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INDEPENDENT MIDWIFERY PRACTICE:

A CRITICAL SOCIAL APPROACH

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

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ABSTRACT

This study commenced three years after the passing of the Nurses Amendment Act 1990 which gave midwives legal authority to practise without medical supervision.

It explored the social and political contexts of the work-lives of four independent midwives in New Zealand. A critical social approach was used to examine how midwives manage and negotiate their practice in an environment in which a dominant medical discourse prevail. In-depth individual case studies were used for data collection and reporting.

The research process provided an opportunity for participants to examine their taken-for-granted work environments and consider those personal actions and hegemonic structures which exist to constrain their practice. The participants surfaced those actions which could be described as counter-hegemonic and resistant to the dominant medical discourse. The study also illuminated those cognitive and physical actions which demonstrated compliance with medicalised childbirth and thus maintained the status quo. Midwives in this study used strategies of responsible subversion, the generation of midwifery language and the presentation of an alternative midwifery model of childbirth to contest medicalised childbirth. Within a context of assumed authority by doctors over the midwives the dominance of medical discourse prevailed. The participants were aware of the vulnerability of midwifery knowledge when it was made visible. It ran the risk of being dismissed as unscientific by medicine, or being incorporated into the dominant medical discourse on a superficial level. Conversely, midwifery knowledge that was not made visible was likely to remain marginalised and unrecognised.

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PREFACE

Background to the Study

Since the passing of the 1990 Nurses Amendment Act, New Zealand midwives have been able, on their own responsibility, to support childbearing families throughout their pregnancy, assist women giving birth at home or in hospital and maintain the postpartum care of those families for up to six weeks. The Act allows midwives the same rights, privileges and remuneration as doctors when conducting normal births. The work environment of midwives, as they experience and negotiate their practices is of interest to many health professionals as the economic and health reforms impact on New Zealand society. As a predominantly female profession attempting to carve a niche previously monopolised by the male dominated medical profession, the experience of midwives provides a unique opportunity to explore the socio-political context of such an endeavour.

The aims of the study are:

- To explore with independent midwives the socio-political context of their practice.
- To analyse the social construction of that practice in order to make it explicit and therefore open to critique and reconstruction.
- To consider actions which might be taken to maintain and further advance midwifery autonomy.

The Research Topic

The research has used case studies within the conceptual framework of critical social theory to explore the political and socially generated constraints on the personal and professional actions of independent midwives. In-depth interviews were used to explore the ways in which independent midwives perceived, negotiated and understood their practice lives. Social critical theory formed the analytical framework for the researcher and participants to explore and describe the social and political underpinnings of each midwife's practice in a way that is *"socially critical"* (Perry, 1986, p.13) rather than personally or "*self critical*".

The researcher anticipated that the study would explicate the social constraints and realities of independent practice so that the beginnings of an emancipatory, counter-hegemonic process could take place. However, much of the politico-historical thinking which lays the foundation to such an exercise had already been discussed, researched and reflected upon by many midwives.

Previous to the study, as women and midwives reviewed the social, historical, and political construction of childbirth, two models of care emerged; a medical model and a midwifery model. Historically and currently there is a tension between those two models. That tension is embedded in historically situated economic, professional and philosophical foundations of maternity care both in New Zealand and world-wide. It is within this tension that independent midwives practice in New Zealand.

The midwifery model, in presenting an alternative philosophy of childbirth, challenges the taken-for-granted authority of medicine to judge what is to be counted as optimal maternity care. Having established legal and economic recognition and autonomy, midwives are engaged in actions which resist the control of their profession by medicine. They experience considerable stress and difficulty in these resistant activities, often finding that embodied and embedded habits emerge which contradict their acclaimed ways of caring for childbearing families.

Structure of the Thesis

This thesis is presented in ten chapters.

Chapters One to Four provide the context and methodological issues relevant to the study. **Chapter One** introduces the social, political and historical contexts of the study. It gives a brief overview of how midwives, with women, came to recognise and contest the medical dominance of maternity care. **Chapter Two** explores the relevant literature both from New Zealand and internationally. It focuses in particular on the medicalisation of childbirth. **Chapter Three** presents the concepts and methodological issues relevant to research using a critical social approach. **Chapter Four** outlines the research process of this study.

Chapters Five to **Eight** present the individual case studies of four midwives as they reflect on and explore the constraints and realities of their work-lives as independent practitioners.

Chapter Nine integrates the four case studies and provides a critical social analysis of independent midwifery practice as perceived by the four participants.

Chapter Ten completes the study. It gives an overview of the study, and discusses its limitations and implications.

GLOSSARY

Cardiotocograph: (toco or C.T.G.). A form of electronic monitoring which measures the fetal heart rate and uterine contractions. These are usually recorded in graph form onto paper to give a visual display.

Ecbolics: Drugs used to stimulate uterine contractions. In some countries it is routine to administer these drugs after the birth of the baby to prevent post partum haemorrhage.

General Practitioner: (GP). A medical practitioner or doctor who has a general private medical practice within the community. Some who have obstetric qualifications also deliver infants under the same sort of arrangements as midwives i.e. they have contracts with the Crown Health Enterprise. Others, who do not attend births, may supervise the antenatal care along with a consultant who delivers the women in a hospital. General practitioners, whether they conduct deliveries or not, are usually the first health professionals a woman sees in order to confirm her pregnancy. These doctors then may refer these women for care during their pregnancy and birth to another GP who practises obstetrics, a consultant obstetrician or a midwife. It is in this power of referral that lies their power to control midwives. The term GP is used throughout the text for this is the common abbreviation used in oral language.

Risk list: The term risk is used to refer to the likelihood that a deviation from normal might occur during a pregnancy, delivery or postpartum. Risk is theoretically calculated according to the mathematical probability of a problematic situation occurring (Rothman, 1993). It is based on a woman's obstetric history and clinical assessment. The risk list is issued by various groups and committees who see themselves responsible for monitoring maternal and infant outcomes. Such guidelines are useful to practitioners in their decisions whether or not to refer women for specialist care. There is some critique of the list when it is used routinely, as routine use may result in a tool to reduce consumers choice of health practitioners.

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