someone who has a heavy bleed in the third stage, then I'm a lot less confident in physiological management for a while and I'm a lot quicker to give syntometrine. I may give syntometrine a couple of times unnecessarily in the next dozen births because I've had a fright (Joyce, p. 104).

A midwife's past experience of working with a woman who has haemorrhaged will affect her present time when she is caring for another woman. Joyce admits to acting with increased caution and having perhaps given syntometrine unnecessarily as nothing had gone wrong. Yet in understanding the notion of past time affecting present time, one understands why Joyce, and other midwives, feel the need to administer syntometrine because of fear (from past time) of another woman experiencing a haemorrhage.

Grace had the experience of a baby who died unexpectedly with conditions incompatible with life. While there was nothing that could have been done for this baby, Grace is left with an added alertness and a heightened sense of responsibility from her past experience:

I always feel that I'm so busy watching out for something not going how I think it should be and so therefore, I maybe act on it a bit over-cautiously because I know the distance we are (Grace, p. 99).

Midwives need to feel safe when practising in the small maternity units (or in a home) and to acknowledge the fact that a 'scare' or a fright will influence their practice. Past time travels forward with the midwife, and there are occasions when

cautious practice by the midwife means that she is ensuring safe practice in the light of 'past to present knowing'. Differences in the perception of space and distance are also apparent when providing intrapartum care in small units and in a large hospital.

The Difference in the Meaning of Space

According to Van Manen (1990), "In general we may say that we become the space that we are in" (p. 102). That is to say, space affects how one feels and how one behaves. With respect to this study, the space of the small maternity unit or alternatively of the large obstetric hospital might affect the practice of the midwife who is providing intrapartum care. The space of the small maternity unit is considered to be relaxed, and engenders feelings similar to attending a homebirth, while the space of the large obstetric hospital is busy and full of technology:

That's a huge shift [from practising in a small unit] to working in a big hospital where you've got machines and technicians and other medical personnel that might be, not actually interfering, well I guess it is interfering with that basic in-built knowledge that you've got (Grace, p. 70).

It's not like a hospital at the [small maternity unit]. On the whole, the staff that are there are pleased to see you, and I don't want to sound bad against [the large obstetric hospital], but it's a different mind game. They are so busy (Elizabeth, p. 79).

The participants' perception of space views the large hospital as an impersonal array of machines and technicians, while the space of the small unit has an ambience similar to a space where one meets friends. According to Bollnow (1960), "When I leave the protection of my house, I do not immediately step into a hostile world. I remain at first in a protective neighbourhood, an area of trusted relationships, of vocation, friendships etc" (p. 35). The small maternity units might engender feelings of trust and friendship where "the staff that are there are always pleased to see you" (Elizabeth, p. 79) and there is a feeling of a leisurely, relaxed pace (Joyce, p. 78).

The participants in this study feel comfortable within the space of the small maternity units, and this enables them to be flexible concerning time, to allow women to make noise during labour, to try different options for managing pain, and to practise more autonomously. In contrast, the space of the large hospital is a rushed, busy space where timeframes are imposed upon midwives and labouring women.

Another meaning of 'lived space' is the distance involved between places. In the context of this study this is inextricably intertwined with the notion of time, where the time available influences the feeling of distance. According to Bollnow (1960), "Distances within lived-space depend strongly on how a man [or woman] feels at the moment" (p.38). That is to say for example, if a midwife has plenty of time to transfer a woman from a small unit to the large hospital, the distance is probably not an issue. When difficulties arise such as an emergency situation that requires urgent assistance, the distance of the small maternity unit from the necessary services is exaggerated:

I phoned [the large obstetric hospital] ... and it wasn't very helpful ... And so at that point, it was very distressing and I felt like I might as well be in the desert as being in the satellite (Kirsty, p. 97).

And I got a ring early in the morning to say the glucose had been fine half an hour earlier, and then she'd gone back in with the mother and the baby had actually died ... There was absolutely nothing that we could've done, and I mean we found that out afterwards, but that didn't help at the time. ... But that's the first time I think, in all the years, ... that I actually felt that we were so far away (Grace, p. 99).

Kirsty and Grace's feelings reflect the aloneness, the isolation, the vulnerability and responsibility of being distant from back-up services when time is of the essence. The findings from this study indicate that independent midwives do experience a feeling of vulnerability within the space of the small maternity unit, an issue that could be explored further. It would be interesting to know if this is a

reason why some independent midwives choose not to provide intrapartum care outside of a large hospital setting.

Midwives might occasionally experience vulnerability when practising in small maternity units. However, they generally express their pleasure with practising in these settings. Another dimension of 'lived space' follows. Bollnow (1960) compared the motorised highway and a hiking path. The motorised highway is there only as a means of moving from one place to another. "It is therefore no place for loitering" (p. 36). The motorist moves through the highway without noticing the panorama of the surrounding countryside. In contrast the hiking path is altogether different. It curves and winds, while the highway is straight. Movement on this path is different, and the feeling of space is different. "The path does not shoot for a destination but rests in itself" (p. 36). The path is a restful path and invites loitering and a sense of freedom of space.

This analogy of space can be related to maternity facilities. The small maternity unit can be compared to the hiking path, where women in labour curve and wind their way toward the destination of birth. They might not take the straight route at one centimetre per hour that is pre-determined for women who labour at the large hospital. Within the small maternity unit, the labour is allowed to rest in itself, 'to be'. The midwives enjoy the sense of freedom. They are alert to the subtleties of the labour and are aware of their own senses. The sense of time is fluid in the small maternity unit. In contrast, midwives practising at the large hospital move at a different pace, as do vehicles on the highway. The large hospital is not a place for loitering, it 'shoots for a destination' and women are assisted to labour according to a timeframe.

The experience of being in a particular space is linked with time and the past experience of the midwife. When emergencies occur and during times when the midwife is fearful, she might wish she were in a space that had specialist assistance available. However, the findings from this study suggest that a strong belief in natural childbirth and the need to have freedom of practice encourages midwives to use the small maternity units. The experience of 'lived space' is also related to the 'lived other'.

Relating to the 'Other' or 'They'

As stated previously in chapter five, who the 'other' is perceived to be is not the issue. Heidegger (1927/1962) said the world that we share is always shared with others. In the world, we sometimes refer to 'they' who judge, and 'they' who affect I. Heidegger noted, "The 'they' can, as it were, manage to have 'them' constantly invoking it" (p. 128). Perhaps, 'they' instigate protocols at the large hospital, and the independent midwives, in general follow these protocols, because that is what 'they' expect.

The findings from this study suggest that midwives practising in small maternity units are subjected to judgement from others, through the very nature of practising outside the dominant setting. The literature review in chapter two provides an historical overview of the factors that shaped maternity care and the influences concerning place of birth. Some practitioners favour the medical model viewpoint that deems a high technology setting as the most appropriate place for birth. Midwives practising in small maternity units seem to worry about the judgement that might be meted out to them by 'others':

She said, "I don't want to be induced up there". So I said, "Well I can break the waters with a sharp fingernail and hope you come into labour, and then I'll have to take the responsibility that, if you don't come into labour, we're inducing anyway". ... I don't know how I would've explained myself if things had not gone to plan, (Anon, p. 106).

You're having to cover your back to justify why you've moved and why you haven't moved ... Like it's only on reflection now that it does have an effect on your judgement of when you're going and when you're not going to [the large obstetric hospital] (Bronnie, pp. 114-115).

The independent midwives practising in the small maternity units are perhaps in a difficult situation when trying to meet the wishes of their clients and at the same time being seen to be safe by 'them' at the large obstetric hospital. Page (1995b) commented that when the woman and her family are taken into account, decisions fall into shades of grey rather than black and white. Fleming (1995), an

experienced practitioner and scholar said, “By grounding their practice in the needs of their client, midwives sometimes feel that the distribution of power which they would expect to be equitable tilts away from this to almost untenable situations” (p. 148). Fleming provided examples of midwives acting for their clients, where the outcome was satisfactory for the woman and baby, yet lacking satisfaction for the midwife. The example of which is above, verifies an occasion when although the outcome was satisfactory, the midwife reflected that she might not repeat that scenario, indicating the responsibility and burdensome worry of ‘carrying the can’ for one’s decisions.

The midwives practising in the small maternity units indicated that they do ask some or all of the following questions at some time in relation to ‘them’:

Should this woman be labouring in the small maternity unit? (Kirsy, pp.117-118).

How do I explain that this woman will not go to the large obstetric hospital? (Anon, p. 106; Nettie, p. 118).

Who is on duty at the large hospital and what will ‘they’ say about this transfer? (Bronnie, pp. 114-115).

Why don’t ‘they’ show some understanding of practising in the small unit? (Tyrrell, p. 116; Nettie, p. 115).

On the contrary, the participating midwives did experience support as opposed to judgement from some colleagues at the large obstetric hospital. An example of this appreciation follows:

... we knew this woman wasn’t going to [the large obstetric hospital]. ... We knew that the reality was, she was going to end up on our doorstep with us having to cope with it. So I just quickly rang [the consultant]. I said, “This is the situation, she’s got a haemoglobin of 83 a week ago ... [The consultant] said, “Good luck!” ... those two words “Good luck” was like [the consultant] knows about us. We’ve got that support there if we need it. We’re doing the best that we can in the situation we’ve found ourselves in, but no judging (Nettie, p. 118).

Conclusion: The Paradoxes

Letting birth 'be', appears to be the ideal from the point of view of the midwife participants. The midwives enjoy the freedom of being able to practise 'real midwifery' without using technology and anything that may interfere with the woman's labour. On the other hand, the notion of 'carrying the can' means that the midwife in the small unit is solely responsible. She is 'it', and indeed 'the buck stops with her'. Walsh (2000a) recognised that midwives practising in freestanding birth centres have greater autonomy and clinical freedom, but consequently have greater accountability. The midwife participants in this present study acknowledge that they are fully accountable for whatever the outcome might be.

Walsh (2000a) also recognised the need for birthing units to be physically separate facilities, away from the powerful culture of obstetrics, in order for a different philosophy to be put into practice. Pairman (1998b) in her qualitative study, advised midwives to nurture the normal process, whilst at the same time remaining open to recognising when progress is not normal and when intervention is necessary. If midwives do not practise in low technology settings, such as homebirth and small maternity units, will they lose the art of practising normal midwifery? Hunt and Symonds (1995) indicated that the status of midwives increased with interventionist techniques acquired in large hospitals, but on the other hand the craft-skill base of midwifery has altered. They ponder whether traditional midwifery has become "as obsolete as hand-loom weaving or hot-metal print setting" (p. 142). The findings from this present study suggest that large obstetric hospitals do not foster the art of midwifery and the freedom to let labour 'be'.

The paradox of having the freedom to practise in the small unit is that when problems manifest themselves, this very freedom can become a burden, a responsibility of having to cope without specialist assistance on site. However, according to Goer (1995):

Few obstetric problems are situations in which time is of the essence.

Those that are, such as postpartum haemorrhage or a baby that fails to

breathe, are correctable or at least stabilized with low-tech equipment or medications available in birth centres (p. 320).

Goer (1995) notes astutely that in most situations, the woman and/or baby can be stabilised and transferred if necessary. However, she admits that time is of the essence for events such as a postpartum haemorrhage and neonatal resuscitation. Midwives accept the vulnerability of being perhaps one or three hours away from the large obstetric hospital. Small maternity units are a place where midwives feel safe to let birth 'be', but paradoxically they may not be safe when things go wrong. When the midwife practises in a low technology, relaxed environment, paradoxically, she also maintains a subconscious heightened alertness, a foresight, and a sense of confidence to manage any problems. Her 'being-there' is different in a small maternity unit as compared with a large obstetric hospital, as her sense of space and time is different.

Independent midwives and hospital-employed midwives frequently manage high-risk women in the setting of the large obstetric hospital. Yet, these midwives are less likely to experience the aloneness when there is no help at hand. Emergencies are expected in a high-tech environment and the midwife does not have to factor in the time of transfer. If an emergency arises at the large hospital, the midwife is already in the right place. The medical culture considers the large hospital, as the safest place for midwives to provide intrapartum care, hence there is less tension associated with the choice of setting if emergencies occur.

There is also a paradox concerning the 'being' of the midwife, her lived self. Midwives are allegedly the guardians of normal childbirth yet paradoxically, midwives are often required to use multiple means of technology. The findings from this present study show that using technology takes away the use of self. Beech (1999) reminded readers of an Australian midwife who committed suicide allegedly because of the tension of trying to provide real midwifery care in a hostile technological environment. This tragedy is a salutary reminder of the pressure a midwife might endure to conform to a culture of medicalised childbirth. Sandelowski (2000) suggested that the challenge facing the late-twentieth century nurse [midwife] is to try to find the balance between high-

technology surveillance and high-touch care. The practitioner of high-touch care uses other means to assess women instead of providing fetocentric care, where the technology is often directed toward showing something about the fetus, which might however distract attention from the woman who is birthing the baby.

Limitations Of This Study

This study has been a small qualitative study that has been undertaken within the greater Auckland area. It is acknowledged that the findings might not be the same for midwives practising in small maternity units and large obstetric hospitals in other parts of New Zealand. The large hospitals in Auckland are 'tertiary hospitals' meaning perhaps that the culture is more medical than in other large obstetric hospitals.

The participants who self-selected are independent midwives who use both small and large hospitals for providing intrapartum care. Those who consented to being interviewed might have a persuasion toward favouring small maternity units. In addition, the midwives who agreed to participate are likely to be confident and comfortable with providing intrapartum care in both settings, otherwise it is unlikely that they would have volunteered to be interviewed.

The independent midwives were interviewed over a period of time from 1999-2000, and the findings might be influenced by factors affecting independent midwifery practice at that time. In keeping with Van Manen's (1990) research method, I interviewed participants by listening to narratives and prompting during silences, as opposed to asking critical questions. It is possible that differentiating between caring for women with risk factors and those without, and who has the role of Lead Maternity Carer, might explain some differences in practice in the different settings. However, examples were given where participants referred to pressure to intervene in situations where low-risk women were labouring in the large hospital.

Implications From This Study

This research has used Van Manen's (1990) approach to thematic analysis to uncover the meaning of the narratives of the participating midwives. The conclusion of the study provides an opportunity to make suggestions from these findings in terms of the implications for practice, education and future research.

Implications for Practice

Findings from this study indicate that midwives providing intrapartum care in small maternity units require additional skills such as:

- Being confident to provide intrapartum care in a low technology setting
- Being comfortable to use embodied knowledge and skills to assess a woman and her baby as opposed to using technology
- Being able to let labour 'be' and not interfere unnecessarily
- Being confident to avert or manage problems that might arise
- Being willing to employ other options to manage pain without access to epidurals
- Being solely responsible for outcomes without access to on site specialist assistance
- Being confident to trust the process of labour and be flexible with respect to time
- Being a midwife who enjoys practising what the participants call 'real midwifery'.

Findings also suggest that there could be an improvement in the relationships between those who work at the large hospital and the independent midwives who practise in small maternity units. If independent midwives were to receive encouragement and support when liaising with staff at the large hospital, perhaps a greater number of midwives would use small maternity units as a venue for intrapartum midwifery care. Midwives in this study want to be able to practise autonomously and to practise unshackled by technology. Perhaps it is timely to examine the culture of the large hospital and whether or not this culture fosters clinical freedom for independent practitioners.

Implications for Education

The findings of this study raise a number of issues for midwifery education pre and post registration. Student midwives could benefit from practice experience with independent midwives who provide intrapartum care in small maternity units. As the number of women experiencing homebirth is limited, and student midwives might not be invited to attend a woman's homebirth, experience in a small maternity unit does provide an opportunity for learning away from a medicalised culture that dominates a large obstetric hospital. The exposure to 'real midwifery' is too valuable an experience for fledgling midwives to be excluded from.

Perhaps some independent midwives need support and encouragement to use small maternity units for intrapartum care. Some midwives might need to update their skills concerning management of emergencies without specialist assistance. Undergraduate and postgraduate midwives need to be familiar with research that shows that birth is safe in small maternity units and that timeframes imposed upon labouring women are not justified.

Hospital-employed midwives might benefit from rotation between small and large hospitals. This could be an educational experience in learning normal midwifery practice at the small units, and acquiring technological expertise at the large obstetric hospital. If all midwives regularly practised in different settings, understanding about the meaning of practice in different contexts could be enhanced.

Implications for future Research

This study has raised many issues as I have reflected on what I have learnt and what I have discussed with colleagues. A question that has been put to me is the concern, as with any research study, that the findings might be peculiar to the context in which the study was undertaken. Further research related to the context of practice, and how this influences midwifery practice would be valuable. The issue of intrapartum transfer is worthy of further research in order to increase understanding of the experience for all involved. It would also be interesting to research the philosophies of midwives, and the relationship, if any, with the places

where they feel comfortable practising. In addition, further research could address issues of vulnerability when practising outside the dominant setting of large hospitals.

This study has focussed on the experience of independent midwives and I did not interview midwives who were employed by the hospital services. It would be intriguing to research the perceptions of hospital-employed midwives concerning practice in different settings. It would also be interesting to know why some independent midwives do not use small maternity units for intrapartum care, and to explore further the notions of tolerating noise, managing pain in different contexts, and making difficult decisions. As indicated in the limitations of the present study, a New Zealand study addressing the intrapartum care of women without any risk factors in large obstetric hospitals might provide valuable information concerning models of care.

Concluding Statement

The research question for this study was: How is the provision of intrapartum care by independent midwives different in a small maternity unit as compared with a large obstetric hospital?

The aims of this study were:

- To describe the experience of independent midwives providing intrapartum care in both a small maternity unit and a large obstetric hospital.
- To highlight the differences in providing labour care in different settings.
- To identify issues that influence independent midwives' choice of environment for provision of intrapartum care.

The research question and the aims of the study have been addressed.

It is valuable to capture the experience of independent midwives practising in the New Zealand context, in order for midwives to understand the experiences of each

other, and to have an historical record of practice during changing times. This study has focussed on the differences between independent midwives providing intrapartum care in small maternity units as compared with a large obstetric hospital. The findings from this study provide some insights into these differences and in particular to the notions of clinical freedom, practising more autonomously in small maternity units, and accepting that this autonomy entails the notion of 'carrying the can' or being more responsible for one's practice.

The assumption that the context influences practice is supported by the findings from this study, and such findings are of concern for the future of midwifery. If births continue to occur in large obstetric hospitals with technological interventions, some midwives will become increasingly removed from the art of 'real midwifery' where there is a belief in natural childbirth and where midwives feel affirmed practising normal, low intervention midwifery. The traditional art of midwifery might become as obsolete as handloom weaving. It would be encouraging to see independent midwives and women using small maternity units as a place for labour and birth as well as during the early postpartum period. If birth numbers continue to decline in small maternity units, there are likely to be further closures as has happened in the past.

While independent midwifery practice is relatively new within the New Zealand context, midwives have the autonomy and the opportunity to provide care in a variety of settings. Small maternity units should be an option for rural and urban women in this country, and be recognised as venues that foster 'real midwifery' practice.

References

- Abel, S., & Kearns, R.A. (1991). Birth places: A geographical perspective on planned home birth in New Zealand. Social Science Medicine, 33 (7), 825-834.
- Annandale, E.C. (1988). How midwives accomplish natural birth: Managing risk and balancing expectations. Social Problems, 35 (2), 95-110.
- Annells, M. (1996). Hermeneutic phenomenology: Philosophical perspectives and current use in nursing research. Journal of Advanced Nursing, 23, 705-713.
- Ashford, J. R. (1978). Policies for maternity care in England and Wales: Too fast and too far? In S.Kitzinger & J. Davis (Eds.). The place of birth (pp. 14-43). Oxford: Oxford University Press.
- Axe, S. (2000). Labour debriefing is crucial for good psychological care. British Journal of Midwifery, 8 (10), 626-631.
- Baker, C., Wuest, J., & Stern, P. (1992). Method slurring: The grounded theory/phenomenological example. Journal of Advanced Nursing, 17, 1355-1360.
- Beech, B. (1999). The safety of hospital birth: The myth versus the reality. Aims Journal, 11 (4), 1-3.
- Benn, C. (1999). Midwifery partnership: Individualism, contractualism or feminist praxis? New Zealand College of Midwives Journal, 21, 18-20.
- Benner, P., & Wrubel, J. (1989). The primacy of caring: Stress and coping in health and illness. California: Addison-Wesley Publishing Co.
- Bennetts, A.B., & Lubic, R. (1982). The free-standing birth centre. The Lancet, 378-380.

- Berg, M., Lundgren, I., Hermansson, E., & Wahlberg, V. (1996). Women's experience of the encounter with the midwife during childbirth. Midwifery, 12 (1), 11-15
- Black, J. (2000). Neonatal Resuscitation. Proceedings of the 6th New Zealand College of Midwives Conference, Cambridge, New Zealand: New Zealand College of Midwives.
- Bluff, R., & Holloway, I. (1994). 'They know best': Women's perceptions of midwifery care during labour and childbirth. Midwifery, 10 (3), 157-164.
- Bollnow, O. Lived-Space. (1960). Philosophy Today, 5, 31-39.
- Bonham, D. (1982). Whither obstetrics. Unpublished document, Postgraduate School of Obstetrics and Gynaecology, University of Auckland, New Zealand.
- Bryar, R. (1995). Theory for midwifery practice. London: Macmillan Press Ltd.
- Buus-Frank, M. (1999). Nurse versus machine: slaves or masters of technology? Journal of Obstetric Gynecologic and Neonatal Nursing, 28 (4), 433-441.
- Butler, C. (1994). Hospital midwifery-where to now? New Zealand Health and Hospital, 46 (2), 7-8.
- Callaghan, H. (1996). 'Hands on' and 'hands off': Two models of midwifery care. In L. Barclay and L. Jones (Eds.), Midwifery: trends in clinical practice (pp. 53-68). Melbourne: Pearson Professional Pty Ltd.
- Campbell, R. (1997). Place of birth reconsidered. In J. Alexander, V. Levy & C Roth. (Eds.), Midwifery practice: core topics 2. London: Macmillan Press Ltd.
- Campbell, R., Macfarlane, A., Hemsall, V., & Hatchard, K. (1999). Evaluation of midwife-led care provided at the Royal Bournemouth hospital. Midwifery, 15, 183-193.
- Carter, L. (1994). Taking over. Nursing Times, 90 (12), 34-36.

- Cioffi, J. (1998). Education for clinical decision making in midwifery practice. Midwifery, 14 (1), 18-22.
- Coney, S. (1988). The unfortunate experiment. Auckland, New Zealand: Penguin Books.
- Creasy, J.M. (1997). Women's experience of transfer from community based to consultant-based maternity care. Midwifery, 13 (1), 32-39.
- Crotty, M. (1996). Phenomenology and nursing research. Melbourne: Churchill Livingstone.
- Crotty, M. (1998). The foundations of social research: Meaning and perspective in the research process. Sydney: Allen & Unwin.
- Curtin, S.C. (1999). Recent changes in birth attendant, place of birth and the use of obstetric interventions, United States, 1989-1997. Journal of Nurse-Midwifery, 44 (4), 349-354.
- Daly-Peoples, L. (1977). The politics of childbirth. Broadsheet, 49, 24-25.
- Davis, L. (1994). Midwifery challenge to medical paradigm in maternity services. British Journal of Midwifery, 2 (12), 581-586.
- Davis-Floyd, R. (1992). Birth as an American rite of passage. California: University of California Press.
- Department of Health (1990). Nurses Amendment Act: Information for health providers. Wellington, New Zealand: Department of Health.
- Donley, J. (1986). Save the Midwife. Auckland, New Zealand: New Women's Press Ltd.
- Donley, J. (1989). Professionalism: The importance of consumer control over childbirth. New Zealand College of Midwives Journal, 6-7.
- Donley, J. (1990). Autonomy for midwives. New Zealand College of Midwives Journal, 3, 7.

- Donley, J. (1995). Independent midwifery in New Zealand. In T. Murphy-Black (Ed.), Issues in Midwifery (pp. 63-80). Edinburgh: Churchill Livingstone.
- Duff, M. (1998). Labour behaviours: A journey in assessing labour progress. Proceedings of the 5th New Zealand College of Midwives Conference, Auckland, New Zealand: New Zealand College of Midwives.
- Edwards, J., & Bess, M. (1998). Developing effectiveness in the therapeutic use of self. Clinical Social Work Journal, 26 (1), 89-105.
- Elliott, H. (1997). Holistic nursing and the therapeutic use of self. Complementary Therapies in Nursing and Midwifery, 3 (3), 81-82.
- Enkin, M., Keirse, M., Neilson, J., Crowther, C., Duley, L., Hodnett, E., & Hofmeyr, J. (2000). A guide to effective care in pregnancy and childbirth (3rd ed.). New York: Oxford University Press.
- Feldman, E., & Hurst, M. (1987). Outcomes and procedures in low risk birth: A comparison of hospital and birth centre settings. Birth, 14 (1), 18-24.
- Fleming, V.E.M. (1995). Partnership, power and politics: Feminist perceptions of midwifery practice. Doctoral Thesis, Palmerston North: Massey University.
- Fleming, V.E.M. (1996). Midwifery in New Zealand: Responding to changing times. Healthcare for Women International, 17 (4), 343-359.
- Fleming, V.E.M. (1998a). Autonomous or automatons? An exploration through history of the concept of autonomy in midwifery in Scotland and New Zealand. Nursing Ethics, 5 (1), 43-51.
- Fleming, V.E.M. (1998b). Women and midwives in partnership: a problematic relationship? Journal of Advanced Nursing, 27, 8-14.
- Flint, C., Poulengeris, P., & Grant, A. (1989). The 'know your midwife' scheme: A randomised trial of continuity of care by a team of midwives. Midwifery, 5, 11-16.

- Fox, B., & Worts, D. (1999). Revisiting the critique of medicalized childbirth: A contribution to the sociology of birth. Gender & Society, 13 (3), 326-346.
- Friedman, E. (1954). The graphic analysis of labor. American Journal of Obstetrics and Gynecology, 68, 1568-1575.
- Fullerton, J.T., Hollenbach, K.A., & Wingard, D.L. (1996). Practice styles: A comparison of obstetricians and nurse-midwives. Journal of Nurse-Midwifery, 41 (3), 243-250.
- Gagnon, G., & Waghorn, K. (1996). Supportive care by maternity nurses: A work sampling study in an intrapartum unit. Birth, 23 (1), 1-6
- Garcia, J., & Garforth, S. (1989). Labour and delivery routines in English consultant maternity units. Midwifery, 5 (4), 155-162.
- Goer, H. (1995). Obstetric myths versus research realities: A guide to the medical literature. Connecticut: Bergin & Garvey.
- Gould, D. (2000). Normal labour: A concept analysis. Journal of Advanced Nursing, 31 (2), 418-427.
- Graham, W. (1997). Midwife-led care. British Journal of Obstetrics & Gynaecology, 104 (4), 396-398.
- Grant, L., & Devlin, G. (1999). In other words: A dictionary of expressions used in New Zealand. Palmerston North, New Zealand: The Dunmore Press Ltd.
- Griffith, P. (1996). The culture of midwifery practice: Does it have a relationship to birth environment? And what are the implications for midwifery. Paper presented at the International Confederation of Midwives, Oslo, Norway.
- Guignon, C. (Ed.) (1997). The Cambridge companion to Heidegger. Cambridge: Cambridge University Press.
- Guilliland, K., & Pairman, S. (1994). The midwifery partnership: A model for practice. New Zealand College of Midwives, 11, 5-9.

- Gulbransen, G., Hilton, J., McKay, L., & Cox, A. (1997). Home birth in New Zealand 1973-93: Incidence and mortality. New Zealand Medical Journal, 87-89.
- Health Funding Authority. (1999). New Zealand mothers and babies: An analysis of national maternity data. Wellington, New Zealand: Government Printing Office.
- Hedwig, J., & Fleming, V. (1995). Midwifery practice in New Zealand: A dynamic discipline. In T. Murphy-Black (Ed.), Issues in Midwifery (pp. 207-220). Edinburgh: Churchill Livingstone.
- Heidegger, M. (1927/1962). Being and Time (J. McQuarrie & E. Robinson, Trans.). Oxford: Basil Blackwell.
- Hendry, C. (1995). Burwood continuity of midwifery scheme. New Zealand College of Midwives Journal, 13, 14-16.
- Hendry, C. (1996). Continuity of midwifery care. Primary Healthcare New Zealand, 43-44.
- Hewison, A. (1993). The language of labour: An examination of the discourses of childbirth. Midwifery, 9, 225-234.
- Hodnett, E. (1996). Nursing support of the labouring woman. Journal of Obstetric Gynecologic and Neonatal Nursing, 25 (3), 257-264.
- Hotchin, C. (1996). Midwives use of unorthodox therapies: A feminist perspective. Master of Arts Thesis, Palmerston North, New Zealand: Massey University.
- Hundley, V.A., Cruickshank, F.M., Lang, G.D., Glazener, C.M.A., Milne, J.M., Turner, M., Blyth, D., Mollison, J., & Donaldson, C. (1994). Midwife managed delivery unit: A randomised controlled comparison with consultant led care. The British Medical Journal, 309, 1400-1404. Retrieved December 9, 2000 from Ovid database on the World Wide Web: <http://gateway.ovid.com>

- Hunt, S., & Symonds, A. (1995). The social meaning of midwifery. London: Macmillan Press Ltd.
- Huntingford, P. (1978). Obstetric practice: Past present and future. In S.Kitzinger & J. Davis (Eds.). The place of birth. (pp. 229-250). Oxford: Oxford University Press.
- Jabaaij, L., & Meijer, W. (1996). Home births in the Netherlands: Midwifery-related factors of influence. Midwifery, 12 (3), 129-135.
- Jowitt, D. (2000). The paradox of pain relief: Discourses around childbirth in New Zealand over the last century. Proceedings of the 6th New Zealand College of Midwives Conference, Cambridge, New Zealand: New Zealand College of Midwives.
- Kaczorowski, J., Levitt, C., Hanvey, L., Avar, D., & Chance, G. (1998). A national survey of use of obstetric procedures and technologies in Canadian hospitals: Routine or based on existing evidence? Birth, 25 (1), 11-18.
- Kaelin, E. (1989). Heidegger's Being and Time: A reading for readers. Florida: The Florida State University Press.
- Katz Rothman, B. (1983). Midwives in transition: The structure of a clinical revolution. Social Problems, 30 (3), 262-271.
- Katz Rothman, B. (1991). In labour: Women and power in the birthplace. New York: W.W. Norton & Company.
- Katz Rothman, B. (1996). Women, providers, and control. Journal of Obstetric Gynecologic and Neonatal Nursing, 25 (3), 253-256.
- Kirkham, M. (1997). Stories and childbirth. In E. Perkins (Ed.), Reflections on Midwifery (pp.183-204). London: Bailliere Tindall.
- Kirkham, M. (2000). How can we relate? In M. Kirkham (Ed.), The midwife-mother relationship. (pp. 227-254). London: Macmillan Press Ltd.

- Knox, A.J., Sadler, L., Pattison, N.S., Mantell, C.D., & Mullins, P. (1993). An obstetric scoring system: Its development and application in obstetric management. American Journal of Obstetrics & Gynecology, 81 (2), 195-199.
- Koch, T. (1994). Establishing rigour in qualitative research: The decision trail. Journal of Advanced Nursing, 19, 976-986.
- Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. Journal of Advanced Nursing, 21, 827-836.
- Koch, T., & Harrington, A. (1998). Reconceptualizing rigour: The case for reflexivity. Journal of Advanced Nursing, 28 (4), 882-890.
- Kohl, H. (1965). The age of complexity. New York: Mentor Books.
- Larkin, J. (1985). Reprieve for small maternity units. Broadsheet, 130, 6.
- Lawton, R., & Parker, D. (1999). Procedures and the professional: The case of the British NHS. Social Science and Medicine, 48 (3), 353-361.
- Lavender, T., & Malcolmson, L. (1999). Is the partogram a help or a hindrance? The Practising Midwife, 2 (8), 23-27.
- Lazarus, E. (1997). What do women want? Issues of choice, control, and class in American pregnancy and childbirth. In R. Davis-Floyd & C. Sargent (Eds.), Childbirth and Authoritative Knowledge. Los Angeles: University of California Press.
- Leap, N. (2000). The less we do, the more we give. In M. Kirkham (Ed.), The midwife-mother relationship (pp. 1-18). London: Macmillan Press Ltd.
- Leap, N., & Hunter, B. (1993). The midwife's tale. London: Scarlet Press.
- Legat, N. (1997, May). Difficult birth: The end of the family doctor delivering babies? North and South, 74-87.
- Leonard, V. (1989). A Heideggerian phenomenological perspective on the concept of person. Advances in Nursing Science, 40-55.

- Levy, V. (1999). Protective steering: A grounded theory study of the processes by which midwives facilitate informed decisions during pregnancy. Journal of Advanced Nursing, 29 (1), 104-112.
- LoBiondo-Wood, G., & Haber, J. (1998). Nursing Research (4th ed.). St. Louis: Mosby.
- LoCicero, A.K. (1993). Explaining excessive rates of caesareans and other childbirth interventions: Contributions from contemporary theories of gender and psychosocial development. Social Science and Medicine, 37, 1261-1269.
- Lofland, J. & Lofland, L. (1995). Analyzing social settings: A guide to qualitative observation and analysis (3rd ed.). California: Wadsworth.
- Longman Idioms Dictionary (1998). Edinburgh: Addison Wesley Longman Ltd.
- Machin, D., & Scamell, M. (1997). The experience of labour: Using ethnography to explore the irresistible nature of the bio-medical metaphor during labour. Midwifery, 13, 78-84.
- Mackin, P., & Sinclair, M. (1998). Labour ward midwives' perceptions of stress. Journal of Advanced Nursing, 27, 986-991.
- Maternity Services Committee (1976). Maternity services in New Zealand including summary and recommendations. (Board of Health publication No.26). Wellington, New Zealand: Government Printers.
- McKay, S. & Roberts, J. (1990). Obstetrics by ear. Journal of Nurse-Midwifery, 35 (5), 266-273.
- McLoughlin, D. (1993, August). The politics of childbirth: Midwives versus doctors. North and South, 54-68.
- Mein Smith, P. (1986). Maternity in dispute. Wellington, New Zealand: Government Printer, Wellington.

- Mikaere, A. (2000). Mai te Kore ki te Ao Marama: Maori Women as Whare Tangata. Proceedings of the 6th New Zealand College of Midwives Conference, Cambridge, New Zealand: New Zealand College of Midwives.
- Moloney, J. (1992). Midwifery Practice: Unfettered or Shackled? Master of Arts in Nursing Thesis, Massey University, Palmerston North, New Zealand.
- Morrison, I., Carter, L., McNamara, S., & Cheang, M. (1980). A simplified intrapartum numerical scoring system: The prediction of high risk in labour. American Journal of Obstetrics & Gynecology, 138 (2), 175-180.
- Murray, G. (1995). A Midwife: The definitions. New Zealand College of Midwives Journal, 12, 23-26.
- New Zealand College of Midwives (NZCoM). (1993). Midwives handbook for practice. Dunedin, New Zealand: Author.
- New Zealand Government. (1990). Nurses Amendment Act. Wellington, New Zealand: Government Printer.
- New Zealand Government. (1993). The Privacy Act. Wellington, New Zealand: Government Printer.
- O'Connor, T. (1994). Guiding Midwives. New Zealand Nursing Journal, 2 (2), 12-14.
- O'Driscoll, K., & Meagher, D. (1986). Active management of labour (2nd ed.). London: Balliere Tindall.
- O'Leary, L., & Bilton, T. (1993). Women offered choices. Nursing New Zealand, 1(1), 20-22.
- Oakley, D., Murtland, T., Mayes, F., Hayashi, R., Petersen, B.A., Rorie, C., & Andersen, F. (1995). Processes of care: Comparisons of certified nurse-midwives and obstetricians. Journal of Nurse-Midwifery, 40 (5), 399-409.
- Ogden, J., Shaw, A., & Zander, L. (1998). Women's experience of having a hospital birth. British Journal of Midwifery, 6 (5), 339-345.

- Page, L. (1995a). Change and power in midwifery. Birth, 22 (4), 227-231.
- Page, L. (1995b). Putting principles into practice. In L. Page (Ed.) Effective Group practice in midwifery: Working with women. (pp. 12-31) Oxford: Blackwell Science Ltd.
- Page, L. (Ed.). (2000). The new midwifery: Science and sensitivity in practice. Edinburgh: Churchill Livingstone.
- Pairman, S. (1998a). Developing and crafting a vision: A strategic plan for midwifery. New Zealand College of Midwives Journal, 18, 5-9.
- Pairman, S. (1998b). The midwifery partnership: An exploration of the midwife/woman relationship. Master of Arts in Midwifery Thesis, Victoria University, Wellington.
- Pairman, S. (1998c). Women-centred midwifery: Partnerships or professional friendships? New Zealand College of Midwives, 19, 5-10.
- Papps, E., & Olssen, D. (1997). Doctoring childbirth and regulating midwifery in New Zealand. Palmerston North, New Zealand: The Dunmore Press.
- Partridge, E. (1963). A dictionary of slang and unconventional English (5th ed.). London: Routledge & Kegan Paul Ltd.
- Patterson, J. (2000). Rural midwifery: Challenges of the last decade and where to from here? Proceedings of the 6th New Zealand College of Midwives Conference, Cambridge, New Zealand: New Zealand College of Midwives.
- Pearse, J. (1998). Informed consent - Issues for midwives. Proceedings of the 5th New Zealand College of Midwives conference, Auckland, New Zealand: New Zealand College of Midwives.
- Pelvin, B. (1996). On the edge: Midwifery and the art of knowing. New Zealand College of Midwives Journal, 15, 14-15.
- Proctor, S. (1998). What determines quality in maternity care? Comparing the perceptions of childbearing women and midwives. Birth, 25 (2), 85-93.

- Rama, J., & Taiatini, J. (1993). Maori women midwives form Putea O Pua. Te Maori News, 2 (21), 23.
- Real, T. (1990). The therapeutic use of self in constructionist/systemic theory. Family Process, 3, 255-272.
- Reiger, K. (1999). Birthing in the postmodern moment: Struggles over defining maternity care needs. Australian Feminist Studies, 14 (30), 387-403.
- Rimene, C., Hassan, C., & Broughton, J. (1999). Ukaipo: The place of nurturing Maori women and childbirth. Dunedin, New Zealand: University of Otago.
- Robertson, S. (1999). Listening to them and reading me: A hermeneutic approach to understanding the experience of illness. Journal of Advanced Nursing, 29 (2), 290-297.
- Rooks, J.P. (1999a). Evidence-based practice and its application to childbirth for low-risk women. Journal of Nurse-Midwifery, 44 (4), 355-369.
- Rooks, J.P. (1999b). The midwifery model of care. Journal of Nurse-Midwifery, 44 (4), 370-374.
- Rooks, J.P., Weatherby, N.L., & Ernst, E.K.M. (1992). The national birth center study: Part II - intrapartum and immediate postpartum and neonatal care. Journal of Nurse-Midwifery, 37 (5), 301-330.
- Rooks, J.P., Weatherby, N.L., Ernst, E.K.M., Stapleton, S., Rosen, D., & Rosenfield, A. (1989). Outcomes of care in birth centres: The national birth centre study. The New England Journal of Medicine, 321 (26), 1804-1811.
- Rosenblatt, R.A., Reinkin, J., & Shoemack, P. (1984). Regionalisation of obstetric and perinatal care in New Zealand: A health services analysis. Unpublished report for the New Zealand government.
- Rosenblatt, R.A., Reinkin, J., & Shoemack, P. (1985). Is obstetrics safe in small hospitals? Evidence from New Zealand's regionalised perinatal system. The Lancet, 429-431.

- Rosser, J., & Anderson, T. (1998). Normal birth-going...going... The Practising Midwife, 1 (4), 4-5.
- Rountree, K., & Laing, T. (1996). Writing by degrees. Auckland, New Zealand: Addison Wesley Longman New Zealand Ltd.
- Rowley, M.J., Hensley, M.J., Brinsmead, M.W., & Wlodarczyk, J.H. (1995). Continuity of care by a midwife team versus routine care during pregnancy and birth: A randomised trial. The Medical Journal of Australia, 163, 289-293.
- Sakala, C. (1988). Content of care by independent midwives: Assistance with pain in labour and birth. Social Science Medicine, 26 (11), 1141-1158.
- Sakala, C. (1993). Midwifery care and out-of-hospital birth settings: How do they reduce unnecessary caesarean section births? Social Science Medicine, 37 (10), 1233-1250.
- Sandelowski, M. (1995). Qualitative analysis: What it is and how to begin. Research in nursing and health, 18, 371-375.
- Sandelowski, M. (2000). 'This most dangerous instrument': Propriety, power, and the vaginal speculum. Journal of Obstetric Gynecologic and Neonatal Nursing, 29 (1), 73-82.
- Sangala, V., Dunster, G., Bohin, S., & Osborne, J.P. (1990). Perinatal mortality rates in isolated general practitioner maternity units. British Medical Journal, 301, 418-420.
- Siddiqui, J. (1999). The therapeutic relationship in midwifery. British Journal of Midwifery, 7 (2), 111-114.
- Simkin, P. (1995). Reducing pain and enhancing progress in labour: A guide to non-pharmacologic methods for maternity caregivers. Birth, 22 (3), 161-171.
- Skinner, J. (1999). Midwifery partnership: Individualism, contractualism, or feminist praxis. New Zealand College of Midwives Journal, 21, 14-17.

- Smith, L. (1998). Referral of labouring women from community to consultant unit. British Journal of Midwifery, 6 (1), 47-52.
- Smith, L.F.P., & Jewell, D. (1991). Contribution of general practitioners to hospital intrapartum care in maternity units in England and Wales in 1988. British Medical Journal, 302, 13-16.
- Smythe, E. (1997). Phenomenology: A research approach for midwifery. New Zealand College of Midwives Journal, 16, 16-19.
- Smythe, E. (1998). 'Being safe' in childbirth: A hermeneutic interpretation of the narratives of women and practitioners. Doctoral Thesis, Massey University, New Zealand.
- Smythe, L. (2000). 'Being safe' in childbirth: What does it mean? New Zealand College of Midwives Journal, 22, 18-21.
- Steele, R. (1995). Midwifery care in the first stage of labour. In J. Alexander, V. Levy & S. Roch (Eds.), Aspects of midwifery practice: A research-based approach. (pp. 24-47). London: Macmillan Press Ltd.
- Stewart, S.M. (1999). Midwifery standards review in New Zealand: A personal view. British Journal of Midwifery, 7 (8), 511-514.
- Stone, P., & Knight, D. (Eds.). (1999). National Women's Hospital Annual Clinical Report. Auckland, New Zealand: University of Auckland.
- Stuart, C. (2000). Invasive actions in labour: Where have the 'old tricks' gone? The Practising Midwife, 3 (8) 30-33.
- Stuart, J. (1994, June 8). Effective obstetric care: Myth and reality. GP Weekly, p. 13.
- Sutton, H. (1996). Childbearing and the ethics of technology: A feminist approach. In L. Barclay and L. Jones (Eds.), Midwifery: trends and practices in Australia (pp. 35-52). Melbourne: Pearson Professional Pty Ltd.

- Sweet, B., & Tiran, D. (Eds.) (1997). Mayes' midwifery (12th ed.). London: Balliere Tindall.
- Symon, A. (1998). Litigation: The views of midwives and obstetricians. Hale, England: Hochland & Hochland.
- Taylor, G.W., Edgar, W., Taylor, B.A., & Neal, D.G. (1980). How safe is general practitioner obstetrics? The Lancet, 1287-1289.
- Tew, M. (1985). We have the technology. Nursing Times, 20, 22-24.
- Tew, M. (1986). Do obstetric intranatal interventions make birth safer? British Journal of Obstetrics and Gynaecology, 93, 659-674.
- Tew, M. (1990). Safer childbirth: A critical history of maternity care. London: Chapman & Hall.
- Timutimu, W.M. (1992). Te Awhi Whaanautanga. New Zealand College of Midwives Journal, 7, 24-25.
- Tolich, M., & Davidson, C. (1999). Starting fieldwork. Auckland, New Zealand: Oxford University Press New Zealand.
- Transitional Health Authority (1997). Guidelines for referral to obstetric and related specialist medical services. Auckland, New Zealand: Transitional Health Authority.
- Tucker, J.S., Hall, M.H., Howie, P. W., Reid, M.E., Barbour, R.S., Florey, C.D., & McIlwaine, G.M. (1996). Should obstetricians see women with normal pregnancies? A multi-centre randomised controlled trial of routine antenatal care by general practitioners and midwives compared with shared care led by obstetricians. British Medical Journal, 312, 554-9. Retrieved 19 September, 2000 from EBSCO database on the World Wide Web: <http://globmidwife>.

- Turnbull, D., Holmes, A., Shields, N., Cheyne, H., Twaddle, S., Harper-Gilmour, W., McGinley, M., Reid, M., Johnstone, I., Geer, I., McIlwaine, G., & Burnett Lunan, C. (1996). Randomised, controlled trial of efficacy of midwife-managed care. The Lancet, 348, 213-218.
- VandeVusse, L. (1997). Sculpting a nurse-midwifery philosophy: Ernestine Wiedenbach's Influence. Journal of Nurse-Midwifery, 42 (1), 43-48.
- Van Manen, M. (1990). Researching lived experience. Ontario: The Althouse Press.
- Wagner, M. (1994). Pursuing the birth machine: The search for appropriate birth technology. Camperdown, Australia: Ace Graphics.
- Wagner, M. (1995). A global witch-hunt. The Lancet, 346, 1020-1022.
- Waldenstrom, U. (1998). Continuity of carer and satisfaction. Midwifery, 14, 207-213.
- Waldenstrom, U., & Nilsson, C-A. (1997). A randomised controlled study of birth centre care versus standard maternity care: Effects on women's health. Birth, 24 (1), 17-26.
- Waldenstrom, U., Nilsson, C-A., & Winbladh, B. (1997). The Stockholm Birth Centre trial: Maternal and infant outcome. British Journal of Obstetrics and Gynaecology, 104, 410-418.
- Waldenstrom, U., & Turnbull, D. (1998). A systematic review comparing continuity of midwifery care with standard maternity services. British Journal of Obstetrics and Gynaecology, 105, 1160-1170.
- Walker, J.M., Hall, S., & Thomas, M. (1995). The experience of labour: A perspective from those receiving care in a midwife-led unit. Midwifery, 11, 120-129.
- Walker, P. (1995). Should obstetricians see women with normal pregnancies? Obstetricians should be included in integrated team care. British Medical Journal, 310, 36-38.

- Walsh, D. (2000a). Evidence-based care series 2: Free-standing birth centres. British Journal of Midwifery, 8 (6), 351-355.
- Walsh, D. (2000b). Part three: Assessing women's progress in labour. British Journal of Midwifery, 8 (7), 449-457.
- Walters, A. (1994). Phenomenology as a way of understanding in nursing. Contemporary Nurse, 3 (3), 134-141.
- Warren, C. (1999). Why should I do vaginal examinations? The Practising Midwife, 2 (6), 12-13.
- Webster's Dictionary of the English language unabridged. (1977). Chicago: JG Ferguson Publishing Company.
- Weitz, R., & Sullivan, D. (1985). Licensed lay midwifery and the medical model of childbirth. Sociology of Health and Illness, 7 (1), 36-54.
- Whiteside, L. (1982). Maori women and birth. Broadsheet, 99, 37.
- Wood, F. (1969/1979). The Macmillan dictionary of English colloquial idioms. (Revised by R. Hill). London: Macmillan Press Ltd.
- Woodley, J. (2000, September). Papakura Maternity Unit. Midwives News, 2-3.

Appendix I

Information Sheet for Midwife Participants

Provisional Title: *How is the provision of intrapartum (labour) care different in a small maternity hospital as compared with a large obstetric hospital.*

Dear Midwife,

I am undertaking a research project toward the completion of a Master of Arts (Midwifery) at Massey University. My supervisor is Cheryl Benn, Associate Professor and midwife lecturer at Massey University, Palmerston North. The research study is a qualitative study aiming to describe midwives experience of providing labour care in small and large hospitals, and to identify issues that influence midwives choice of environment for provision of labour care.

I am keen to interview 10-12 midwives about their experiences. If you meet the following criteria you are invited to participate in the study:

- You have provided labour care to women in a small maternity hospital and a large obstetric hospital during the past two years.
- You are fluent in English.

What will you be expected to do?

- You will participate in an interview that will take approximately 60-90 minutes, and will be conducted at a mutually agreeable private venue.
- With your permission, I would like to audio tape the interview and have the tape transcribed by a typist who will sign a declaration of confidentiality. I may take notes during the interview to assist my analysis.
- I will send a transcript of the interview back to you for confirmation, or to enable you to make any changes. You have the right to delete any parts of the transcript, and to withdraw from the study at any time until you return the transcript to me for data analysis. If I wish to clarify information in the transcript, I will ask your permission to conduct a brief interview by telephone, or at a subsequent meeting.

- Once the transcript has been returned to me, I will assume that you give me your permission to undertake thematic analysis, to use the data for my thesis, and for any publication or presentation that may arise in association with this research study. An academic colleague familiar with thematic analysis will be invited to check my analysis for validity. This person will sign a confidentiality form prior to viewing any transcripts.
- Your audio tape and transcript will be stored in a locked filing cabinet labelled with a pseudonym, and kept separate from consent forms. At the completion of the study I will return the audio tape and transcript to you, or alternatively I will destroy the tape and transcript after five years (timeframe is for auditing purposes).

You have the right

- to decline to participate
- to refuse to answer any particular questions
- to withdraw from the study up until the time the transcript is returned to me
- to ask any questions about the study at any time during participation
- to provide information on the understanding that your name will not be used unless you give permission for your name to be used
- to be given access to the summary of the findings of the study when it is concluded

Potential risks and benefits from participation: A benefit from your participation is the opportunity to talk about your practice which most midwives enjoy, while a potential risk is the cost of your valuable time. I will aim to minimise the cost of your time by travelling to meet you and by only conducting one or two interviews.

If you are interested in participating in the research, I would appreciate return of the slip provided, or you are welcome to telephone me. Should you wish to ask any questions concerning this research study, please do not hesitate to contact me or my supervisor.

Thank you for your consideration.

Marion Hunter (Work telephone 09-307 9999 Ext. 7365.)

Research Supervisor: Cheryl Benn (Massey University: 09-443 9700 Ext. 2543).

Return Slip **(Please detach and return in the envelope provided).**

I am interested in the research study outlined above, and Marion Hunter may contact me regarding potential participation in this study:

Name: _____

Contact number: _____

Title of study: How is the provision of intrapartum (labour) care different in a small maternity hospital as compared with a large obstetric hospital.

Consent Form

- I have read the information sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.
- I understand I have the right to decline to answer any particular questions.
- I agree to provide information to the researcher on the understanding that my name will not be used without my permission. The information will be used only for this research and publications arising from this research project.
- I understand the interview may be approximately 60-90 minutes in duration and that Marion may take notes during the interview process.
- I understand that the interview transcript will be returned to me for confirmation, or for me to make changes. I understand that I am free to withdraw from the study at any point until the transcript has been returned to the researcher to undertake thematic analysis.
- I am aware of my right to participate, not to participate, or to participate with the right to withdraw from the study, until such time that I return the transcript to the researcher.

(Please circle the option you have chosen).

- I agree / do not agree to the interview being audio taped. I also understand that I have the right to request the audio tape to be turned off at any time during the interview.
- I wish to have the audio tape and transcript returned to me/ I consent to disposal of the audio tape and transcript five years after the completion of the research (for purposes of auditing).
- I agree to participate in this study under the conditions set out in the information sheet

Signed: _____

Name: _____

Date: _____

Appendix II

Letter sent to each participant with return of transcript

Dear Independent Midwife,

Thank you for the opportunity to interview you about your experience of providing labour care both in a small maternity hospital and a large obstetric hospital. I very much appreciate your time and willingness to share your stories and views. The transcript is typed from the audiotape, however the spoken word is never as precise as the written word. Don't feel alarmed if you notice a lack of fluency as that is how we normally speak in conversation.

I am returning the transcript of the interview to you. You may recall from the information sheet and consent form:

- The transcript is returned to you as part of the research process
- You have the right to delete any parts of the transcript, and to withdraw from the study at any time, until you return the transcript to me for data analysis.

If you give permission for your data to be used in my study, please return the transcript to me (a stamped addressed envelope is enclosed).

If you would like to keep a copy of the transcript please indicate this to me, and I will happily photocopy one for you. If you have any queries about the research study, please do not hesitate to ask. Once again, thank you for your valuable time and all the information you shared with me.

Yours sincerely,

Marion Hunter.

MA student, Massey University.

Appendix III

Title of study: How is the provision of intrapartum (labour) care different in a small maternity hospital as compared with a large obstetric hospital.

Non Disclosure Form for Typist(s)

I understand that information being transcribed is confidential in all respects. All information being transcribed belongs to the consenting research participant and will not be disclosed in any manner whatsoever.

I will not discuss the contents of the audiotapes, in general terms, or in specific terms with any person. I accept that any knowledge gained from the transcript of audiotapes, or through correspondence with the researcher is confidential and may not be discussed or revealed. I understand that I may not retain any copies of the transcripts on hard drive or on disc.

Signed: _____

Date: _____

Witness _____

Title of study: How is the provision of intrapartum (labour) care different in a small maternity hospital as compared with a large obstetric hospital.

Non Disclosure Form for Academic Colleague

I understand that I have been invited by Marion Hunter (researcher) and Dr. Cheryl Benn (supervisor) to review the process of thematic analysis for purposes of validity for this qualitative research study.

I understand that the transcript belongs to the participant, and that no information from the transcript may be disclosed or discussed with any person other than the named researcher and supervisor. I understand that I am not allowed to retain any electronic or hard copies of the data analysed.

Signed: _____

Date: _____

Witness _____