MIDWIFERY PRACTICE:

UNFETTERED OR SHACKLED?

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ABSTRACT

This thesis examines the ways that neophyte midwives experience their everyday practice world. The critical reflexive analysis of the perceptions of five practising midwives illustrate how socially generated constraints function to restrict professional midwifery care. This approach directs attention toward generating emancipatory knowledge which may assist midwives to overcome some of the contradictory and constraining conditions of their practice.

The theoretical assumptions of critical social science expose for critique the ways in which socio-political forces constrain individual and professional action. There is an underlying assumption that the collaborative nature of the research process will enable midwives to make deliberate choices between alternative courses of action. This may be achieved by subjecting values and intentions to inquiry in the light of structural constraints on individual practice situations. The study is particularly timely when legislative changes continue to contribute to the changing context of midwifery practice.

The research process and the findings of this study may provide the basis for an ongoing open-ended dialogue and critique so that midwives may be enabled to transform their practice world through collective action. Although political action was not demonstrated in the time frame of this study, it is argued that engaging participants in critique will provide the basis for an ongoing liberating effect toward autonomy and self-determination in midwifery practice.

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CHAPTER ONE

INTRODUCTION AND OVERVIEW

This study explores midwives' perceptions of midwifery practice through a collaborative, open-ended critique. It is premised on the belief that socio-political action will occur through critical analysis of midwifery practice by the joint participation of researcher and researched. Such an interactive contextual exploration and analysis of midwifery practice has the aim of generating emancipatory knowledge and empowering midwives in a reflexive process of critical inquiry.

CONTEXT AND SIGNIFICANCE OF THE STUDY

'Autonomy' for midwives is a topical issue in New Zealand, both inside the midwifery profession and outside. The potential for professional autonomy lies at the heart of much debate, particularly since 1990 amendments to the Nurses Act (1977) which have provided the necessary structural change facilitative of an autonomous midwifery practice.

More generally 'professional autonomy' in midwifery is an important issue when there is a push for rationalisation of the health system; a reorganisation of health care services into funder/provider and user; a greater recognition of the individual rights of women as 'users' of health services; and a trend toward community-based services, allied with a focus on primary health care. The legislative changes give midwives more scope to practise in what some have termed "the expanding 'role' of the midwife" (Pairman & Cameron, 1990:4). This is all indicative that the future of midwifery lies in an expanded scope of practice.

Concerned primarily with the future direction of midwifery, a diverse range of indivduals and women's groups were involved in the process of

regaining the legal sanction of an independent midwifery practice. The lay involvement in this process is evident from a Midwifery Policy Statement that incorporates a report on a Consumer Survey conducted between 1987 and 1988 (NZNA, 1989, Appendix II:33-39). Of particular note is a clear recognition that midwives are "undervalued professionals who deserve more status and autonomy" (Bickley, 1989:13).

Lay criticism of New Zealand's maternity services arose initially in the 1950s when individuals became dissatisfied with inflexibility. In the last two decades lay groups have been instrumental in pressing for change away from the idea of a technologised and highly interventionist childbirth as the only way to give birth. **Chapter Two** provides a more comprehensive discussion of consumer involvement within a historical context. It is sufficient at this point to say that since the 1970s, a growing number of lay organisations have engaged in pressure-group action that challenges the monopoly of medicalised childbirth, seeking instead to involve women in culturally appropriate and sensitive care.

In an endeavour to effect social change, women have "lobbied health systems and politicians constantly on behalf of themselves and their midwives" (Guilliland, 1990:2). Despite the demand for change however, the practice of midwifery has continued to be eroded. Legislative changes to the Nurses Act 1977 in the last decade demonstrate this.

Prior to the Nurses Act 1971 midwives in New Zealand had some degree of autonomy in practice. This is more readily apparent with domiciliary midwifery. As a domiciliary midwife herself, Donley (1986:16) writes that domiciliary midwives were able to "book their own cases, provide the mother with the necessary antenatal supervision, care and advice, and conduct deliveries in the home on their own responsibility". After the 1971 legislative changes domiciliary midwives were prohibited, as were all midwives, from taking full responsibility for the care of women throughout uncomplicated pregnancies, normal labour and the puerperium. That is, the Nurses Act 1971 took away midwives' independent status by making

it illegal to attend births without a supervising doctor. This effectively reduced the midwife to the status of an obstetric nurse. Thus, in matters concerning decision making in clinical practice, the Nurses Act 1971 was pivotal in decreasing the autonomy and status of all midwives who subsequently held delegated authority derived through medical opinion.

Legislative changes in 1983 further decreased the status and autonomy of the midwife, despite an acceptance of midwifery as an independent practice from a range of organisations (such as the World Health Organization since 1965, the International Confederation of Midwives 1972, and the International Federation of Gynaecologists and Obstetricians 1973). The 1983 amendments to the Nurses Act (1977) made it legal for any registered nurse, with a maximum of seven weeks obstetric 'training', to direct and supervise obstetric nursing by allowing nurses without midwifery qualifications to carry out maternity care under the supervision of a doctor (Donley, 1990a; Guilliland, 1989; McQueen, 1986). It essentially classified 'midwife' and 'obstetric nurse' as the same. These amendments also restricted Direct Entry midwives' scope of practice and intensified domiciliary or homebirth midwives' legal requirements (Guilliland, 1989). As a consequence, Donley states, (1986:135) it became "even harder for Maori to become nurses and midwives" through prohibiting further registration of Direct Entry midwives as domiciliary midwives. Thus, the Nurses Amendment Act 1983 limited the options that were open to all midwives, both in education and in practice.

A third legislative change in the Obstetric Regulations which also govern midwifery practice illustrates the diminishing status of the midwife in practice. The Obstetric Regulations (1986) allowed Hospital Boards to run maternity institutions without midwifery care at all times. For some midwives this reinforced the view "that the doctor was the professional best suited to dealing with childbirth" (Guilliland, 1989:14). However, in combination, the statutory changes decreased the profile of the midwife by sharply reducing the available midwifery positions and therefore reducing the number of practising midwives.

A decline in practising midwives up to March 1986, was reflected in the Health Department statistics as midwifery positions were filled by nurses other than midwives. A chronic deficit of midwives was displayed in such communities as Invercargill, Christchurch, Wellington and Auckland. The shortage of practising midwives was exacerbated by the introduction of early discharge from hospitals and the closure of postnatal beds (McQueen, 1989). In addition, the shortage of midwives was compounded by a decreasing number of midwives educated in New Zealand since the inception of the combined Midwifery/Advanced Diploma of Nursing course in 1979. These combined factors contributed to negative consequences in the practice of midwifery in New Zealand.

Midwives began to resist the rapid changes to the health system that adversely affected midwifery care and their professional interests. According to Guilliland, (1989) midwives began to recognise that the New Zealand Nurses Association (NZNA), the Department of Health, and the educational objectives for nursing could well be at the expense of midwifery when, in 1979, midwifery education became a combined course in the technical institutes. A remit to have the midwifery component separated from the advanced diploma was passed at the NZNA Conference of 1980, 1982 and 1984, in spite of the fact that technical institutes were in favour of retaining the status quo (McQueen, 1986). The proposed Nurses Amendment Act 1983 also met with resistance. But without a professional body that was receptive to their concerns, all communication reaching midwives was at the discretion of their parent body the NZNA.

On presenting submissions reviewing the Nurses Act 1977, midwives were informed, by the NZNA in 1983, that their concerns were groundless. But in retrospect, as the Nurses Act 1977 stood, "it was not an offence for an obstetric unit, whatever its size, to be staffed entirely by people untrained in the special skills of midwifery" (McQueen, 1986:23). Moreover, for those midwives who understood that what they were doing as obstetric nurses was not midwifery, the Nurses Amendment Act 1983 represented a threat to the very survival of the profession (Donley, 1986; Guilliland, 1990).

Since the establishment of the midwifery register, in 1904, the midwifery tradition in New Zealand has been founded upon that of nursing. More recently, as midwives have come to grips with their near demise "they began to perceive themselves as quite different from either medicine or nursing" (Guilliland, 1990:2). In response, midwives received "a degree of professional isolation from some nursing and medical colleagues" (McQueen, 1986:2). That the concerns of midwives have not been well addressed over the years is at best a reflection of how the education and practice of midwifery was in different ways a casualty to other concerns, to the detriment of midwifery education and practice, professional interests, and the public interest.

The legitimisation of claims to autonomy necessitated that midwives become more active politically by establishing their own professional body, preparing standards of midwifery practice (both for practice and education), and be answerable to those in their care. While this list is by no means exhaustive, it illustrates the conscious commitment of midwives to align themselves more closely with the community they serve in order to raise the status of midwives and transform midwifery into an autonomous practice. According to Smyth (1986b:4), "self-determination, autonomy and self-control is the ability of members to exercise responsible control over what counts as knowledge in their field". Exercising responsible control over what counts as midwifery knowledge extends the possibility that midwifery practice will be enhanced by gaining knowledge through critical reflection of actions. Individual practitioners however, may announce their willingness to take responsibility for the consequences of their actions but may not have deliberated about them. An acknowledgement of the existence of an obligation alone is not the same as actually engaging in a reflective process and action. There is both the risk and challenge that comes from being accountable to the mothers, the community, and the profession.

The conscious commitment by midwives, in 1983, to align themselves more closely to the community they serve, was initially evidenced by the formation of the group calling themselves 'Save The Midwife' which

was made up of midwives and consumers. Out of this group arose the Direct Entry Task Force that had the specific objective of establishing a direct entry course in addition to the technical institute course in midwifery (Guilliland, 1989). In effect, midwives gained legitimation as autonomous professionals through the community sanction of a women-centred approach to care that involved a commitment to the sharing of knowledge. As part of this approach the newly formed New Zealand College of Midwives (NZCOM) includes non-midwives and consumers as active members since its establishment. The "actual spearhead for the foundation of the College was at the Caroline Flint Conference in August 1988" (Stimpson, 1992). "The NZCM was launched officially on April 2nd, 1989..." (Guilliland, 1989a:4) and the College produced their first journal in September of that same year. Midwives consciously began to work with the community in order to achieve a profession and health service which reflects the interests of mothers, babies and midwives. By looking outside the profession for support, midwives also regained the legal sanction to be autonomous in practice based on mutual regard and interdependence of one group with another.

With the implementation of the Nurses Amendment Act 1990, (subsections (1) and (2) of section 54) the locus of control arises from inside the profession rather than from any related discipline such as medicine or nursing. The statutory changes place a registered midwife in the same legal position as a medical practitioner for the purposes of section 54. Midwives have the discretionary authority or autonomy to be self-determining in practice in order to provide a service that women want and with which they feel safe. This in turn increases women's freedom of choice in relation to midwifery care by providing a complementary service to that of the medical profession.

With autonomous decision making at the practitioner level there is an assumption that midwives are accountable for their actions and decisions in relation to mothers and babies. That is, "professional accountability and responsibility of an individual member is also the professional accountability of services" (Hawken & Tolladay, 1985:4). According to Maas (1973) autonomy is granted an occupation in

recognition of the esoteric knowledge possessed by practitioners when society is confident that members place service or community interests above self-interests.

To be legally autonomous at all levels of midwifery practice however, it became necessary to amend or repeal five Acts and Regulations further to the principal Act. Additionally, a supplementary order paper was passed through Parliament clearing the way for direct entry courses in midwifery. The statutory changes create new practice options for midwives who are now permitted to carry out certain related services. The new responsibilities allow midwives to extend their practice and include:

* prescribing a limited number of medicines normally used in maternity care;
* ordering certain diagnostic tests;
* assuming the responsibility for record keeping and obstetric referral in the same way as previously required of medical practitioners;
* claiming pharmaceutical benefits, payments and refunds for services performed by registered midwives;
* contracting with the Area Health Boards to allow midwives to have access into Board hospitals.
(Department of Health, 1990)

While the Nurses Amendment Act 1990 provides in principle for midwives to practice independently, the implications and implementation of changes to the principle Act are unknown. There may be contradictions which arise from within the system to prevent midwives from fulfilling their mandate to practise autonomously. An example of this is the New Zealand Nursing Council's opposition to Direct Entry midwifery on "philosophical grounds" (Donley, 1990b). A domiciliary midwife may also be prevented from transferring with clients into a hospital setting (in the event of an unforeseen complication) without a contract with the local Area Health Board (or in the future the Regional Health Authority). In some situations there is also a matter of payment when two practitioners, or more, are involved. At present

there is provision for the payment of a midwife and a doctor but this matter is under review.

In 1992, all Area Health Boards will have issued contracts for independent domiciliary midwives and other independent midwives who may share the care of a woman and therefore wish to follow through with them from home into hospital. By contracting with the Board, domiciliary midwives as primary caregivers, have access to a hospital's facilities and are able to fulfil in practice their mandate to be self-determining. However, there may be other difficulties. The NZNA consumer survey highlighted that the inadequacies in midwifery services were often seen by respondents as a reflection of the structural constraints in which midwives work rather than as a criticism of individual midwives themselves (NZNA, 1989). Midwives also perceive the organisation of services as problematic:

> The fragmentation of the pregnant woman into her antenatal, labour and postnatal parts to suit medical direction and hospital management played a major role not only in breaking up the midwifery tradition, but also in determining and undermining the woman's control over her own normal birth process.
> (Guilliland, 1990:2)

It is generally accepted that most midwives work in a hospital setting, and thus, "to a lesser or greater extent, within the technocratic paradigm" (Bassett-Smith, 1988:12). A prevalent technocratic approach to care may diminish a sense of personal agency so that midwives show deference to controls within hierarchical organisations that were established and are maintained on grounds that are clearly open to challenge. Through regaining an independent status, there is an opportunity for midwives to gain insight into how the health care system might be reorganised beyond medical domination, and how social change may be brought about in institutional hierarchies that are dominated by technical forms of knowledge. However, as already noted, midwives may be constrained in practice by their personal capacity to act independently. Their understandings and actions may be simultaneously shaped by ideological forces within bureaucratic organisations. Under these circumstances the knowledge

embedded in everyday clinical practice is dominated by controls that have a practical consequence (Clare, 1991; Hickson, 1988; Perry, 1985).

In general, some of the practical consequences that professionals confront in modern organisations may be contributed to conflict which arises from the basic difference between the dominant bureaucratic model for practice and that of the independent professional (Etzioni, 1965; Clifford, 1981; Schon, 1983; Smyth, 1986). Schon (1983) has made the observation that as professionals become increasingly unionised and industrialised they move towards a state of bureaucratisation with an accompanying decline in the perceived importance of autonomy and independence of action which has hitherto characterised them. Accordingly, Schon (1983:14) points out that "professional knowledge" located in the traditional disciplines is out of step with "the changing character of the situations of practice". Schon concludes that professions generally are no longer able to deliver solutions to important social problems. Midwives, for example, may have beliefs and assumptions that guide their everyday practices which are obscured by formal theories, rigid rules, or prescriptive procedures. Smyth (1986b) argues that it is the indeterminacy of professional knowledge (as the inability to reduce knowledge to which professionals lay claim down to rules, and prescriptions for practice) which gives professionals their strongest argument for autonomy. Thus, through learning from everyday experience, and making this knowledge explicit, there is the possibility that midwives may enhance their practice through responding to situations in an active, critical and independent way.

With an escalation in technological development, coupled with rapid social change, it is vital that midwives remain responsive to the health care needs of women and families and make this knowledge accessible to others. Through a continuing dialogue with practice, as suggested by a workshop on midwifery practice in 1986, (Pybus, 1987) midwives may become increasingly adept at building up knowledge about 'what works for them' and thus become researchers into their own practice. Understanding of practice acquired through critical

reflection is not, therefore, static and dependent upon legitimation by outside 'experts' (Smyth, 1986b).

To be autonomous in midwifery practice, and not simply reproduce the social constraints both in education and in practice, it is argued here that midwives must examine the taken-for-granted, or unquestioned and therefore unchallenged, assumptions, values and beliefs that underlie their actions as well as the institutional practices and the forms of knowledge that reinforce them. As a hierarchical hospital setting is the working environment for a majority of midwives in New Zealand, how they perceive, act and reflect on their clinical practice and what they accept as legitimate knowledge and why, becomes an important area for research.

This study arose from a concern with developing the knowledge embedded in midwifery practice as a basis for theorising and critique. The NZNA Midwifery Policy Statement (1989:12) recognised the need for midwives to critically examine their practice and the context in which it is delivered. The extent to which midwives critically reflect on their practice and its context has not been systematically explored. Historically the transmission of knowledge in midwifery practice has tended to be a passive process of 'instruction' (Hill, 1982). Thus, in the past, midwives have been passive recipients of knowledge selected for them by others rather than actively constructing knowledge. That there is little explicit documented theory development in midwifery is indicative of such an approach.

This study therefore aims to facilitate the critical examination of midwives' perceptions of their everyday practice by examining meanings and assumptions midwives attribute to their actions as well as the constraints on these understandings and practices. The researcher proposes to engage with participants in dialogue which will locate social understandings and practices historically and subject them to rational criticism. It is recognised that such a critical reflection of self-understandings and actions may result in insights which are likely to change midwifery practice. The research process may however,

empower midwives to be self-determining in practice through increasing the possibilities for informed choices and actions.

In the next chapter, literature relevant to this study is explored.

STRUCTURE OF THE THESIS

The thesis is presented as three parts. **Part One** (chapters 1-4) provides a general introduction to the context and process of the study. Following on from the overview presented in **Chapter One, Chapter Two** introduces the historical context in which midwifery practice and education occurs in New Zealand. **Chapter Three** sets out theoretical concepts relevant to the study and explores the theoretical and practical implications of previous studies in the field. **Chapter Four** presents the methodological issues and process of inquiry relevant to the study.

Part Two of the thesis (chapters 5-8) presents the theoretical interpretation of the research. **Chapter Five** provides an overview and a synthesis of the perceptions and views of the five midwives in this study as they reflect on their practice worlds. **Chapter Six** presents a descriptive account of the competing discourses within midwifery. **Chapter Seven** discusses the contradictions between belief and action that the midwives experienced in their practice worlds. **Chapter Eight** integrates personal and contextual factors of the study and discusses the studies limitations and implications.

Part Three completes the thesis by presenting the five individual case studies. These include Case Study **One:** Rebecca, Case Study **Two:** Ingrid, Case Study **Three:** Jessica, Case Study **Four:** Ericka, and Case Study **Five:** Sarah.

CHAPTER TWO

REVIEW OF THE RELEVANT LITERATURE

This chapter reviews the literature relating to midwifery practice in New Zealand. The discussion begins with an historical overview of the changing practice of midwifery. The social constraints that have diminished and increased the autonomy of midwives are explored. These constraints are shown to be historically linked to the medicalisation of childbirth. The review next discusses knowledge in relation to theory development in midwifery and how midwives' understandings have been shaped by dominant forms of knowledge. The qualitative studies presented, reflect a philosophical change in midwifery from a medically orientated approach toward one which is based on an equal 'partnership' with women. The chapter concludes with a brief outline of research indirectly associated with midwifery education.

HISTORICAL CONTEXT OF MIDWIFERY PRACTICE

Throughout most of history women having babies were attended by women. The lay female midwife or traditional birth attendant was "esconced in the rituals of virtually every culture" (Arney, 1982:21). New Zealand colonial life from 1840, as with pre-European Maori society, was no exception. Women gave birth at home often with the assistance of lay midwives. Labouring women in Pakeha households called upon a relative, a neighbour or a 'midwife' (Hill, 1982:24) and mothers placed implicit faith in anyone calling herself a nurse or midwife (Neill, 1961).

As with many aspects of early colonial life, the founding of the British settlement in New Zealand relied heavily upon the principle of self-reliance (Bush, 1980; Gardner, 1981). "Poor communications and transport made self-sufficiency a necessity for Pakeha settler households" (James & Saville-Smith, 1989:23). Each locality was

expected to look after its own needs through shared community institutions. Midwifery, as an institution which centres upon a conception of childbirth as a normal event in a normal life process, developed according to community needs. Knowledge was transmitted on an ad hoc basis as midwives would have had little reason to communicate with each other, isolated as they were in their own communities.

Prior to 1904, formalised midwifery training was virtually non-existent in New Zealand. There were a few trained midwives but the numbers of lay midwives were far in excess of those who trained in other countries (A.J.H.R., 1906:3). 'Untrained' women depended upon autonomous sources for their knowledge and skills based on the sharing of learned experience and the accumulated lore of generations of mothers. Practical knowledge was transmitted locally in an oral tradition. In this sense midwives were independent practitioners.

Some midwives administered herbal medicines appropriate to the cultural context. The oral histories of traditional Maori culture, the Ngati Porou for example, reveal that knowledge of particular plants and processes, necessary for preparing herbal medicines used in pregnancy and for making baby clothing, was only taught to pregnant women and older women. The sexual and social division of labour within the 'iwi' (tribal group) ensured that only female members of particular 'hapu' (kin group) were initiated into the practice of midwifery (Emery, 1989).

Until the beginning of the twentieth century, midwifery interests were local in character. Midwives were not well organised, nor did they have a recognised body of knowledge to which they could lay claim. In addition, there were no regulations which governed midwifery practice. The 'qualification' of the lay European midwife was only that she should have borne a child herself. These midwives were called 'handywomen' as they were expected not only to attend women in labour and deliver the baby with or without a doctor present, but to care for mother and child during the postnatal period and to undertake the everyday household tasks (Neill, 1961). However, prior to 1904, the

lay New Zealand midwife's position was relatively secure as they "were badly needed at the time" (A.J.H.R., 1907:4).

Primarily through the pioneering work of Grace Neill, an English trained nurse and midwife and Assistant Inspector of Hospitals, the State Registration of midwives was secured. Although it was clear to Neill the need for this reform, there was opposition to the proposed Midwives Registration Act from practising midwives and many doctors who resented the intrusion of the State into their preserves (Neill, 1961).

With the implementation of the Midwives Act 1904, both midwives and doctors demonstrated more sectional occupational interests. Threatened by the proposed Midwives Act, the activities of doctors enabled them to make inroads on the practice of midwifery. The Midwives Act held the promise that midwifery would be self-regulating in practice but this was not to be realised. In a short space of time midwifery became subordinated to the medical profession as medical knowledge began to dominate maternity care.

Although writing about the United States and Western Europe, Davis' (1981:102-103) comments are applicable to the New Zealand context. Davis writes that in the latter half of the nineteenth century "decisive changes took place in the social organisation of the medical profession". Doctors sought to protect vested interests and undue competition among medical practitioners. What emerged was the nineteenth century ideal of an independent professional, an individual who acted in many ways as an entrepreneur in the market for personal services, but who was protected from undue competition by an occupational monopoly. The sanctity of a private contract between medical practitioner and client meant that any form of third party involvement was strenuously opposed. Davis describes how doctors managed competition and developed a business monopoly by controlling the potential functions of allied health practitioners before the turn of the century.

The doctors feared not so much the initial loss of 'patients' as the threat of a future complete control over the childbirth arena. This was particularly expressed by the older, more established and influential doctors. The untrained midwives, "who were mainly elderly experienced women, were also threatened by the advent of highly-trained young modern women entering midwifery" (Neill, 1961:51). Once passed however, the Midwives Act (1904) laid down that no woman could use the title of a 'midwife' unless deemed competent to do so through passing the midwifery State Registration examination (A.J.H.R., 1906:3). This requirement set the scene for modern midwifery practice and education in New Zealand.

Midwifery practice predated midwifery education in New Zealand as it did in other countries. Since the Midwives Act (1904) provided for the setting up of St Helens maternity hospitals, the training schools for candidates for midwifery registration was ensured. St Helens hospitals, in the four main centres of Wellington, Auckland, Dunedin, and Christchurch, were organised so that "the wives of working men could obtain at a fixed charge, care and attendance during childbirth" (A.J.H.R., 1906:3; Neill, 1961).

In contrast to midwifery care given at the St Helens hospitals, wives of the upper classes gave birth at home with a private doctor and live-in midwife in attendance. It ceased to be fashionable for upper class women to give birth at home from 1920 onwards when the trend toward hospitalised births began for all women (Mein Smith, 1986). However, the rise of "a large and affluent middle class" in the nineteenth century advantaged those doctors who were "able to support independent private practice on a fee-for-service basis" (Davis, 1981:102). Many of the privately owned maternity hospitals that existed at the turn of the century were not open to the working class. They could not afford to pay the fee set by owners who were often leading medical men with vested interests (Neill, 1961).

The emergence of a business monopoly, in what amounted to medical control of health services and allied health professionals, was such that doctors were able to influence state legislators to their

advantage. State-provided charitable institutions existed from the nineteenth century for the care of unmarried mothers (Neill, 1961) and a lying-in ward at Dunedin General Hospital provided medical students with midwifery experience (A.J.H.R., 1884:1). This was a forerunner of modern state obstetric services.

After the passing of the Midwives Act 1904, and subsequent medical ascendency, doctors were in a powerful position to establish dominance over less prestigious female health workers who might pose a threat to their monopoly. In particular, practising midwives were under constant scrutiny by members of the medical profession and were therefore unable to exercise the full power conferred by registration. That is, midwives were unable to assume the function which in older times and the middle ages was exclusively left to women to act as accoucheuses, only calling in the physician in case of need (A.J.H.R., 1912).

Aside from their dependence upon medical opinion in matters related to midwifery practice, midwives lacked autonomy in ways that are related to 'gender' as a social phenomenon. The untrained and unregistered women were given three to four years grace before they had to apply for registration in order to practice. These women far outnumbered the registered midwives who had gained their certification overseas (A.J.H.R., 1906). More than 166 lay midwives who had been practising for a minimum of three years availed themselves of the opportunity to pass an 'elementary' examination and register (A.J.H.R., 1907:4 & 1908:8). Many of these women were not considered to be 'fit or proper' to pass registration examinations set by medical men (A.J.H.R., 1907:4). The medical profession, also determined who fitted the stereotype of a female midwife; that is, who was of "good character" (A.J.H.R., 1906:3). The way this patriarchal ideology functioned was to exercise social control by ensuring acceptable group 'norms' for female midwives. Occupations, such as nursing and midwifery, that may have created a sphere of apparently autonomous female activity, were not independent of male direction (James & Saville-Smith, 1989).

The manner in which certain organisational procedures systematically, though often unintentionally, privilege one group over another in the

New Zealand context is explored by James and Saville-Smith (1989). Whereas the pioneer social order was modelled on flexible and imprecise gender roles up to the 1860s, a changing social context, compatible with a modern industrial society, dictated a more rigid sexual division of labour. 'Communality' was replaced with 'rationality' and 'family'. Men gained superiority in the public spheres of life and women were restricted to the caring roles of wife and mother. The feminisation and growth of nursing and midwifery was an extension of women's nurturing roles rooted in a female 'cult of domesticity'. According to James and Saville-Smith, (1989:33) together with teaching, "these occupations, where women were protected from direct male competition, became increasingly important as a means by which women could achieve some economic independence and social status". However, as Arney (1982:29) points out, "medical men were able to make significant inroads on the practice of midwifery." This was achieved through technological advances, facilitated by a new science of birth, and the capability of medicine to expand through education and the control of key resources and foci of organisation. This put (medical) men in the ascendence and was apparent in midwifery by the early twentieth century in New Zealand. Midwives, who might otherwise have critically reflected upon their own position from a standing of knowledge and experience, were devalued by their gender and by their lower social status in relation to medicine.

A male-dominated medical profession increasingly determined the content of women's 'roles' in New Zealand society by the early twentieth century. Through 'scientific' evidence, medicine tried to show that the division of labour between the sexes was "biologically determined" (James & Saville-Smith, 1989:34; Ritchie, 1988:52). By embracing the myth of biological determinism, medical men were unable to extricate themselves from the accepted but unproven dicta of their times. Midwives as a group, had no documented body of prescriptive knowledge with which they could resist the ideological and practical advances of medical men armed with their new scientific evidence. Thus, patriarchal ideologies served to confirm a dependent and inferior status for midwives in the same way as they served to reinforce the low status and inferiority of women.

An oral transmission of knowledge in midwifery helped to prevent the emergence and growth of a professional self-concept. Hill (1982) writes that midwifery students at the beginning of the twentieth century needed to be 'instructed' and 'trained'. This implies that medicine adopted a position of superiority through the transmission of knowledge, irrespective of experience. Midwives thus learned to be passive recipients of knowledge rather than actively participating in the construction and documentation of their knowledge.

Ideological advances into midwifery by the medical profession is reflected in the earliest recorded examination paper for the registration of midwives (Kai Tiaki, 1908). A closer look at this paper reveals a focus only on physical aspects related to pregnancy, childbirth, and care of the infant. If students were to pass the examination they were compelled to answer according to a biomedical perspective. This defined the situation in medical terms which was a reflection of the 'zeitgeist' of the times.

Midwifery students were recommended The Differences and Emergencies of Obstetrical Practice (1915) which was the standard text for midwives of the day (Hill, 1982). This text also reflects a medical model. As such, biological processes are believed to require active medical management in the normal course of labour and delivery with a readiness for medical intervention should any problems arise. The medical model stresses treatment of clients' physiological systems based on the identification of organic factors as the sole source of various problems. A focus on the treatment of physical conditions downplays a more holistic approach. Furthermore, treatment is expected to occur in the context of hierarchical authority relations between practitioner and client, with the practitioner assuming responsibility for the treatment of his or her 'patient' (Weitz & Sullivan, 1985). Such an approach was deemed to be sufficient 'theoretical' knowledge for midwifery practice.

An indication that midwifery inculcated a dominant curricula ideology is given in 1926 when the syllabus changed. The syllabus (Kai Tiaki, 1926) begins to reflect a focus on abnormal obstetrics in emphasising

practical activities associated mainly with 'disease states' of pregnancy and childbirth; asepsis and sepsis are viewed as distinct categories with only occasional reference to midwifery care. Thus, the training that midwives received reinforced a medical perspective of birth. In this way, midwifery education has been an instrument of social control as midwives conformed to the expectations of a more powerful group - the medical profession.

After securing its dominance over the midwifery profession, medicine developed and defended its dominance over pregnancy and birth. Birth became something to be 'managed' rather than 'attended'. This is well documented in a historical case study by Mein Smith (1986) and Fougère (1990). Mein Smith shows how this occurred between 1920 and 1939, with negative implications for women and midwives. The transition from domiciliary to hospitalised childbirth was a double transformation of the birth process. By 1920, women were no longer attended at birth solely by a midwife but increasingly by a doctor, while simultaneously more births ("35 percent by 1920", Fougere, 1990:153) were occurring in hospital rather than at home. After the turn of the century, the decline of midwifery care in the home environment is synonymous with the ascendancy of medical care over pregnancy and birth.

The significant changes in childbearing patterns by 1935 do not include the Maori population which does not appear in birthing statistics before the 1950s. The Maori population reflect a similar trend toward hospitalised childbirth but three decades later than the Pakeha statistics. In 1937, 83 percent of Maori women were still confined at home; by 1962, 95 per cent of Maori births were taking place in hospital (Jenkins, 1989). The expansion of hospitalised deliveries for both groups - Maori and Pakeha - provide the most visible evidence of the medicalisation of childbirth.

Hospitalisation did not, however, bring a reduction in maternal mortality. Instead, maternal mortality peaked at 6.48 per 1000 live births in 1920, a rate higher than in any other developed country except the United States (Fougere, 1990). The most important single cause of death was puerperal sepsis which became the official target

for reform by the State. The newly recognised Department of Health set out to remedy this situation through the implementation of antenatal care for all mothers, the dissemination of a standardised aseptic technique for childbirth, the regulation and inspection of private hospitals, and the improvement of medical and midwifery 'training'. Fougere (1990:154) notes that "in different ways, each of these measures posed a threat to the medical profession's control of birth" by subjecting the clinical practices of doctors to scrutiny and thereby challenging "medicine's claim to be the appropriate provider of maternity care".

Mein Smith (1986) suggests that doctors did not waste any time responding to what was perceived to be an attack on medical authority. She elucidates how doctors mobilised under the banner of the Obstetrical Society, which was formed in 1927 by Dr Doris Gordon, to defend and extend their control of the birth process. As part of the process to stop the development of an alternative service, funded by the state and staffed by trained midwives, doctors categorised pregnancy and birth as "pathological" (Mein Smith, 1986:117). Doctors, by successfully promoting the idea of birth as pathology, by improving their training and techniques, and by fending off state officials who were promoting a midwife based alternative, ensured their own position in the 1930's. They also fought on a number of fronts with the aim of gaining access to the ultimate power of state regulation (Fougere, 1990).

The attraction of 'painless' childbirth, through analgesia and anaesthesia, helped to sway women's support toward hospital delivery. This ensured that a technologised birth would become the norm for New Zealand mothers from the 1930s. Doctors **and** trained midwives could both offer 'safe' births by the 1930s. But only doctors could offer the freedom from pain through anaesthetics that women were demanding. The support of women's organisations and trade unions for access of all women to 'safe' and 'pain free' childbirth underpinned the 1935 Labour Government's maternity policy. By the time Labour became the Government in 1935, the medical dominance of pregnancy and birth had been secured (Mein Smith, 1986; Fougere, 1990). The law changed in the

1940s, entitling all women to free medical care in pregnancy. As well as controlling the education of midwives, medical authority effectively restricted midwives' autonomy in practice and thus inhibited their practice. This in turn limited the choices available to women who may have wished to give birth with predominantly midwifery care.

By the 1950s, maternity care in New Zealand was reported to give high standards of physical care but to show relative neglect of the equally important emotional aspects of maternal and child care (WHO, 1952). Mattison, (1951:172) who was concerned with the impersonal nature of care-delivery to women, urged midwives to become more conscious of the social factors and problems associated with their work. She writes: "The science and art of obstetrics has made the world a safer place for mothers and babies. Now we must sublimate our art to the considerations of the mothers as human beings, and not just 'cases'." It is suggested that the ascendency of the medical profession over childbirth jeopardised not only the status, practice and skills of midwives but their level of social consciousness as well.

The trend toward increased medical intervention in childbirth has not however, been without its opponents. Since the late 1950s the existing obstetric services have been challenged through the new phenomenon of organised consumer dissatisfaction. A Maternity Services Survey Report (1960) recommended more consumer input and by 1960 consumers were demanding a more family-centred and humanistic approach (Hill, 1982). A number of lay organisations were formed in response to a perceived need for change from technological and highly interventionist childbirth. These organisations reflect wider cultural changes as well as being agencies of social change.

From the 1950s the International Childbirth Education Association, a group of lay and professional people interested in childbirth, were the vanguard of many organised movements developing in response to a perceived need for a change from technological birthing. They were instrumental in increasing women's awareness of the need to decrease their reliance on medical intervention when giving birth. The Parents

Centre movement, promoting natural childbirth, began in 1959 through the leadership of Mary Dobbie in Auckland. The La Leche League arose in 1967, started by Yvonne Procuta of Cambridge. She was inspired by a resurgance of the fundamental right of mothers to feed their babies at the breast.

In response to a crisis in the falling numbers of domiciliary midwives, the Home Birth Association was formed in 1978 with the multiple aims to promote homebirth and natural birth, to raise the status and conditions of domiciliary midwives, and to ensure the survival of midwifery as a profession (Ministry of Womens Affairs, 1988). A group of Auckland homebirth women, concerned about the practice and future of midwives, formed the 'Save the Midwives' Society in 1983 (Donley, 1990a). These organisations together continue to play a significant role in supporting and educating those involved in promoting natural birth and parenting. Despite their formation, however, most women give birth with institutionalised care. That is, approximately one percent of women, or five hundred births per annum, gave birth at home up to 1988 (Hasslacher, 1988). The Home Birth Association statistics are published up to 1990. These figures reflect that, although homebirths have increased every year by twenty percent since 1984, homebirths remain approximately one percent of the total births (McKay, 1992).

The regionalisation of maternity services began in the 1960s and resulted in the closure of thirty-three rural maternity units between 1970 and 1984 in New Zealand (Rosenblatt, Reinken, & Shoemack, 1985). The medical profession's ideology was that intervention through advances in obstetric technology led to a decline in perinatal, neonatal and maternal mortality rates and that medical involvement should therefore be made available for all births (Donley, 1986). This approach was reflected in an aggressively managerial approach to obstetrics, recommending to the Postgraduate School of Obstetrics and Gynaecology the use of early amniotomy, intravenous fluids, low forceps, and episiotomy as routine practice for all births (Bonhamn, 1982). Subsequently, a revised paper (Bonham, 1986) omits routine

episiotomy but essentially recommends an interventionist approach for childbirth.

In opposition to a blanket approach to obstetrics, Donley (1986:58) criticises the takeover of maternity care by doctors who redefined birth as a medical event to the detriment of women and midwifery practice. Donley rightly maintains that routine technological management of childbirth is more dangerous than natural childbirth. The Rosenblatt Report (1985) supports this stance as it confirms the safety of midwifery care that is performed with low technology and in a less formal atmosphere than would be the case in large obstetric units. In particular, the Rosenblatt report shows that childbirth is as safe, if not safer, in small maternity hospitals than in large high-technological units (Rosenblatt, Reinken, & Shoemack, 1985). Yet the trend in the maternity services since the Rosenblatt Report (1985) was released has been the nation-wide closure of most small maternity hospitals throughout New Zealand.

In society at present there is a ground swell of public opinion in support of midwifery as part of the wider context of women's health generally, rather than under the umbrella of a medical or nursing specialty. With pressure from women, who have recognised that midwives are in the position to lead the way for changes in midwifery education and practice to occur, widespread change within midwifery is a reality. Midwives "have already had a big influence in the changing attitudes of many within the medical profession" (Field, 1987:17). At the heart of change in midwifery lies a belief in a social model of care and a commitment to the "power of partnership" (Guilliland & Hassen, 1990:9) between women and midwives.

KNOWLEDGE IN MIDWIFERY

Although the context in which midwifery is practised may have changed, autonomy requires knowledge to inform judgement. Midwives have only recently begun to research midwifery practice both in New Zealand and overseas. This has led some to argue that the science used in

midwifery is unclear to those who are not midwives (WHO, 1985; Peters, 1988). Yet Oakley (1989:219) points out that "love (or caring) is a scientific concept and its effects on perinatal health can be quantified". However, the obscurity of the knowledge embedded in midwifery practice may be partly attributed to the limitation of scholarly writing by midwives. Not only is the literature limited in scope but it is deficient of any explicit theoretical or philosophical midwifery perspective. Bryar (1988) argues that it is due to the paucity of theory development in midwifery, that midwifery practice is undertaken within an obstetric/medical model. In the same article, Bryar cites British studies (Methven, 1982 & 1986; McDonald, 1986; Castledeine & Jones, 1987) as evidence for midwives applying nursing models to midwifery practice. These models extend beyond a reductionist medical model toward a more holistic focus.

In studying the introduction of individualised care into midwifery, Bryar (1985) reports that much of the care was orientated towards physical needs and was routinised; the midwifery records identified the majority of problems as physical. Although midwives expressed a belief in an individualised approach to care, they were constrained by the policies and procedures of the organisation within which they worked. The effect of social constraints and the means by which individual midwives circumvent these policies and procedures to provide individualised care has been studied by Garforth and Garcia (1987).

In their endeavour to increase the knowledge embedded in midwifery practice, Houston & Weatherston (1986:66) rightly point out that research "must be grounded in reality, and practising midwives know that reality well." These authors write that much current practice in obstetric and midwifery care is based on accepted dogma, rather than soundly based theory. But by stating that "a widely acknowledged gap between theory and practice has existed in nursing and midwifery for some time" is misleading. According to Smyth, (1986b:9) what statements of this kind convey is that theory is superior or more important than practice because it is assumed that "theory is capable of being generalised...". Practice on the other hand, is "by

definition inferior, because it is non-generalisable..." As Smyth states:

> By continuing to insist on the translation of theory into practice; closing the gap between theory and practice; (or) integrating theory and practice, we are still fundamentally wedded to the idea that theory and practice are separate. (Smyth, 1986b:9)

In an endeavour to stimulate a greater individualisation of midwifery care, Bryar (1987:113) cites several midwives and researchers (Keane, 1982; Methven, 1982, 1986b; Roper et al., 1983; McDonald, 1986) who have applied the nursing process as a systematic approach in midwifery. An application of knowledge in such a utilitarian and linear way does not do justice to the complex, uncertain, unstable and unique nature of the practice world; theory and practice are portrayed as in opposition to one another. Cox and Moss (1988:7) observe that practice is about "utilising all knowledge in flexible and multivariate ways at once" in order to achieve an appropriate outcome in the real world of practice which they describe as "chaotic in nature". In the light of our own personal histories, we each look at the world from a different perspective and view that world uniquely. It is this unique perspective that makes for multiple realities. Flint (1985) speculates that the midwifery literature is indicative of other approaches (than the linear, reductionist, midwifery process) which midwives take to provide more individualised care.

Rather than theory being applied to practice, midwives hold and develop theories about their own practice. This is portrayed by Bassett-Smith (1988) who focused on the process of midwifery care and the effects of that care on women's experiences of childbirth in a hospital setting. Bassett-Smith (1988) explicates the knowledge which midwives have and use in their practice. Taking a grounded theory approach to generate theory in midwifery, this New Zealand study moves away from traditional research methods, with an interest in measurement and control of phenomena, towards a position that seeks to interpret and understand the knowledge embedded in midwifery practice.

Bassett-Smith's (1988) pioneering study identified the technical and interpersonal expertness of midwives within the conceptual framework of 'authenticating' which legitimates 'being with' women in childbirth and puts women at the centre of their own experience. The study exemplifies that theory is derivative of implicit understandings which are socially constructed or intersubjective, value-laden, and contextual rather than 'given' in an a priori or technical rational sense.

Furthermore, Bassett-Smith's (1988) study draws attention to two distinct worldviews in professional care of women - the technocratic and the midwifery paradigms. These paradigms, with their underlying philosophies, have different consequences for the recipients of care. The technocratic paradigm is represented by the medical model of childbirth and is currently the primary model within which childbirth occurs in New Zealand. The midwifery paradigm abounds in domiciliary care of women choosing to have a homebirth and in small maternity hospitals and birthing units in New Zealand. This paradigm is characterised by a low use of technology and little intervention where women are expecting a normal birth.

More importantly, Bassett-Smith's (1988:140) study, conducted in a hospital unit of 1900 births per annum, found that the technocratic and midwifery models of care may coexist together. That is, "the differences between the technocratic and midwifery models of childbirth need not be set in opposition to one another". However, the process of 'authenticating' clarifies that the use of the technocratic paradigm in normal childbirth is inappropriate and poses significant difficulties for women. Where a technocratic approach to midwifery is indicated it dictates that birth is a medical event, normal only in retrospect and that highly trained caregivers and high-technology care is necessary to ensure a live baby. But giving birth with a "technocratic paradigm of care increases the possibility of an interventionist birth, which for many women detracts from feelings of satisfaction with the event" (Basset-Smith, 1988:20).

A further portrayal of these two paradigms is described as 'touch' and 'technology' (Gadow, 1984). The empathetic touch paradigm is comparable with phenomenology as a philosophy, based as it is on a 'concern' with the inner lived experience of a person and the understanding of an intersubjective 'involvement' with the world.

Taking a phenomenological approach to studying pregnancy and birthing, Young (1984) explains the alienating effect women experience as a result of a highly technological interventionist approach. Young maintains that a technocratic approach to childbirth takes an objective stance in an attempt to manipulate and control technical obstetric phenomena. Women are 'decentred' when their subjective experiences are disregarded as legitimate knowledge. A decentred person is interpreted as a person who is in the mode of experiencing "not being self" (Young, 1984:42) with the result that they are alienated from their own experience. In this way, women may come to view themselves as passive recipients of medical care rather than central to their own experience.

Bologh (1981) also studied the alienating effect that women experience as a result of a medically orientated approach to care. As with Young's (1984) study, by taking a phenomenological approach Bologh moves away from the more traditional scientific approach and its assumptions. Bologh concludes that the division of 'body' and 'self' in the dominant medical approach serves a purpose. That is, by treating the 'patient' as an objective body the ability to learn, understand and make decisions for 'self' are ignored. This contributes to a distancing between physician and 'patient' and reinforces a dominant position over her vulnerability. From the client's perspective, the physician is seen as a 'curer' instead of a consultant or resource that could be utilised to foster self-responsibility or to give support. By restricting women's access to knowledge and resources, they remain dependent and vulnerable.

The qualitative studies (Bologh, 1981; Young, 1984; & Bassett-Smith, 1988) and literature, (Gadow, 1984) reflect a fundamentally different approach to science than that which dominates obstetric practice.

Doctors who are oriented toward a scientific approach, based on a technical rational view of knowledge, accept the philosophical assumptions that are derived from the physical sciences, or that form of knowledge which is objective, value-free, and subscribes to generalised laws. In this model of science, 'knowledge' is obtained through measurement and control of data or experimentation and analysis according to strict criteria.

A technical rational view of knowledge accepts a position where propositional scientifically derived knowledge is deemed superior to a circumstance in which artistic (practical) and intuitive (personal) knowledge may be equally appropriate. Hence, epistemology, or ways of knowing and acquiring professional knowledge, is dominated by a separation of theory from practice. Accordingly, with an interest in control and manipulation of natural and social phenomena, knowledge culminates in instrumental action. Instrumental action is reflected in midwifery at the point when birth became something to be managed in order to optimise the experience, rather than something to be attended. In this process, personal knowledge may be devalued if it is not seen to be legitimate knowledge. Midwives may also be relegated to doctors' assistants, a position which has historically been reinforced by a rigid 'training', an appropriation of medical forms of knowledge and the paradigm in which this knowledge is created and sustained.

CHANGES IN MIDWIFERY EDUCATION

In 1979, midwifery followed the transfer of nursing (which began in 1973) from the Department of Health to the Department of Education. Preparing midwives at the tertiary level was deemed to have educational advantages not possible in the traditional apprenticeship system. Perry (1985), Hickson (1988) and Clare's (1991) studies demonstrate that assumptions of increased autonomy and independent thinking may not have taken into account the socialisation process within the polytechnic and hospital as learning institutions that students and new graduates go through. The tutors themselves are also products of social and professional conditioning which is passed on in

their teaching (Perry, 1985). The authoritarian atmosphere of the polytechnic and the hospital environment shape or reinforce passivity among nursing students such that they are prepared to be compliant workers. Clare's (1991) study reports that both tutors and students receive many rewards for maintaining the status quo. This is reinforced by the Nursing Council of New Zealand which exercises control through "its registering and disciplinary functions" (Perry, 1985:64). To date, accreditation in New Zealand may enforce midwifery and nursing tertiary education courses to "adopt one form of knowledge - analytical empiricism, manifest in Tyler's (1949) curriculum model" (Dixon, 1991:vi). The irony is that education itself is anti-dialogical (refer to **Chapter Three**) "we do to ourselves and our colleagues what we do to our students (Hedin, 1986 in Allen, 1990). In this way, hegemonic control of education provides the coercive conditions which prevent successful challenge to the dominant ideology, irrespective of whether the course is Direct Entry midwifery or otherwise.

SUMMARY

The ascendency of medicine and it's involvement in childbirth changed midwifery practice in New Zealand from autonomous work to delegated practice determined by doctors. These developments were hegemonic (refer **Chapter Three**) as medical science became the only possible mode of thought which was not open to, or subjected to, rational criticism. Thus, midwives came to experience a subordinate status and midwifery practice became largely delegated practice determined by doctors. Until recently, midwives' understanding of practice has been predominantly viewed through a medical worldview that has prevented the emergence of a professional self-concept. The subordinate position of women at the turn century has contributed to a lack of autonomy in midwifery practice and education. Research evidence demonstrates that hegemonic controls exist in education and practice settings which has further prevented a critical and reflective understanding of midwifery.

The impetus for cultural change initially came through a growing public awareness of the dissatisfaction with the narrow perspective that failed to address the needs of individual women during childbirth. A fundamental shift in the public's perception of midwifery has eventually been realised by midwives themselves. This has given rise to a legal sanction of a midwife alternative based on a women-centred approach to care. These counter-hegemonic developments indicate a resistance to the dominant medical ideology.

More recent qualitative studies in midwifery reflect a fundamentally different philosophy underpinning research and practice than that of the past. These historical events and processes are part and parcel of a much wider socio-political force providing the context and impetus for a proclamation of change in midwifery practice. This thesis is an attempt to facilitate critical inquiry so that midwives themselves may be self-determining in practice.

In the following chapter the epistemological concerns central to this study are explored.

CHAPTER THREE

CRITICAL THEORY

This chapter begins with an overview of critical social theory. The key theoretical concepts are then presented which have application for the study of midwives' as they experience their practice within large teaching hospitals. The theoretical concepts presented go beyond 'what is' in order to shape 'what could be'. In this way, they offer a critique of midwifery practice by bringing possible alternatives into view. The nine separate but inter-related concepts used in this study are: **hegemony, culture, ideology-critique, dialogue, power, knowledge, autonomy, authority and praxis.**

Critical Social Theory

Critical theory is a diverse rather than a unified tradition so that it would be more accurate to speak of critical theorising. Nevertheless, it is possible to speak of a central core of issues which identify critical theorising as an intellectual movement. The origins of critical theory are generally located in the establishment of the Institute of Social Research associated with the University of Frankfurt in 1923. The Frankfurt School, as it was termed in 1950 after a period of exile, was caught up in a climate of cultural loss and decline which must be linked to its experience of the rise of Fascism in Germany. The 'critical theory' developed by these theorists during this period was overwhelmingly concerned with the mounting irrationality of social and cultural values and their reflection in the ideas of positivism and 'scientism'. As for the central characteristics which embody social critical science, these have been summarised by Fay (1975:93-94) in the following terms:

The first of these is that a social critical science accepts the necessity of interpretive categories in social science. In this

respect it rests on the premises of the historico-hermeneutic tradition and is at odds with the empirico-analytic tradition. Understanding the intentions and desires of participants is a necessary first step in the research process as this affirms the critical concept of 'human agency'. That is, as agents, human beings have a capacity to be self-determining, self-reflective and to act rationally. Thus, it may be said that critical social theory is not a single theoretical account, as understanding and meanings will be different according to the generic social context.

In the second place a critical social science is one that seeks to uncover those systems of social relationships which determine the actions of individuals and the unanticipated consequences of these actions. This characteristic acknowledges the structural constraints, such as ideological forces which shape understandings and actions.

The third characteristic of a critical social science is built on the explicit recognition that social theory is interconnected with social practice. This means that the theories of such a science will necessarily be composed of, among other things, an account of how such theories are translatable into action. This characteristic reveals a dialectical relationship between theory and knowledge, on one hand, and professional interests in practice on the other; the dichotomies of fact and value, subject and object, theory and practice are denied since they are seen as different aspects of a single reality. Such an approach to science rests on the premise that all knowledge is in some sense a social and cultural construct and there is no possibility of an ideologically indifferent theory or practice.

What this third characteristic of critical social science challenges is the assumption that there are abstract bodies of knowledge which somehow await 'application' in the real world. That is, it challenges the construction of knowledge as instrumental rationality in favour of the possibility of practitioners generating forms of knowledge that clearly works for them.

According to Smyth, (1986a) the embeddedness of knowledge in action is the basis of a new and emerging paradigm. As Giroux (1981) makes clear, it is necessary to move beyond the phenomenological or interpretive perspective to one that is critical. Such a perspective discloses the interests of individuals and groups so that the possibility of emancipation from historically conditioned repression and ideological constraints on thought and action may be achieved. In critical social science, knowledge of any kind is a reflection of human interests; that interest in this paradigm has an emancipatory intent. In the context of a critical social theory, each concept is discussed below in relation to it's relevance to this study.

Hegemony

Hegemony refers to the ability of a dominant class or culture to exercise social and political control over a subordinate group and to legitimate that control through influencing individual's consciousness to accept its particular worldview (Gramsci, 1971).

Through intellectual and moral leadership, certain ideas 'saturate the consciousness' of the members of society. In other words, an alliance is formed among ruling groups, classes or cultures through the exercise of power, who then have the ability to subordinate the interests of other social groups to its own. According to Giroux, (1983) hegemony in this instance signifies a pedagogic and politically transformative process whereby the dominant class is a conduit of common elements embedded in the worldviews of allied groups.

Giroux (1983) argues that hegemony was established primarily through the rule of consent and mediated via cultural institutions such as churches, hospitals, mass media and schools. As such, cultural institutions generally took on a new role in the first half of the twentieth century as both a determinant and a fundamental component of social consciousness. As illustrated in **Chapter Two**, the medical profession and its involvement in childbirth in New Zealand gained dominance so that midwifery practice became largely delegated practice determined by doctors. These developments were hegemonic as midwives'

understanding of their practice world took on forms that were defined for them by historically specific discourses.

Historically, midwives have tended to accept without question the reasoning of technical rationality by appropriating both the forms and the worldview in which this knowledge is created and sustained. Midwives self-understandings were circumscribed by a medium through which they unconsciously or otherwise accepted already fixed 'truths' about practice. The worldview and subsequent knowledge, practices and procedures for discovering and legitimising knowledge claims, were informed by an interest which precluded other interpretive or critical perspectives. This is a form of ideological hegemony. Medical science and the paradigm from which it is derived became the natural or taken-for-granted mode of thought which was not open to, or subjected to, ideology-critique or rational criticism. Thus, midwives came to experience a subordinate status in relation to doctors who had authority over them. Hegemony relies on the consent or the acceptance of self-understandings that guarantee a worldview while at the same time forestalling the emergence of an autonomous self-concept. As culture is the social context in which hegemony occurs, it follows that, as a concept, 'culture' is necessarily closely linked to it.

Culture

Culture articulates symbolic values and norms which summarise the ends of particular forms of structured interaction. These values embody a reality which is the source of beliefs, attitudes and behaviour. But as Geertz says (1973:14) "the term 'culture' is not a power, something to which social events, behaviours, institutions, or processes can be causally attributed; it is a context..." This context is, among other things, the historical and societal forces that produce, mediate and legitimate meaning and includes the notions of conflict, struggle, and resistance that exist in institutional life. The idea that people do make history, or that they are producers as well as the products of history, including its social constraints, has been neglected, according to Giroux, (1983) as human subjects 'disappear' amidst a

theory that leaves no room for moments of self-creation, mediation, and resistance.

Thus, an adequate definition of 'culture' must incorporate, among other things, the idea that culture includes not only multiple groups but particular groups and individuals in relation to one another. This understanding advances a dialectical view of culture as a site both of oppression and of resistance since culture is never static or homogeneous. It is enacted in asymmetrical relationships which reflect the struggles and contradictions between midwives and groups as they produce and reproduce social structures and their content. If the production and reproduction of culture is so closely related to human interests, then its significance for the politics of oppression or liberation in midwifery is immense. To effect a counter-hegemony, it is therefore argued that midwives must engage each other in an 'ideology-critique' of their social and historical circumstances.

Ideology-critique

Following a neo-Marxist tradition of the Frankfurt school, Habermas developed the strategy which he termed 'ideologie-critique'. This strategy rested on the assumption that ideologies systematically 'distort' communication. Ideologies and the institutions they interpret may become mutually reinforcing. It is for this reason that common sense understandings should be subjected to critical scrutiny. Based on this assumption, Habermas (1972) proposed a critical approach to social practices by disclosing deformations of communication and thus restoring to people their position in history. Accordingly, a critique of midwifery practice would offer an interpretation of the past, an explanation of the present, and a vision of the future by exposing systematically distorted patterns of communication within social practices.

It was the possibility of forming an ideological unity, between different social groups, that was problematic to Gramsci (Mouffe, 1979). Gramsci (1971) emphasised the role of ideology as an active force used by a dominant class to shape and incorporate the

commonsense views, needs, and interests of subordinate groups. Thus for Gramsci, ideology was the operation of a selective process which ensured that certain meanings are given credence and not others (Grundy, 1987). Foucault (1980:36) suggests that these meanings and understandings are conceived in close proximity to practice and as 'dominant discursive practices' rather than as 'dominant ideology', the latter a term which he found to be problematic. However, ideological control is exercised in discourses, both in written and oral forms, and in the social practices of everyday life. These understandings may be diffused in the subtle shaping of individuals through socialisation into practice. Ideologies become hegemonic when they monopolise the range of social and political discourse or when they constitute the unquestioned assumptions of a society or social group (Burbules, 1986). The power of 'common sense' knowledge comes from its claim to be natural, obvious and therefore 'true' (Weedon, 1987:77).

For Gramsci, an ideological struggle was not to reject the system and all its elements by replacing one class ideology by another, but to break it down to its basic elements and then sift through past conceptions to see which ones, with some changes of content, can serve to express the new situation. Once this is done, the chosen elements are finally rearticulated into another system. In this way one class ideology is not imposed upon another.

The diversity of ideologies and processes engaged in by subordinate groups provides critical moments that have the potential to challenge the existing hegemonic culture and counterpose them. Thus, ideologies, that in particular circumstances and for particular purposes can disclose new possibilities and enlarge the scope of social or political discourse, "must be distinguished from hegemony which encorporate enfranchised and inflexible assumptions in belief and value" (Burbules, 1986:114).

Burbules points out that ideology-critique includes the questioning of unspoken assumptions, ambiguity, vagueness, manipulative rhetoric, misrepresentation and 'cultural silence' or what is excluded from

discourse. Thus, ideology-critique exposes the partiality of social and political discourse, not only in terms of incompleteness or inaccuracy, but also in terms of interests served by that discourse. Therefore, as Fay (1975) states, an ideology-critique has a practical interest as its aim is:

> the demonstration of exactly in what ways the ideologies of the social actors are illusions, with the idea that such a demonstration will strip these ideologies of their power; it tries to show men (sic) how they have been deceived, given their experiences, aims, and desires, and in the process it seeks to reveal to them the rational way of going about getting what they want.
> (Fay, 1975:98 -99).

An ideology-critique in midwifery is therefore retrospective insofar as its aim is to initiate self-reflection by which midwives as social actors become aware of, and liberated from, the historical compulsions of the past. In the classical sense, rather than the contemporary sense, an ideology-critique is therefore a form of "therapeutic knowledge" or paideia (education) directed to the cultivation, formation, and turning of the human psyche (Bernstein, 1976). Such a critique is concerned with understanding relations of dependence that are frozen into tradition and can, in principle, be transformed (Habermas, 1972). It is what midwives learn about themselves through reflecting upon their choices and action which, following Habermas, must be recovered and developed through both the theory and practice of critique. This can be achieved by developing a more fully self-conscious notion of reason, one that embraces both the idea of 'critique' and the element of 'human will' for transformative action. For Habermas, it also means entrusting to theory the task of rescuing reason from the logic of a predominant technocratic rationality or positivism.

Following Habermas, it is argued that if midwives are to realise the emancipatory interest which underlies the concept of 'autonomy', they need to engage in a critique of systematic distortions in communication and to articulate interests other than those that are predefined in institutional hierarchies and dominant forms of

knowledge. In particular, ideology-critique may reveal to midwives the possibilities for autonomy in relation to self-formative processes and the way in which these may be systematically distorted by the hegemonic operation of ideology. The medium by which an ideology-critique will be effected in midwifery is in the form of a dialogue.

Dialogue

Dialogue is a form of ideology-critique. It therefore has an important role to play in the development of knowledge in any discipline. In a practical discipline such as midwifery this is the mode through which central concepts and elements of the discipline are transmitted.

Freire's (1973) notion of a dialogical philosophy is that human beings consciously engage in relations with the world through acts of creation and recreation. Individuals make cultural reality and thereby add to the natural world which they did not make. Thus, for Freire, reality is socially constructed and results in knowledge derived through active processes as individuals relate to their world in a dialogically critical way.

To make the meaning of 'dialogue' clear, Freire (1973:46; 1982:108) contrasts the moment of dialogue to that of 'anti-dialogue' which involves vertical relationships between persons and is acritical. In anti-dialogue the relation of empathy between two "poles" is broken. Therefore, anti-dialogue does not communicate, but rather issues communiques as a monologue.

Thus learning, creating and recreating the world - or reality - requires a collaborative approach and a commitment to dialogue by members of a given community. Here dialogue is both reflective, in that it involves thought upon shared practices (rules), and also reflexive, in that it turns back upon itself in an attempt not only to articulate and clarify, but also to evaluate and challenge practices (rules). Reflection and reflexivity is that act of clarity obtained by a community when in dialogue. Through dialogue, midwives, for example,

may be able to grasp their own historical situation and solve problems in relation to strategic action.

Freire (1973) suggests that it is important that dialogue is critical otherwise social constraints, which distort dialogue and hence understanding, will never be acknowledged and assessed. Thus, critical dialogue presupposes a particular kind of context. For Habermas, (1984) this context is an 'ideal speech situation' where all participants have equal opportunity to engage in and participate freely in discourse based on a symmetrical opportunity to choose and apply speech acts. Rationality is thus related to the decision making process itself and has less to do with knowledge as such than the manner in which knowledge is produced and reproduced. Reason is embedded in language in general and in communication in particular (Habermas, 1972). Habermas (1975) argues that no matter what the final decision, if it has been made in a situation in which information has been suppressed or only certain perspectives considered, the outcome will be less than fully rational. It is also anti-dialogical in the Freirian sense. These democratic understandings of midwifery are understood against a socio-political context which encorporates a notion of 'power'.

Power

In general, traditional theories of 'power' have assumed that power is a property of individual persons, wielded instrumentally as a means to particular intended outcomes. According to Burbules, (1986) such an assumption prevents an adequate conceptualisation of 'power' in several ways: the reciprocal character of power relations is not addressed; the inherent power within hierarchically organised institutions is not taken into account; and the efficacy of power as a conservative system is not realised. This conceptualisation of power makes dissent and transformation difficult and thereby perpetuates the status quo as an achievement of discrete and intended purposes.

To overcome these inadequacies several authors (Lukes, 1974; Giddens, 1979; Foucault, 1980) have emphasised a relational view of power which

is seen to be grounded in a conflict of interest. As opposed to thinking that power is only wielded instrumentally, power may be a means of prevention as well as a means of direction and control. For example, Gramsci's 'hegemonic' control is effective and enduring when it takes this preventive form. It can serve the interests of one person or group to maintain a particular state of affairs by concealing it, by discouraging opposition, or by encouraging a range of free action and criticism that does not alter the essential features of the arrangement. Relatively hidden, it is therefore difficult to make problematic, to defy, or to rally opposition as it is implicit and latent in the common sense, in the everyday practice or way of things. Ideological and institutional in nature, such hegemonic control is less obviously pernicious, less personalised, and less dramatic in its effects; it limits without expressly forbidding (Gramsci, 1971; Burbules, 1986). Alternatively, power is strong...because it produces effects at the level of desire - and also at the level of knowledge (Foucault, 1980).

Foucault (1980) argues that knowledge and power are deeply connected; power is invested in knowledge and knowledge becomes useful through truth. Foucault demonstrates this relationship in a triangle which he sees is formed between power, right, and truth. These are organised in historically specific forms of discourse or discursive practice. The rules of right, or authority, provide a formal delineation of power and the effects of truth, that power produces, are transmitted and reproduced in practice. For Foucault, these are new modes of domination in the modern world which are manifest in the mundane discourses of learning institutions that directly affect everyday life or social practices.

Foucault's thesis is that there is considerable power exercised over individuals within institutions. But power must be analysed as "something that circulates in the form of discourse" (Foucault, 1980:98). Thus, discourses are already powers. They are ways of constituting knowledge together with the social practices and positions of subjectivity, or totality, that determine the power relations which inhere in such knowledges and the social relations

between them. However, as Weedon (1987:109) points out, "while a discourse will offer a preferred form of subjectivity, its very organisation will imply other subject positions and the possibility of reversal". Reverse discourse enables the "subjected subject of a discourse to speak in her own right".

Recent historic events have revealed a reverse discourse operating in midwifery. The impetus for this discourse and the cultural change inherent within it came from the lay public (refer to **Chapter Two**) and was later realised by midwives collectively. The constant lobbying of the government by the joined forces of women and midwives, resulted in the legal sanction of a midwifery alternative based on a women-centred approach to care. These counter-hegemonic developments indicate a resistance to the dominant discursive practice or dominant medical ideology. By politicising the tacit forms of knowledge (language, self-image, social routines) in midwifery, alternative forms of knowledge to that of the dominant discourse are legitimated.

In this situation, 'power' is not only domination but also 'empowerment'. This is crucial for understanding how a critical theory can be effective in liberating a dominated group, class or culture. In this sense, power exists not only when a group is controlled but also when a group comes together, becomes energised, and organises itself, thereby becoming able to achieve something for itself. According to Fay this is 'empowerment':

> the paradigm case of power is not one of command but one of enablement in which a disorganised and unfocused group acquires an identity and a resolve to act in light of its new-found sense of purpose. I call this sort of situation one of 'empowerment'.
> (Fay, 1987:130).

In this thesis, the idea of empowerment takes into account tacit forms of knowledge which bind midwives together into a community, as well as the authority and complexity of living traditions - linguistic, institutional, technological, moral, behavioural and so forth. As such, the epistemic conditions are provided for the development of

emancipatory knowledge. To reiterate, the concept of power is closely linked to the concept of knowledge.

Knowledge

Habermas (1972) revealed the ways in which different kinds of knowledge are shaped by the particular human interest that they serve. Habermas differentiated between three interrelated but distinct domains that he called 'knowledge constitutive areas of cognitive interests'. The three categories of knowledge, which he defined as technical, practical and emancipatory interests, represent different ways in which knowledge is conceived depending upon the interests being served. The three knowledge-constitutive interests take several forms according to the practical function to which they are put and are therefore inherent in the development of knowledge for midwifery practice.

The interests served by technical knowledge are those of exercising technical control, usually over the physical environment in order to survive. The form this knowledge takes is typically that of a uni-directional causal explanation that has arisen from the empirico-analytic scientific tradition. Thus, technical reflection is characterised by the application or implementation of existing knowledge to the attainment of given ends.

Alternatively, the interests of practical knowledge are concerned with understandings which inform and guide practical judgements through symbolically structured communicative action. These interests give rise to the historico-hermeneutic scientific tradition. Such understandings are not amenable or reducible to the empirico-analytic scientific tradition but require methodologies of a hermeneutic kind. This interpretive inquiry is aimed at anticipating and clarifying the assumptions that underpin practical activities. Thus if midwives engaged in practical reflection, they would seek to interpret and defend moral, ethical and value considerations that are embedded in practical decisions which rest on a knowledge of self and the shared meanings of others. But interpretive approaches have the inherent

limitation of becoming systematically distorted because of the continuing existence of extant social, political and cultural practices (Fay, 1975).

From the third knowledge-constitutive interest, knowledge is to be understood not only in terms of inherent logic but also in terms of the socio-historical conditions out of which it emerges and of which it is part. Thus if midwives engaged in critical reflection they would adopt the self-reflective stance of the 'practical' in explicating the aims and values of accepted moral positions but extend this to include a concern with ideologically distorted structural forces and constraints within their work setting. It is when communication extends beyond the confines of subjective meanings that social action and interaction, characterised by autonomy and freedom, become possible. It is this critical perspective that enables practitioners to articulate, and ultimately to eliminate, the socio-political conditions that constrain their practice. This is the emancipatory intent of critical social science.

Each level of reflection - the technical, the practical and the critical - encompasses not only a form of reflection but also a view of knowledge that has enmeshed in it certain 'knowledge constitutive interests' that are pertinent to midwifery practice; that is to say, a worldview where knowledge is not neutral but has historical roots and serves particular interests (Habermas, 1872; Smyth, 1986a; Van Manen, 1977). It is argued that the interests of midwives will be served by the development of emancipatory knowledge. This knowledge will extend midwives' personal and professional self-determination which is implied by the concept of 'autonomy'.

Autonomy

The extended use of the concept of 'autonomy' has gained greater significance in midwifery since the Nurses Amendment Act 1990. Underpinning the principal amendment is the objective that legal autonomy granted to midwives will give women more choices and through this will come an autonomous midwifery practice. Removing the

structural constraints at the legislative level is the first step toward attaining independence. The challenge for midwives is to make autonomy work in practice as well as in principle (Clark, 1990).

"The noun 'autonomy' and its adjective 'autonomous' derive from the Greek **auto** meaning 'self', and **nomia** meaning 'law' (or more generally rules or standards)" (Lankshear, 1982:97). Put together these root terms convey the notions of individuals, being a law unto themselves, or of individuals being the source of the law, rules and standards in accordance with which they practice.

To say that individual midwives are autonomous, or self-directing in practice, is to say that they are 'free' to emphasise the over-riding importance of one particular kind of desire or option, namely, to make their own decisions in practice as a regulating principle for what follows. It may be said that midwives are 'free' when their 'real self' governs, and they are subject to no foreign power, either internal or external, to whose authority they have not consented.

The concept of 'autonomy' underpins the critical notion of human agency. Human agency is implied by Smyth (1986b:2) when he says that self-determination, autonomy and self-control is the "ability of members to exercise responsible control over what counts as knowledge in their field". However, it is argued that in order for midwives, as human agents, to exercise responsible control over knowledge in their field of expertise, the notion of human agency must be framed within a socio-historical context of competing discursive practices. It is the contention in this study that, far from being autonomous, or independent of existing social values, trends and practices, midwives are socially constructed through several discourses which may be complementary or competitive. It is only by reflecting upon such discourses and the sites where they are articulated that it is possible to see whose interests they serve at a particular moment.

'Personal autonomy' may also be adopted as an educational ideal as with Peters (1973) and Illich (1971). However, according to Lankshear (1982) as an educational ideal there are different yet equally

coherent accounts of 'personal autonomy'. A rationalist account of 'personal autonomy' has a bias which pervades contemporary educational philosophy. Lankshear contends that many individuals may be hampered, rather than facilitated, by an education aimed primarily at the development of 'rational autonomy' where the growth of free persons is a matter of advancing rationality or reason. Lankshear (1982:148) suggests that the important source of 'autonomy' lies in the satisfaction which is derived from "the experience or perception of oneself as author or originator of one's achievements".

Thus, in this thesis, 'rational autonomy' as an educational ideal in midwifery can be rejected. Received concepts and methods, justified on the basis of rational deliberation or in accordance with rational criteria, appeals to objective standards and principles which may be inherently at odds with the nature of things in the experiential world of midwifery.

However, as 'personal autonomy' involves the attempt to give an ethical embodiement to the idea of being independent and self-governing (that is to invest it with some positive ethical content), "rationality entails two central values: autonomy and responsibility" (Allen, Benner & Diekelmann, 1986:33). Lewis and Batey (1982) describe this rationality as 'discretionary' and crucial to autonomous practice. Resting on such moral deliberation 'good' decisions about care are made and evaluated to check that those decisions are effective. The value of this ideal may be realised in midwifery, for to say that a midwife's practice is 'autonomous' is not the same as saying that it is 'good'. Autonomy necessarily becomes a desirable ideal because the reasoning which characterises the autonomous person is precisely the kind of reasoning which yields sound moral judgement and morally acceptable practice.

It is argued that the impetus for midwives to achieve self-understanding and autonomy of action could be achieved through self-questioning. But, as Fay (1987:198) points out, there is a limit to autonomy. He states that self-questioning may not lead to 'collective autonomy' because, as an ideal, it may fail to take into account the

historical and embedded character of midwifery practice. Thus, midwives are confronted with often "irreconcilable demands and unacceptable options" as they are dependent upon processes outside their control. This point is elaborated in **Chapter Two.** From this discussion it is evident that autonomy as a concept is closely linked to the concept of 'authority'.

Authority

The English word 'authority' originates from the Latin 'auctoritas' and has a range of meanings considerably broader than its Latin original. There is no word in Greek to translate 'auctoritas'. Plato's attempt to introduce such a notion into Greek political thought drew on cases from the role of arts and sciences, or spheres of expertise, in which those who know made authoritative pronouncements. Indeed, 'auctoritas' is more a right to make pronouncements than a command or 'potestas'. The association of both these derivatives holds when we turn from Latin to the English word 'authority' as, unlike its Latin original, 'authority' lives not solely in the sphere of counsel, but also in that of command, 'potestas' as well as 'auctoritas' (Watt, 1982).

As with the notion of autonomy, authority in midwifery must be marked by the appropriate kind of reason or appropriate action. As far as the concept of authority is concerned, whatever lacks that justification or 'appropriate' action cannot be authoritative. Certainly it is only personal excellence, and not the holding of any institutional office, that makes someone an authority on their subject; to call someone an authority is to say that they know it well or they do it well. Benner's (1984) expert nurse is an example of such an authority as 'knowing how' is combined with 'knowing about' a total situation or field. Excellence shows itself, not primarily in the knowledge of general principles, but more in the capacity to deliberate wisely and to make sound judgements through experience.

Thus, certain privileges are justified by reference to authority and the presumption of authority. But like the presumption of privilege,

authority may become a relation of power even when it has legitimate roots. Questioning authority does not mean rejecting authority: it means scrutinising who is an authority, why they merit such a position, and what are the limits of that authority. Unquestioned authority becomes authoritarianism and pervades the minds of both the authorities and those subject to them. When authority begins to appeal to tradition as part of its justification, it is reactionary and a sign that its maintenance has outlived its worthiness. As with the notion of dialogue discussed above, this last point raises to the attention of midwives the importance of embracing the notion of 'praxis'.

Praxis

The term 'praxis' has its origins in Greek philosophy, its home in epistemology and its recent forceful articulation in Karl Marx and the neo-Marxists or critical social theorists. In ordinary Greek usage 'praxis' roughly corresponds to the ways in which we now commonly speak of "action" or "doing" (Bernstein, 1971:ix). But 'praxis' is not simply about doing something and thinking about it. According to Grundy, (1987) praxis involves freely choosing to act in ways which are informed by critical social theorems. It is not assumed that because the action is informed by such theorems it will automatically be 'right action'. Such actions must in turn become the subject of reflection, as must also the theorems which informed the action. For praxis to be the true object of knowledge, it must be accepted that knowledge cannot be separated from the practical historical circumstances of its acquisition. That is, there is no transcendental viewpoint, or indubitable foundations for knowledge and human practice.

Freire (1973) goes so far as to suggest that to become more fully human is to become more critically aware of one's world, and to be in creative control of it. The more one engages in conscious action, to understand and transform the world in a praxis of reflection and action, the more fully human one becomes. In the process of creating (or naming) the world, that is, creating history and culture, we

express our uniquely human potential to be actively involved in creating what we become (Freire, 1972; Lankshear & Lowler, 1987).

Grundy (1987:113) maintains that in praxis, theory and practice must both be open to critical scrutiny. "Being of this character, praxis is not action which maintains the situation as it presently is; it is action which changes both the world and our understanding of that world". This is what is meant by saying that praxis is the act of reflectively constructing or reconstructing the social world. The conscious spaces in thought and social practice are where basic assumptions, social practices and beliefs will be defined and redefined and thus are the areas of social life within which midwives must, in Habermasian terminology, exercise 'communicative competence'. In this way, praxis is informed by an emancipatory interest which would preserve for midwives the freedom to act within their own social situations in ways which enable them to be in control, rather than the ultimate control of their actions residing elsewhere.

Given the necessity for midwives involvement in practice as their 'raison d' etre', the prescriptions which are generated by 'praxis' cannot be adopted in the abstract but must be filtered through the contextual constraints within which action is located. This focus will make some choices more relevant than others. If the true object of knowledge is praxis, then knowledge itself cannot be separated from the practical historical circumstances of its acquisition. While extant theories provide the reasons and motives for purposeful practical action in midwifery, they direct practice within situations where contextual variables have to be considered. If actions in midwifery practice and education are to be grounded in praxis, actions must be praxis oriented. Praxis-orientation implies that actions must be informed by a critical social theory that names the world and in so doing subjects theory and practice to critical scrutiny.

SUMMARY

There are several arguments for using a critical approach in this study. There is an underlying striving toward 'disciplined subjectivity'. This may be interpreted as a circumstance in which the researcher maintains a constant "inner traffic between observations and conceptual models" (Smyth, 1986a:42). Rather than striving for objectivity, where concepts and problems are passed down as in the empirico-analytic paradigm, the approach advocated requires an inductive process. Here the problems, needs and genuine concerns are passed up to be defined and resolved against an interpretive worldview.

Starting from the notions of 'human agency', 'structural determinants', 'history' and 'shared interests', the study adopts a collaborative stance to examine and analyse the ways in which midwives experience their practice world. This approach requires a commitment to dialogue insofar as the researcher and participants reconstruct practice based on an understanding of the assumptions upon which midwifery practice rests. In dialogue they jointly discover and illuminate social processes and experiences in a critical reflective and reflexive critique. As part of this process, the research participants are encouraged to historicise their position by thinking back to the past, and to perceive the circumstances that brought the present conditions about in the first place. Such a discourse has as its aim that act of clarity which is obtained when participants grasp their own historical situation and are able to see the possibility of change in relation to strategic action. In this way midwives may be able to see themselves, not only in relation to past history, but as active participants in influencing the present and the future.

Thus, a critical social science begins with a genuine desire to experience change, a change that is not externally or experimentally imposed. Hence, authentic meanings can be given to a particular situation and a new set of beliefs and actions can be acquired for the future. But it is not enough that midwives should come to grasp their socio-historical circumstances in which they practice, but also, the

process should liberate them from 'domesticating' thought structures and debilitating forms of social control. Therefore an adequate critical social theory needs to be able to show how to move out of the present situation. What this requires is a commitment to change. It is suggested that if midwives take charge of their own practice needs and educational aspirations this will be both enabling and liberating for the discipline.

In the following chapter the design and methods compatible with a critical research approach are discussed.

CHAPTER FOUR

THE RESEARCH PROCESS

This chapter addresses the process of conducting the present study. The chapter falls into three sections. The first discusses the case study method and establishes the rationale for the chosen design as well as some of the ways this approach differs from case study undertaken from different perspectives. The second section details the procedures and techniques of data collection and includes a description of the following: contact with participants, the chosen setting, gaining access to the field, ethical considerations, and data collection methods. The third section describes the process of data analysis and the measures taken to establish the 'trustworthiness' of the study.

SECTION ONE: RESEARCH DESIGN

This study uses five critical case studies as a methodological approach to generate knowledge within a 'critical' tradition. Research located in a critical tradition accepts the following underlying epistemological assumptions: knowledge is socially constructed and contains divergent and multiple viewpoints; the standards of 'truth' are always social; criteria used to separate knowledge from fiction are based on social conventions or negotiated agreement which change historically; for negotiated agreements to occur, it is essential that interaction is not coercive; social life is structured by meaning, rules, conventions, or habits adhered to by people as social beings; and the meaning of midwifery and the perception of midwifery care received from midwives is closely tied with social process (Reason & Rowan, 1981; Allen, Benner, and Diekelmann, 1986; Lather, 1986).

In addition, knowledge in the critical tradition is "available for disciplined debate and critique" (Perry & Moss, 1989:38) and aims at

developing emancipatory knowledge (refer to **Chapter Three**). An emancipatory research project recognises the contradictions inherent in social understandings and in the social order and specifically seeks to locate counter-hegemonic practices at work (Giroux, 1983).

The rationale supporting this methodology is that case study is logically compatible with a socially critical approach in arriving at a balance between thought (theory) and action (practice) or theory as intervention. The ultimate purpose is therefore not only to understand the nature of knowledge, which is embedded in and informs midwifery practice, but to expose the ideological positions of particular interest groups and forms of knowledge that reinforce them. Through the process of exposing distorted power relations, midwives may reach an 'altered reality' which affirms their everyday experience in their practice world and their place in the construction of a more fully human world. Such a reality, according to Thompson, (1987) includes the development of new language, new meanings, and new social practices, and hence the potential for transformation of social institutions that have formerly been oppressive.

As a method, case study is used across a number of practice disciplines including: law, education, medicine, psychology and nursing. Consequently there are many different forms of writing that have been labelled 'case studies' with considerable diversity in elucidating its distinctive features. As Lincoln and Guba (1985:360) note: "While the literature is replete with references to case studies and with examples of case study reports, there seems to be little agreement about what a case study is."

A well known example of a case study approach from psychology is Sigmund Freud's case studies of psychiatric patients. Freud depended upon the case study method to generate psychoanalytic theory. In nursing, Wilson (1982) used a case study design to study young diagnosed schizophrenics in a health care setting. These studies stand alongside an array of descriptive and conceptual case studies by nurses and other social scientists on topics related to the delivery of health care. The approach is purported to be useful in gaining

insight into little known problems; developing explanations of social-psychological and social-structural processes; and offering rich descriptive anecdotes to illustrate findings (Wilson, 1985). The unit of analysis in case studies focus either on individuals, an agency, an event, or a culture. But where the unit of analysis, or case, is the individual, the design examines either a single individual or a small number of individuals with respect to history, characteristics, and social interactions.

However, what is generally not explicated in these texts are the merits of case study methods with regard to the fundamentally different traditions that underpin social scientific enquiry and their place in the generation of knowledge for professional practice. As Hickson (1988) explains:

> ...there is a failure to acknowledge that differing assumptions about the nature of reality (ontological assumptions), assumptions about the nature of knowledge (epistemological assumptions) and differing views regarding the purposes of social science enquiry give rise to distinctly different types, and consequent evaluations of the value of case study approaches.
> (Hickson, 1988:23).

Hickson's (1988) critique demonstrates that there are at least three research traditions - empirico-analytic, historical-hermeneutic and critical - which vary according to the technical, practical and emancipatory interests that constitute what is viewed as legitimate knowledge and the use of that knowledge. Research, like knowledge, is therefore non-neutral, has historical roots and serves particular interests (Fay, 1975; Reason & Rowan, 1981). As a set of rules and procedures (metatheory) for conducting research, each tradition has an inherent place in the generation of knowledge for midwifery practice. Thus, the case study method may be distinguished by the tradition which underpins the social scientific enquiry. The following explicates different uses of a case study approach within these distinctly different research traditions.

Empirico-analytic Approach To Case Study

Case study design has been utilised within the empirico-analytic tradition. Some have divided studies within this tradition into 'exploratory' descriptive case studies and 'explanatory' case studies (Barnard, Magyary, Booth & Eyres, 1987:53). While exploratory case studies "are designed to identify and describe the complexity of the phenomena as it evolves over time under real-life conditions," explanatory case studies "are designed to examine the causal links underlying a particular phenomenon." Both categories are not suitable for identifying the prevalence of a phenonmenon in a defined population or to determine the distribution of individual differences for a given phenomenon. Therefore, from the perspective of the empirico-analytic tradition, explanatory case studies, and to a more limited extent, exploratory case studies, must by nature be restricted to 'pre-scientific enquiry' as they fail to meet the evaluative criteria (reliability, validity and generalisation) imposed by an objective scientific worldview. For as Fay (1975) observes, it is the interrelationship between scientific explanation and prediction that gives the 'value-neutral' scientific enterprise the possibility of control and therefore its power.

However, explanatory case study fit within the context of a semi-controlled or tightly controlled setting. An example of this is given within the context of behavioural treatment modalities or behavioural modification. Used in this way, the principles of an experimental design are modified so that the case study is a single-subject experimentally designed study. The strength of explanatory case study is said to lie in its ability to handle "a wide variety and large amount of information about a particular phenomenon" (Barnard et al., 1987:53). Thus, a detailed account of a subject's baseline data may be compared with data (a few select, defined behaviours) taken after an experimental intervention. Phenomena are controlled and manipulated so that a selected dependent variable may be measured before, during, and after the use of an intervention with one patient. Thus, technical 'control' of decontextualised phenomena becomes the defining element in explanatory case studies. But the precise quantification of a few

isolated behaviours is said to be "problematic" with respect to the clinical relevance beyond the somewhat artificially imposed setting (Ibid:52).

Following the procedural rules of their science, which gives the empirico-analtyic or positivist (natural science) model 'scientific detachment' or neutrality, explanatory case studies may be undertaken from an objective perspective. Maintaining an objective stance, the researcher refers to what is observable and measurable as this science can only concern itself with 'what is' and how it came to be so. It can say nothing about 'what ought to be' as it is assumed to be value-free. The aim is to formulate principles that have the same objective status as natural scientific laws. The event or phenomenon to be explained is deduced as a necessity from these laws or principles that explain social events or phenomena and specify the particular circumstances in which that law has application.

Writers, and others working within the traditions of 'interpretive' perspectives, (Fay, 1975; Reason & Rowan, 1981; Lather, 1988) have criticised the empirico-analytic model by arguing that the social sciences require different forms of explanation from the natural sciences. These critics maintain that the way scientists interpret what they observe cannot be entirely 'scientifically detached.' The theories, research conventions, and interpretations of scientists working in the interpretive tradition are socio-historical products as is the socio-cultural world in which the research is located.

Where science is equated with the empirico-analytic tradition, Habermas (1972) has also challenged the underlying assumptions of this 'scientifically detached' model by arguing that it is limited in character since it presents one side of an argument. Others have called this 'scientism' (Bernstein, 1976) or the tendency toward reification of a 'received' reality. That is, there is a tendency toward mistaking historically conditioned social and political patterns for an unchangeable reality which is simply 'out there' to be confronted. According to Habermas, to generalise from regularities of a value-free paradigm, and to claim that scientists are discovering

universal laws that govern human beings, is to mask an ideological basis. However, the assumptions that arise from this model have consequences for the way case study is viewed by those working in this tradition and for the use to which they can see it legitimately being put (Fay, 1975).

A Historical-hermeneutic Approach To Case Study

The case study from an 'interpretive' perspective views research participants and researchers as members of a community rather than as objective instruments of data production. Hence, those who work from a historical-hermeneutic scientific tradition (Wilson, 1982) recognise science as a social product and follow different assumptions from those who work from within an empirico-analtyic tradition. Writers working within the historical-hermeneutic scientific tradition see that information is processed in a different mode from "rationalism" (as in explanatory case studies) or even "pragmatism" (as in exploratory case studies) (Reason & Rowan, 1981:127). They also see different uses for which case study can legitimately be put. Rather than aiming for 'objective' knowledge of how events or properties of systems are related, (and therefore the possibility of control and manipulation of phenomena) the case study is aimed at an in-depth 'understanding' of meanings within natural settings. The boundary between the phenomena and context is not clearly evident and multiple sources of evidence are therefore accepted (Yin, 1984). From this perspective, the researcher is able to probe qualitative aspects of interpersonal understanding in detail as communication of meaning, or 'perceived' reality, becomes a defining character of what counts as 'truth' within this tradition (Hickson, 1988).

Within a Habermasian framework, this form of scientific enquiry is identified as a 'practical' interest which is concerned with intersubjective meanings of social activity and understanding the way people interpret their action and interaction. Working within this tradition, Wilson (1985) has described case studies as providing an in-depth analysis of a 'subject' for investigation. The individual is studied through detailed observation within their social context or

life world. Thus, 'understanding' of contextual phenomena becomes the defining element of case study from within this paradigm.

A Critical Approach To Case Study

The case study method within a critical tradition is consciously aimed at enabling participants to understand the situation they find themselves in and through these insights actively change their situation. Two examples of studies which have used a critical case study method to explore the ways in which nurses exercise personal and professional agency are Perry (1985) and Hickson (1988). As these studies explain, many assumptions of the historico-hermeneutical tradition are accepted but extended through critical social science. Of particular note is the notion of research as 'praxis' (Lather, 1986). Praxis fuses theory and practice resulting in a "philosophy in action" (Codd, 1989:157). Within this scientific tradition, critical reflection, critique, and challenge become modes of intervention in the everyday practice world, as critical social science questions the political nature of all knowledge. This includes the production of knowledge and the use to which knowledge is legitimately put.

In light of these dynamics, contemporary researchers within this 'reflexive' tradition have treated the basis of their knowledge (theories, constructs and experience) as problematic. Hence, during the research process and presentation of results I have followed the same reflexive pathway. Case study method within critical social science is therefore by nature openly ideological as it has at its core an emancipatory intent and seeks to develop knowledge that "frees participants from outmoded and reified conceptions of reality" (Comstock, 1982:314). Through dialogue, the practice world may be examined for forms of knowledge which have become frozen into a tradition and therefore ideological (Habermas, 1972).

Such a critique forms the basis for a continuing dialogue beyond the research project itself. The ongoing critical engagement by midwives, who consciously channel the "reality-altering" (Lather, 1986:272) impact of the research process, is the criteria upon which the success

of the case study is based. In this way self-determination results from the consciousness of new possibilities and transformative action.

Case studies within a critical tradition commence with an examination of the social context in which the social actions are situated. In this study I used participant observation to carry out such an examination. This gave me an opportunity to take into account the social interaction and characteristics of the everyday practice world in which the midwives worked. Allied to this approach, the case study was derived from interviews which provided participants with the opportunities to critically reflect upon their world and to reveal meanings which may be ideologically distorted. This required a reflexive and collaborative approach, beginning with the problems of the research participants and proceeding through an ongoing process of reflection and action. The researcher and participant together openly reflected, not only upon the research data, but on the methodology and on the values and understandings that both brought to the research project. The study also sought to examine the historical circumstances that may have given rise to ideologically distorted understandings and practice. Such critical activity enabled each individual midwife to explore new possibilities within her particular situation and to determine the relevance it has for midwifery practice. The changed self-understanding and the subsequent socio-political action provide the test of value of each case study.

SECTION TWO: TECHNIQUES

Participant Selection

As an inservice educator within a large teaching hospital in New Zealand, I was in a position to assess the level of interest in a collaborative study of midwifery practice. With an underlying commitment to develop the knowledge embedded in midwifery practice, I invited the participation of midwives to work with me in exploring practice and the context in which it occurs.

I made initial contact with the participants of this study during their orientation as new graduate midwives. As neophyte practitioners, the midwives entered the hospital after completing a one year New Zealand midwifery course in 1989. Five potential research participants were identified from this group and gave their verbal consent. An arrangement was made with these midwives to keep them informed of progress through the stages of writing a research proposal, obtaining access to the field, and gaining ethics committee approval. I maintained communication with these midwives through face-to-face interaction or by telephone contact.

Once ethics committee approval was gained, I contacted the potential research participants and obtained written informed consent from four of the original group. One midwife withdrew her verbal consent for personal reasons. During the interactive process of fieldwork, I met with two other midwives from the same midwifery course who were interested in becoming involved. I gained written informed consent from one of these midwives after the implications of participating in a reflexive study were explained. By the data collection stage of this study, these midwives had been registered for eighteen months.

The setting for the study

The practice setting was circumscribed by where the participants themselves were working which was in two large teaching hospitals. This setting was thought to be the most appropriate context for observing the way in which midwives make sense of their practice within power/knowledge relationships. It transpired that field observations occurred in two practice settings: the labour and birthing area and the antenatal area.

The labour and birthing areas admitted women along a wellness - illness continuum and who experienced labour and birth within either a 'midwifery paradigm' or a 'technocratic paradigm' (Bassett-Smith, 1988). The antenatal area on the other hand, admitted pregnant women into hospital with either a poor obstetrical history or a diagnosed physiological condition. In this situation the mother and/or baby are

considered to be "at risk" and may need medical intervention to ensure a live baby and a live mother.

Each area was staffed predominantly by midwives, although there were a few enrolled nurses and nurse aides. Student midwives rotated through each area at different times. A charge midwife was present on the morning shift in both areas. On other shifts there was either a charge midwife or a midwife who was designated as being in charge. A mix of both private clients, admitted under their own doctor, and public clients, admitted under one of the hospital medical teams, were involved. In both areas, the midwives notified the medical staff as women were admitted to the ward and sought specialist medical knowledge and skills as necessary.

Midwifery practice in the antenatal area may be described as one of assessment and education of pregnant women. In the labour and birthing areas midwifery practice may be described as primarily supportive with ongoing assessment throughout the labour and birthing process. The midwives worked as autonomous practitioners in the sense that they were primary caregivers. In a 'shared care' situation, the doctor took overall responsibility for a woman's care but the midwife remained the primary caregiver for purposes of the 'acute' situation (that is labour and birth) and continued assessment following birth.

Access To The Field

The process of gaining access to the field necessitated engaging in both formal and informal procedures. As part of the formal procedure a proposal was submitted to Massey University Human Ethics Committee. After gaining their approval, I sent a proposal to the appropriate Area Health Board Ethics Committee to gain approval to collect data in the clinical field. After amendments to the proposal, the Area Health Board's approval was also received.

As an employee of an Area Health Board at the time of writing the proposal, I had little difficulty in identifying gatekeepers and negotiating access to the field. Once ethics approval was received, I

sent a letter of introduction and a copy of the study's proposal to the two hospital's Maternity Services Managers informing them of the proposed study and asking for their cooperation. Following the letter of introduction, I met with the Maternity Services Manager in both hospitals for the purpose of clarifying the aims and the intent of the study. Similarly, I also met with the Professional Head of Nursing. Following these preliminary and introductory meetings, I met with the charge midwives of the areas involved and left with them an explanation of the study. I also sent a notice of introduction to the Maternity Services Manager to distribute in each area. The purpose of this was to identify any further potential participants and to invite midwives to contact me should they have any queries about the study.

Ethical Considerations

In any research project, safeguarding the moral integrity of participants must always remain a higher priority than the quest for knowledge or scientific achievements. This understanding was paramount during my interactions with participants as the personal nature of some of the information that they shared with me was at times highly contentious and political in nature. That is not to say that research from another perspective is not political but is to keep within a socially critical approach by openly admitting that the research process itself relates the personal to the political and is by nature openly interventionist.

Some have argued that "as an interactive process, research is intervention in people's lives" (Middleton, 1988:137). Based on this assumption it is argued that it is better for the researcher to examine their own biases, to be open about them, and to be aware of the anticipated effects of the research process as well as being alert for the possibility that there may be unintended consequences of research. This study follows in this openly ideological tradition.

Before signing consent forms, the midwives involved in this study were made aware that a socially critical, self-reflective study may result in changed perceptions which in turn may stimulate them to make

changes to the way midwifery is practised. These anticipated effects meant that I was responsible for giving participants information in such a way that they were able to understand the implications of participating in a study of this nature. Underlying this process was the principle of autonomy which affirmed the right of the research participants to be self-determining, or free from coercion of any kind. As such, this principle validated the doctrine of informed consent. Once initial consent was given, the participants understood that they were free to withdraw from the study at any time.

The principle of autonomy also applied to the women that each midwife was 'working with'. This meant that during field observations each midwife approached women in her care for consent before introducing me to them. In this way they were given the right to refuse to participate without coercion. These women were then given a brief explanation of the study before they were presented with the opportunity to give their written consent. They were also given the opportunity to have a copy of the research findings sent to them on completion of the study.

The information that participants shared with me was protected by my commitment to confidentiality. This was maintained by the following measures: my reassurance that all information would not be shared in detail with any other person; that I would collect all data and analyse it myself; that data would be secure and kept in a safe location; that recorded interviews were erased as soon as the thesis was examined; that pseudonyms would be used in all published material; and that audio-tapes would be destroyed on completion of the study.

The participants were given control of recording the interviews by being shown how to operate the on/off switch on the taping device. In this way participant's autonomy was preserved. As with Clare's (1991) study, I gave each participant the opportunity to 'talk out' unrecorded any sensitive issue before continuing with recorded dialogue.

All personal names and places were changed in the written material which served a dual purpose of protecting participant's identities and preserving confidentiality. The need to protect the participants from potential harm meant that some of the data had to be altered or left out of the study altogether.

Data Collection Methods

In this study I have relied mainly for data on field observations converted into field notes and on reflective interviews. The two qualitative methods of participant observation and tape-recorded interviews were utilised as part of a case study approach. Following in a critical tradition, which views research as praxis, (Lather, 1986) the study was guided by a democratised process of inquiry characterised by negotiation, reciprocity and empowerment. From this position, it follows that inquiry which aims at empowering those researched must begin within the actual research encounter itself. Thus rapport was established with each participant prior to gathering data in the field.

Participant Observation

As field research means entering the everyday world of the people under study, I was engaged in the process of making "descriptive observations" of five midwives' practice within their everyday work environment. In a sense, when making "descriptive observations" I participated in this social situation and then "treated myself as an informant" (Spradley, 1979:76) when interviewing participants at a later stage. The rationale underlying this approach is provided by an anthropologist Clifford Geertz:

> ...if you want to understand what a science is, you should look in the first instance not at its theories or its findings, and certainly not at what its apologists say about it; you should look at what the practitioners of it do. (Geertz, 1973:5).

The field observer, according to Spradley, (1980:81) begins with descriptive observations stimulated by "grand tour" questions. In other words, descriptive questions are in response to descriptive observations which are made about midwifery practice. These observations were recorded in the form of fieldnotes. As well as taking numerous notes of what midwives did and said verbatim, I took note of my own actions, thoughts and feelings. This data served a dual purpose. Firstly, the observations provided a springboard for the reflective interviews that followed by suggesting areas that needed further exploration. Secondly, observations were sensitive to the process of midwifery practice in relation to social interaction within which each midwife was situated. This process was inherently dialectical. As an instrument of data collection I was affected by the social situation; the midwives under observation were simultaneously affected by my presence and note-taking. For this reason I tried to take notes unobtrusively.

I observed each practising midwife for two full rostered shifts and spent over eighty hours in the clinical field. This meant that I was present at 'handover' or the beginning and end of each shift. A typical pattern of data collection was to divide the observational times into different shifts. When the first observational 'session' occurred on a morning shift, for example, the second was planned for an afternoon. This pattern was not possible for one participant who worked at night.

Interview

After observing each midwife in their everyday practice world, I engaged them in at least four in-depth, focused, reflexive interviews. These interviews lasted between one hour and three hours and took the form of an open-ended, mutually engaging dialogue between myself and each participant. Following Oakley's (1981) approach to the interview situation, I made a deliberate attempt to engage participants in a joint enterprise and thereby generate a collaborative effort. This approach established a non-threatening environment so that a mutual exchange of knowledge could occur throughout the process of enquiry.

All interviews were tape-recorded and the audio-tapes were transcribed by myself. After the formal interview, several hours of informal discussion sometimes followed which served to elaborate anecdotal narratives.

The reciprocal nature of the interview process meant that there was a mutual sharing of personal experiences between myself as researcher and the researched. Just as participants shared with me aspects of their personal lives, my experience as a midwife, a mother, a teacher, a student, and a nurse was shared with them as questions about my personal life arose. Using Oakley's (1981:41) words, I was prepared to invest my "own personal identity in the relationship" that developed between interviewer and interviewee.

Following Giddens, (1986) prior to each interview the transcripts from the previous interview were checked by each participant before they were used as data. Thus, data was fed back to participants as a way of arriving at more securely based interpretations. This process was dialogical, a process which Tripp (1983:40) terms "meaning negotiation" whereby a participant modifies the text, or their views, in the light of their reaction to reading the transcripts of their initial statements. I involved each participant in three stages of negotiation. The first of these established the conditions of this study or how it was to be conducted. The second stage involved the clarification, analysis and sometimes rewriting of transcripts. The third stage involved participants reviewing my preliminary analysis of their practice using their words to illustrate my own interpretation. Some participants suppressed aspects of their views because of the possible social effects of their statements.

In relation to the review of research data, Tripp (1983:38) has asked the question: "At what point will the process of negotiation work counter to the production of a fair representation of a person's view?" Tripp is under the impression that researchers are "the majority shareholders" of the data. As "shareholders" all participants (including myself) are entitled to criticise the published study publicly. However in this study, it was the content which was

negotiated by the participants as "minority shareholders", rather than the reflexive process.

Profile Of Study Participants - The Midwives

Before graduating from the 1989 midwifery course, all participants in this study were registered nurses who had graduated from either general and obstetric or comprehensive programmes. The midwives ages ranged between early twenties and mid forties. All were Pakeha and born in New Zealand. However, it is argued that to reveal particular demographic characteristics of each case study would readily identify the midwives involved to many people. In a country the size of New Zealand, to reveal the specific location of where each midwife worked, for instance, would make it easier to trace the particular people involved. Therefore, as with other research, (Middleton, 1988; Clare, 1991) to protect the identity of participants, some of the data has had to be either left out or changed without altering the essence of the interpretation.

Selection of participating midwives occurred on the basis of particular characteristics rather than to gain a representative sample. Criteria for inclusion in the study included:

* A midwife who had graduated from one specific midwifery based course.
* A midwife who was working full time in a hospital.
* A midwife who had no intention of moving from the midwifery area during the course of the study.
* A willingness to participate in the study.

The Researcher

As a participant of this study and in keeping with an openly ideological critical social science methodology, my values and interests are explicated. I had ceased to be employed by an area health board when the data collection phase of this study was reached. This aspect was considered to be a necessary precondition for the

success of a study of this nature as I was completely independent of hospital management.

From my observations as a practising midwife, I was aware that midwives have tacit knowledge embedded in their practice. Schon (1983:42) describes the knowing in professional practice as either a firm "high ground", where there is an effective use of research-based theory and technique, or a "swampy lowland", where the situations are confusing messes incapable of technical solution. Either way, where knowing-in-practice is implicit there is a commitment to taken-for-granted ideological positions that may be supported by particular interest groups rather than from the strength of an underlying theoretical basis or rationale. This knowledge motivated my continued interest in the study.

As an inservice educator I had experienced a "contradiction between what is openly intended (midwifery) students learn and what they actually do learn" in some situations within hospital practice settings (Perry, 1985). By studying the contradictions between beliefs and action in nursing, Perry (1985) found that nurses experience forms of social domination that reinforce bureaucratic values rather than professional values and that this impedes them from developing a critical consciousness. That there are different ways of framing midwifery practice that entail distinctive approaches to problem setting and solving has been researched by Bassett Smith (1988). However, what is not explored in Bassett-Smith's study is the consideration of social structures and processes of social interaction that may distort ways of knowing in practice.

As a student who has studied education at the masterate level, I have experienced anti-intellectual attitudes within practice and educational institutions that are committed, for the most part, to a particular epistemology. This fosters a view of knowledge whereby there is selective inattention to professional artistry, critical inquiry and to the way this knowledge is legitimised. Such an inattention critically influences learning outcomes.

And finally as a mother, I have experienced midwifery care within a hospital setting in New Zealand and I am aware of the organisational problems within such settings which need to be faced if women are to receive the quality of service they want and midwives are to provide the service they are educated to provide.

SECTION THREE: DATA ANALYSIS

The third and final section of this chapter discusses the procedure of data analysis or interpretation of data. As well as being viewed as research tools, the methods used in this study were also viewed as objects of analysis which yielded a rich source of data.

All data was analysed as a whole before any of its components were interpreted. This meant that after all data was collected, I wrote the theoretical concepts which emerged from my observations and the transcripts as a gestalt. This gestalt, which appears as theoretical concepts in **Chapter Three**, was produced by the interaction of all the studys parts before I proceded to analyse the interview material.

Each case study interview was analysed and written up as a separate case study report. These reports appear in **Part Three** of this thesis and are the result of analysing five individual interview schedules. Analysis and intergration of the case studies elucidate the themes that appear in **Chapters Five, Six, Seven** and **Eight.**

Rather than a narrow literal meaning of the text, I analysed the transcripts with a view to illuminate the subtext. As Tripp (1983:42) points out, the meaning of words are context-dependent and the aim is to exclude all meanings which misrepresent the participant's views and interpretations of an issue "in order to convey accurate information to the reader." Therefore, during analysis of interviews I focused on ascertaining how the specific utterrances fitted into the broad communicative outline that I had sketched in **Chapter Three.** I spent much time transcribing tapes, reading notes and transcripts, and thinking about the data in order to be able to discern the broader

significance of meaning. This phase has been termed as a "profound dwelling with" the data (Parse, Coyne, & Smith, 1985:5) throughout data collection and analysis. The arduous process of transcribing the taped interviews was beneficial as it served to familiarise me with the data as it was collected. Altogether, these processes allowed me to become more familiar with the data and to discern certain themes.

The reflexive process of inquiry meant that intersubjective understandings could be explored. In this sense, the research process provided a forum for strengthening the basis of each midwife's knowledge by validating their direct experience as seminal to their work. This forum also affirmed the possibility for growth and change as each midwife was able to analyse her knowledge as a social issue rather than merely locating knowledge in the realms of personal beliefs and values.

Trustworthiness Of The Study

Certain measures were taken to ensure what Lincoln and Guba (1985:29), Sandelowski (1986:29) and Lather (1986:268) refer to as 'trustworthiness of the study'. These measures are outlined using the criteria of credibility, transferability, dependability, and confirmability.

Credibility is achieved when the findings, interpretations and analysis are found to be acceptable by both the research participants, as constructors of the multiple realities, and by other researchers who judge the interpretations as being faithful to the data. In this study, I took the following activities to enhance the criteria of credibility:

* I developed rapport with participants prior to data collection.
* I spent over eighty hours observing practising midwives in their practice settings.
* A triangulation of data collection methods in two different settings enhanced the precision of the research process.

* I gave the transcipts and draft interpretations of each case study report to participants for validation.

The criterion of transferability refers to the researcher giving sufficient descriptive material for another researcher to be able to transfer the study design to a similar site and produce similar conclusions. I have given sufficient descriptive detail to permit another person contemplating application in another setting to make the needed comparisons of similarity.

The criterion of dependability refers to an inquiry audit. As part of fulfilling the requirements of a masterate thesis, I met at milestone points with two supervisors who examined the process of the study including the final case study report. One supervisor had experience with methodological issues related to social critical science, and the other, experience with midwifery as the substantive area of inquiry.

The criterion of confirmability refers to an audit trail and is when there is an adequate record of materials so that an auditor can follow the transactions and decisions in relation to a study's findings and interpretations. This criterion was met by leaving enough residue records for an auditor to be able to follow the decision trail or to be able to see how the interpretations, findings and analysis were derived from the data.

In addition to all of the above, Lather (1986) points out that these strategies are insufficient to establish data credibility in praxis-oriented research. Lather cites Reason & Rowan (1981) in proposing that catalytic validity should complement the above criteria as discussed. Lather (1986:272) states that catalytic validity "represents the degree to which the research process reorients, focuses, and energises participants toward knowing reality in order to transform it, a process Freire (1973) terms 'conscientization'."

Lather goes on to say that the argument for catalytic validity is premised not only "within a recognition of the reality-altering impact of the research process, but also in the desire to consciously channel

this impact so that participants gain self-understanding and, self-determination through research participation." However due to the artificial constraints of this study this criterion is difficult to demonstrate.

SUMMARY

This chapter has detailed specific methodology used for data collection and analysis. Participant observation, fieldnotes and critically reflexive interviews were used together as a basis for participants and the researcher to critique the current situation in midwifery and to identify areas for transformative action.

Although the individual case studies (refer to **Part Three**) stand alone, the building blocks for all of them are the same: the practising midwife's perceptions of her experience as a student and a graduate midwife. These perceptions were the basis of a dialogue which developed between the researcher and participants and created the opportunities for emancipatory discourse.

Part Two (Chapters Five, Six, Seven and **Eight)** which follows, presents the themes which emerged from the data in individual Case Studies and are grounded in each midwife's perceptions and experience of midwifery practice. The interpretations are available as an ongoing critique in midwifery.

As with the Case Studies presented in **Part Three,** midwives' protocols are labelled with a pseudonym and the interview number. Protocols in **Chapters Five, Six, Seven** and **Eight,** are also referenced to the appropriate Case Study and page number. The interviewer's comments are typed in bold print.

PART TWO

INTERPRETATION, IMPLICATIONS AND CONCLUSION

CHAPTERS FIVE, SIX, SEVEN AND EIGHT

CHAPTER FIVE

CONFLICTING IDEOLOGIES

Critical reflection by participants in this study provided anecdotal evidence of socially dominant relationships that are antithetical to personal and professional beliefs of 'good' midwifery practice. By questioning the assumptions, values and attitudes of social action, participants revealed the interests that were served by such discourse. These interests emerge as themes in the data and have significance from a socially critical perspective. The first theme to emerge exposes a conflict of social and political discourse that is either women-centred or authoritarian.

A Women-centred Approach

Midwives in this study conceptualised midwifery practice to be a working partnership in which the midwife and women in her care are empowered through mutuality. The midwife and women exchange knowledge (power) with the aim of achieving mutually defined goals. The following extract is typical of a women-centred approach which is articulated by all participants and illustrated here by Rebecca:

> Midwifery care is looking out for women and babies...you can't separate the two...so they have the best possible outcome. **What does 'looking out for them' mean?** It's giving women information and the ability and strength to make an informed choice so that there is an increased chance there will be an outcome women are happy with...It's not making a decision for them, but it is about allowing them to make their own decisions that they feel is correct for them in the situation at the time.
> Rebecca, Case Study 1, Int.3, refer page 158.

Thus, the midwife becomes a resource person whose central focus is the woman as she sorts through the relevant values and issues in her situation. A woman's involvement and ability to make decisions appropriate to her own personal beliefs is facilitated by an understanding of the rationale for, and consequences of, her choice. A

woman's personal knowledge is therefore centrally important in helping her arrive at a decision or outcome that is "correct for them in the situation at the time." As Jessica and Rebecca illustrate:

> I try to determine the woman's knowledge level. **What difference does this make?** If they're obviously very clued up on what they should and need to know for labour and birth, then what you're going to tell them...is going to be different. If I know where the deficit is in their knowledge it really determines what...you're going to give them.
> Jessica, Case Study 3, Int.2, refer page 185.

> In the situation where a woman wanted to have a natural third stage (of labour) I would first of all ask her what she knew about this. I would find out her knowledge and then fill in the gaps so that decisions are based on informed choice. I would also point out that there was possibly a time after the delivery that she may need to have an ecbolic...like if she was haemorrhaging.
> Rebecca, Case Study 1, Int.3, refer page 155.

Jessica and Rebecca learn about women's prior experience and understanding of childbirth so that their practice takes into consideration personal needs and concerns. There is a sense of cooperation between the midwife and a woman which is continued throughout their interaction with each other. In the context of the birthing process, Bassett-Smith (1988:110) has described this interaction as "mutually engaging" or an intense involvement between the midwife and the birthing women. Similarly, Rebecca encapsulates the essence of 'mutually engaging' during childbirth with the concept of "meshing":

> Meshing is a sort of being on the same wave length as a woman. It's being with her and moving along with her from here once you have established rapport. It is a joining together for that brief intimate time to help women feel that birth is something they've done, not something that's done to them...You have to be able to empathise with how a particular woman is feeling and 'suss out' what's right for her.
> Rebecca, Case Study 1, Int.4, refer page 158.

A midwife is able to "mesh", or to maintain a harmonious relationship, with a labouring and birthing woman when they are "on the same wave length." Rebecca suggests that this is possible once a midwife has

"established rapport" with the woman in her care. Such a relationship is dependent upon a 'balancing' (Bassett-Smith, 1988) in favour of an individual woman's needs, values and desires rather than a view or ideology held by the midwife. The midwife communicates empathetic understanding of a particular woman's beliefs about childbirth and how they should be cared for. They are then in a position to share knowledge to achieve mutually defined goals so that "women feel that birth is something they've done, not something that's done to them". For Ericka, who refers to a wider context than labour and birth, it is the degree of intimacy or engagement that enables her to be 'with women':

> Midwifery practice enjoys the privilege of a degree of intimacy that enables midwives to be 'with women' as individuals. Effecting a standard course of action for a given situation won't be appropriate for every woman. While a standard action may restore meaning for one woman, it may completely destroy meaning for another.
> Ericka, Case Study 4, Int.3, refer page 200.

Ericka uses her midwifery knowledge and skills to help restore meaning for pregnant and birthing women. Rather than detachment, 'engagement' facilitates an individualised approach. It is this knowledge which allows for the immediate and abstract apprehension of a situation based on past experience of similar events. This is illustrated by Ericka in my fieldnotes:

> Ericka entered the room at the same time as the house surgeon. The house surgeon systematically examined the four women in the room. Ericka saw that Mrs Jones needed attention and went to help her immediately. Later, Ericka commented on the house surgeon's lack of response to the woman: "Doctors are scientists and don't always pick up on intuitive things". The woman was later diagnosed as being in cardiac failure.
> Fieldnotes, June, 1991, Case Study 4, refer page 203-204.

Ericka's prescience, foreknowledge or "intuition", enables her to understand and grasp the salient features of a situation for timely intervention. The house surgeon lacks the local and experiential knowledge to be able to respond appropriately to a women in cardiac failure. Ericka's intuitive way of knowing complements rational or scientific knowledge which is essential for clinical judgement. As

Rebecca and Ericka explain:

> A lot of what you're doing is intuitive...(This means) the observations made in practice...and includes listening to the way women sound, watching the way women act, and maintaining therapeutic touch for the assessment and reassessment of change. This allows the midwife to think about what is going on at the time and apply this knowledge to what she can expect is happening physiologically...
> Rebecca, Case Study 1, Int.4, refer page 168.

> Intuition forms an essential part of midwifery practice. It's a way of knowing that is often not acknowledged as it is a rather nebulous means of assessment for the otherwise logical mind. But it's mandatory.
> Ericka, Case Study 4, Int.1, refer page 203.

Intuition is a way of knowing which Ericka and Rebecca identify as an essential part of midwifery practice and which is based on experiential synthesis rather than analysis. It is informed by the responses of others so that midwives are able to help women to "restore meaning" in their situation. The ability of a midwife to restore meaning for a woman includes two phases which, in the context of labour and birth, Bassett-Smith (1988) has described as helping women to 'make sense' of the situation they are in and to 'reframe' this situation. Some women, who are admitted into hospital after developing a medical or an obstetrical complication during their pregnancies, 'make sense' of their new situation and experience by talking with other hospitalised pregnant women. As Sarah explains:

> The women all talk amongst themselves...they're all comparing what's happening with each other. I think they need to do this to reaffirm themselves and to make sense of their own experience.
> Sarah, Case Study 5, Int.1, refer page 213.

By sharing experiences, women are strengthened to find new meaning in a changed situation. But as Sarah explains in the next excerpt, midwifery knowledge and skills help women to "choose the best option from their particular situation":

> Women who are admitted into the antenatal area of the hospital are often long stay...They are often alienated from their husbands, families and communities...They've got to come to terms with the fact that there is something wrong and that they may not have a normal birth. This means they

> need a lot of support from the midwife...you actually need to be skilled at counselling. The women are extremely sensitive in the situation they're in...and they need help to choose the best option from their particular situation. Just because they are going to have a highly technical approach to their pregnancy and birth, does not mean that they have to loose their control in every situation. Their experience needs to be the best it can be for them. It's the way you handle the women in your care that makes a difference. Often you need to spend time with them.
> Sarah, Case Study 5, Int.2, refer page 212-213.

As Sarah states, "just because they (women) are going to have a highly technical approach to their pregnancy and birth, does not mean that they have to lose their control in every situation." That is, a women-centred approach is as important for a woman who is to experience a highly technological pregnancy and birth as it is for a woman who is to experience predominantly midwifery or non-interventionist care. As with Bassett-Smith's (1988) study, a women-centred approach is not in opposition to a technocratic approach to pregnancy and childbirth when it is indicated, such as to ensure a live mother and a live baby. Sometimes this will mean hospitalisation during pregnancy. This results in a woman being removed from supportive relationships from which she derives much strength. The situation is compounded when women live a long distance from hospital and have to become accustomed to an unfamiliar hospital culture. Midwives make a difference to the way pregnant women cope with their new situation. A midwife's physical and psychological presence, expert knowledge and skills, (interpersonal, listening and counselling) help women make sense and reframe what is happening to them.

As well as gaining knowledge of individual women's personal power, these midwives are conscious of the effects their own personal and professional power has on women in their care. Rebecca, Ericka and Sarah explain:

> ...there's a lot of power (knowledge) there that can be given away to the person who's caring for her. It's up to you (the midwife) whether you choose to share power or to take that power and withhold it...
> Rebecca, Case Study 1, Int.3, refer page 159.

> Women can be in a vulnerable position and need to retain power and dignity, much of which can depend upon the type of exchange you plan to have with them...On an individual level we potentially have an enormous amount of power over the women in our care.
> Ericka, Case Study 4, Int.1, refer page 202-203.

> Midwifery is about sharing knowledge so that women are empowered because withholding knowledge is to be in a more powerful position.
> Sarah, Case Study 5, Int.2, refer page 213.

Thus, midwifery practice may be premised on the belief that professional knowledge and skills put midwives in a more powerful position than the women in their care. That women associate the authority which underwrites midwifery practice with some human limitation is expressed by Rebecca and Ericka:

> Looking after someone denotes dependency on behalf of the woman...I try to 'work with' someone not 'look after' someone. I try to be involved in the situation to an extent that I don't detract from it and run the risk of our relationship developing into one of dependency. When I go into the room of the woman I say "I'm working with you today" not "I'm looking after you today".
> Rebecca, Case Study 1, Int.4, refer page 159.

> You've got a women who is expected to have had a normal pregnancy and she's got plans to maintain her own power throughout her pregancy and birth...and suddenly she gets hit with this terrible toxaemia and she comes in (to hospital) and you plonk her into a bed so she's down there (shows with hand) and you're up here (raises hand) telling them what's going to happen...and why she's here...she's immediately disadvantaged. She's in an environment that's completely unfamiliar to her for a start and you're the one with expert knowledge...But that knowledge and power implies that you have some responsibility as well...So you've got to try and give her information... But it's the 'way' you say something rather than 'what' you say.
> Ericka, Case Study 4, Int.2, refer page 200-201.

Midwives however, may deliberately try to counteract a woman's feeling of dependency or powerlessness which may be engendered by professional action. As Ericka and Sarah have stated ..."its the 'way' you say" something or handle the women in your care that makes a difference "rather than 'what' you say." A woman's ability to "retain power and

dignity" is dependant upon the "type of exchange" the midwife has and "plans to have" with her. A feeling of powerlessness may also be intensified by an unfamiliar environment, or, as in the following extract, when knowledge is kept private through the use of medical or technological language. As Sarah explains:

> Sometimes they (women) don't understand the medical terms or the language that the doctor uses. How can they make an informed choice if they don't have the knowledge about it?
> Sarah, Int.2, Case Study 5, refer page 214.

Based on a belief that to be self-determining, women need to make their own informed decisions, midwives assume the role of cultural mediator. Sarah and Ericka illustrate this in the following extract:

> A lot of women don't...feel they can disagree with their care as prescribed by the doctor. If I'm there then there is a different dynamic. I can interpret and support the woman and...make sure they understand. It's a bit like being their advocate really...they (women) feel they can ask the midwife who mediates between the woman and the doctor when necessary.
> Sarah, Case Study 5, Int.2, refer page 214.

> ...it's really important that you take on the negotiation for them (women in the midwife's care) sometimes...It's advocacy really isn't it? Being a mediator, if you like, for someone who feels they can't say something is right for them when you know that is what they want.
> Ericka, Int.2, Case Study 4, refer page 201-202.

When appropriate, midwives mediate and negotiate with the doctor to ensure that a woman's needs and desires are taken into consideration. Although Ericka is prepared to negotiate with the doctor on a woman's behalf, she is mindful of the woman's fundamental right to autonomy. This enables her to discriminate between when it is appropriate to be a woman's advocate and when it is not, a position which reinforces a women-centred approach. As Ericka explains:

> When the doctor came to see Lynette, it wasn't her wish that I would negotiate some leave for her. Without a doubt she didn't feel brave enough to do so on her own. But she also didn't want me to do it for her. This understanding was established before the doctor arrived.
> Ericka, Case Study 4, Int.3, refer page 202.

Midwives strive toward an equitable distribution of power (knowledge) throughout their interaction with women. Ingrid and Jessica observe that some doctors also "take on" this midwifery perspective:

> ...there are some (house surgeons) who are very good midwives... **What makes the difference?** The difference is that the care is more cohesive for the woman. It's not...fragmented, it's flowing.
> Ingrid, Case Study 2, Int.3, refer page 179.

> ...some doctors are different in that they do sort of act more as midwives. They take on a midwifery perspective in a lot of ways...They have a different rapport with the women. They don't hassle them along...And the women....have a good knowledge base...One of the best consultants here...explains everything to the woman about what is going on...has good communication skills, both with the women and with the midwives...gives women options in their care and...will clean up after himself...If the midwives are busy and haven't had time for a teabreak, he will sit with the women and take their recordings ecetera. He is also for midwifery autonomy and is not against homebirth. He says that that would not be his choice but he accepts that women have that choice.
> Jessica, Case Study 3, Int.1, refer page 186.

Some doctors "take on a midwifery perspective in a lot of ways" by 'balancing' in favour of an individual woman's desires and needs rather than a view or ideology held by them. However, a doctor's ability to be 'with women' will be constrained by medical practice which is not conducive to being with women throughout the labouring process. As Jessica and Rebecca explain:

> We get good at handling labours because doctors are typically not there...And some doctors put women off. I've had women say "I can't push when he's here". I think women sometimes hold back when the doctor is there. They won't always tell me this but I sense it...It's not enough for the doctor to just come in for the delivery. They need to spend some time with the woman during her labour too...
> Jessica, Case Study 3, Int.1, refer page 186.

> The midwives who are there all the time see changes...Someone who is not there all the time can miss the subtle changes...they don't have the same 'meshing'. It's harder for them to join in with women when she's actually working really hard...
> Rebecca, Case Study 1, Int.3, refer page 160.

The midwives who are 'with women' throughout labour have tacit understandings of the nuances in interpretation, a kind of communication that takes place among familiars. This kind of knowledge is not possible when one lacks a background of familiarity which may pose a problem for midwives who do not have continuity with the women in their care. As Ericka comments:

> You can feel pressurised to make assumptions about the way women might feel...rather than get to know her...you have to raise issues when ever you meet them...rather than in a relationship which is built up between woman and midwife...
> Ericka, Case Study 4, Int.3, refer pages 208.

And, as Rebecca says, when practitioners "do not have the same meshing" it is "harder for them to join in with women." These examples illustrate that it is the 'being with' that constitutes a women-centred approach in midwifery.

Although practitioners may strive toward helping women in their care to make their own decisions, there are times when midwives take control of events. In the following extracts Jessica and Rebecca explain how midwifery intervention sometimes overrides the situation to ensure a safe outcome:

> It would be naive of a midwife, or any caregiver during labour or birth, to expect every woman to make the right decision all the time...So you have to know when to intervene and make decisions for them when the situation becomes unsafe...
> Jessica, Case Study 3, Int.2, refer page 185.

> There has to be a time when your midwifery knowledge and skills take over. You have to know and foresee a situation where you think you'll have to do an episiotomy here or...give an ecbolic right now. In both these situations you haven't got the time at that particular moment to discuss the merits of a particular intervention...You need to use midwifery knowledge to intervene when necessary, when non-intervention would be negligent practice given your knowledge and skills.
> Rebecca, Case Study 1, Int.3, refer page 154.

Midwives intervene to influence the direction of care "when non-intervention would be negligent practice" given the midwife's

knowledge and skills. This is illustrative of authoritative action. Midwives utilise technical knowledge in the context of a practical (ethical and political) knowledge that generally takes precedence over it. Midwives are then in the position to remain in partnership 'with women' while at the same time fulfil the mandate society bestows on them to be responsible practitioners. This mandate includes knowing when to select and refer women for specialist (obstetric or medical) consultation. As Rebecca explains:

> ...at times we recognise that this is not going right and that we need expert medical intervention. It is a team approach and part of that team is the medical model when it is indicated. The thing to keep in mind is <u>when it is indicated</u> so that we don't leap the boundaries.
> Rebecca, Case Study 1, Int.2, refer page 154.

Rebecca states that midwifery is a "team approach". Midwives work collaboratively with other professionals such as the medical profession, as well as with the women in their care. Furthermore, midwives are aware of the boundaries that separate a medical or technological model for practice from a predominantly midwifery one. Thus midwives are better placed to question practitioners who "leap the boundaries" or impose a technological model on practice when it is not indicated. According to its relevance to childbirth, two models are explained by Ingrid and Jessica respectively:

> Midwives are guardians of the normal birth and want the woman to birth the way she wants to provided it's safe for her and the baby.
> Jessica, Case Study 3, Int.2, refer page 184.

> ...with...the medical model, control is routine...because birth is normal only retrospectively or after the event...
> Ingrid, Case Study 2, Int.1, refer page 172.

The conceptual difference between these two models is embedded in divergent philosophies which emphasise either the normality or pathology of childbirth. The former is concerned with wellness while the latter is concerned with sickness. As Jessica explains:

> Midwives are looking after healthy people who are responsible for their own care and have a better chance of determining the outcome. They're calling the shots. Someone

> who is sick is having things done to them. **But some women are sick at this time and midwives are with women throughout the wellness-illness spectrum.** The majority of women are well.
> Jessica, Case Study 3, Int.1, refer page 190-191.

While midwives are 'with women' throughout the wellness-illness continuum, "the majority of women are well." However, depending on the ideological perspective, the midwifery and medical models are central in the attention of caregivers of women in childbirth. They signify a plurality of discursive practice and the social relations which mediate the production and legitimation of knowledge. And between these practices and beliefs stands the mother who may be unaware of different philosophies underlying her care.

An Authoritarian Approach

In the preceding discussion and extracts it is evident that midwives strive toward achieving a more equitable distribution of power between themselves and women in their care. This practice is based on a reciprocal exchange of knowledge with women and a judicious use of intervention. Such a women-centred focus is in contrast to an authoritarian approach prohibititive of developing a partnership with women. In the following extract Ingrid makes a distinction between these two approaches:

> How you interact with women can be a means of control...there's a fine line between empowering a woman by giving her options so that she controls it (a given event) and the other way. **What is the other way?** ...the other way is when the practitioner influences the course of (an event such as) labour according to their own beliefs rather than the woman's. That is a controlling thing rather than an empowering thing. But you influence the woman by what you offer while at the same time it's the way you use your influence that is different...with the other way...control is routine...and the practitioner tells the woman what they should do. This is disempowering as the woman is not given the opportunity to make decisions that effect her.
> Ingrid, Case Study 2, Int.1, refer page 171-172.

Ingrid identifies two approaches which are differentiated by the outcome of either empowering or controlling women. Each approach differs according to the way the practitioner influences the course of

an event such as childbirth. When the practitioner gives a woman options so that she controls her experience, and is there to support her in this, the woman and midwife are thought to be empowered through mutuality. This is described here as a women-centred approach, an approach that is characterised by a relation of reciprocity actualised between the midwife and women in her care. Alternatively, where practitioners do not involve women in actions and decisions related to their care, even when it is appropriate, they are depicted as agents of control. Here practitioners require women to transfer allegience to them by offering in return technical proficiency. This is "disempowering" because the woman is not given the opportunity to be involved in making decisions that effect her.

As agents of control, practitioners possess 'expert' or privileged knowledge which is not reciprocally shared with women in their care. As Rebecca and Ericka explain:

> ...the concept 'professional' is elitist because it lends itself to the idea that the professional knows best. This in turn puts the professional above the person she is attending which is hierarchical and goes against the grain of midwifery being 'with women'.
> Rebecca, Case Study 1, Int.5, refer page 155.

> Basically the professional wants to know a lot about the woman but there's not that reciprocation. The professional demands information, encroaches on physical space and makes all sorts of demands on a woman. There's only so much of that person that she's going to want to reveal. So it's professional versus personal when it should be an exchange of knowledge...It's the whole idea about the professional knowing what's best for somebody else. On an individual level we potentially have an enormous amount of power over the women in our care. **And sometimes it's used...** Badly. What's failed to be recognised in a professional versus person relationship, is...the women themselves potentially have a lot of power (knowledge)...that they will exchange in a situation they feel comfortable with...
> Ericka, Int.3, Case Study 4, refer page 202-203.

Rebecca and Ericka observe that professionals are "elitist and hierarchical" when knowledge is not reciprocally shared one (the professional) with the other (the woman in their care). This is interpreted to be against (versus) or "above women" rather than "with

women." By debunking the concept of 'professional', Rebecca and Ericka are able to decentre the "cult of expertise" (Lather, 1989:28). Here there is the assumption that women follow professional advice because they are the "expert" and therefore know "what's best for somebody else." Out of this assumption the professional fails to recognise that women have a lot of expertise and self-knowledge which they will share with them if "they feel comfortable" to do so. But, where a professional considers themself to be an 'expert' who knows what is best, women are given little or no opportunity to influence the direction of their care. Such univocal authority is authoritarian as the subjective knowledge of women's own experience is presented in an unmediated way. Women become recipients of authoritative knowledge with little opportunity to contribute or to become involved in their experience as knowing subjects. This in turn increases the practitioner's control and domination over women.

In the above extracts, Rebecca and Ericka have linked the 'professional' with a more superior way of knowing. While keeping the discussion at a more general level, Sarah, in the next excerpt, is more specific:

> Rather than being above women, midwifery is being with women. **What is 'being above' women?** By contrast medical knowledge is often elitist and hierarchical because it is not shared with women in their care.
> Sarah, Case Study 5, Int.2, refer page 215.

Sarah links an "elitist and hierarchical" way of knowing with medical knowledge. In the context of medical practice, Rebecca suggests that some doctors take their expert power or authoritative knowledge for granted in their everyday interaction with women:

> ...with some doctors there is that whole...power role, you know, I'm the expert the person who knows what's going on and the woman is the person to whom it's happening. There's that sort of I'm up here and you're down there. There's a fair few obstetricians and GPs - there's not a lot of difference between them - who don't sit on the bed (to maintain face-to-face contact at eye level), who don't sit a woman up before they talk to them after they've examined her, who would leave them lying down if someone didn't sit them up...there's that whole sense of vulnerability. **Are you saying that they treat women in an objective manner rather**

> **than as a person who has concerns and issues relevant to her?** Yes. They deal to the process of what's going on and the person involved in that process is on the periphery. **Does the technology further impair with this process?** Yes. Because they end up looking at the technology and not at the person.
> Rebecca, Case Study 1, Int.1, refer page 157.

In Rebecca's account, the doctor is insensitive toward a woman's vulnerable position by not sitting her up and thereby enabling communication at a face-to-face level. There is no movement toward counteracting a sense of powerlessness or dependency which may be engendered by their professional action and knowledge. In this way the doctor maintains a dominant position in relation to women, a position that may be intensified by an objective approach to knowledge. That is, when the doctor gives priority to technical interests, so that the woman's concerns are on the periphery, the dominant interest is instrumental. And the technology used in this process alienates the woman further from her own experience. That women are in a powerless position and incapable of articulating their needs is explained by Ericka:

> ...even with assertive women that come into hospital, in hindsight, they felt bombarded by the system....they are in a powerless position to the extent that they don't actually ask and therefore get what they want. They aren't able to articulate their needs.
> Ericka, Case Study 4, Int.3, refer page 201.

The very nature and structure of a hospital system render women dependent. This is also magnified when practitioners do not offer women choices as illustrated by Jessica:

> Most women have clear ideas about their preferences in childbirth but it is often the doctor who decides in the end...The doctor steps in even in situations that are not always considered to be unsafe...An example of this would be when a doctor wants to deliver a woman only in a particular position...He just says that shes got to be sitting up in bed or whatever...There are also doctors who put time limits on...and want things to be over and done with. They don't even need to say anything, you can just sense it...(or) they say "Oh well I'll give you another fifteen minutes and then we're going to give you a forceps delivery". And the woman wants another...quarter or half an hour because she knows she can do it...Waiting for the cord to stop pulsating...is another one...

Jessica, Case Study 3, Int.2, refer page 186-187.

In Jessica's account some doctors do not encourage women to adopt different positions for second stage of labour. They also put time restrictions on second stage and want to intervene with ecbolics when a woman plans to have a natural third stage. This illustrates how medical decision making takes precedence over what a woman wants regarding labour and birth. A woman's ability to influence the direction of her care is overriden, as her subjective authority about childbirth is not the doctor's concern. It would appear that these doctors view intervention as 'necessary' to achieve goals set by themselves rather than by women in their care. Thus, they do not take into account a woman's values and concerns. Rebecca elaborates on this point in the context of a woman wanting, but being denied, a natural third stage of labour:

> This woman came in and wanted a natural third stage. The consultant said to the midwife that she could have fifteen minutes for the placenta to separate and to give the ecbolic if the placenta was not out in this time...That is his idea of a natural or physiological, third stage, that is, fifteen minutes. I mean it can take up to half an hour at least, sometimes longer, before the placenta separates which is within the realms of normal, depending on blood loss and whether the baby is fixed to the breast or not. I mean, what's his knowledge of natural third stage and why is he so scared of it? Women have a natural third stage constantly at home without haemorrhaging.
> Rebecca, Case Study 1, Int.2, refer page 154.

In this example, a woman lacks authority to influence medical opinion so that she is alienated from her own experience without the means to achieve an end consistent with her own beliefs about the way childbirth should be. This illustrates how safety as dogma may be instrumentally used whereby the active participation of women in their birthing experiences is denied and the empirical observations of midwives overriden. In the following extract, Ingrid observes that a woman's lack of authority to influence medical opinion commences with antenatal care:

> There are certain doctors who you know will intervene routinely. **Is this regardless of what a woman wants?** Yes but it goes back to pregnancy. I think that when they've looked after them antenatally they've never actually discussed what

> the woman wants in labour...it's never really been talked about. This is important...for women to discuss their expectations and things that they would like to know from their doctor (or caregiver) prior to going into labour...
> Ingrid, Case Study 2, Int.3, refer page 177.

Antenatal education is an important way that practitioners influence a woman's experience of pregnancy and childbirth. When caregivers do not discuss with pregnant women what their concerns and beliefs are regarding childbirth, the greater the chance will be for an outcome that is divergent from women's beliefs about the way birth should go. Rebecca explains how women are often ill prepared for childbirth:

> You see women come in (who have generally gone to particular doctors) who really want an epidural before their labour is established. They are often nervous, to say the least. Often they have gone to antenatal classes. You expect them to be prepared...but they are not...and the moment labour starts it is all over for them. You think...that they are not able to deal with what is happening. It is like the strength of the experience overpowers them before they have really had a chance to come to grips with it. And you wonder why it is...I wonder how much antenatal information/education they get from their caregiver...they may be told that their blood pressure is fine, that their baby is moving well and growing well, but are they talked to through all their antenatal visits...about how they want to approach labour...what they want to do, what they don't want to do...to keep the labour moving and increase their control over the situation?...
> Rebecca, Case Study 1, Int.1, refer page 156.

During antenatal visits doctors may give select information from the 'bank' (Freire, 1972) of medical knowledge which may be technically competent but ultimately not helpful to the way individual women make sense of their pregnancy and experience of childbirth. Rebecca questions the quality of antenatal care which does little to increase a woman's control over her birthing experience. A woman's lack of control in turn, increases the likelihood of analgesic medication and medical intervention during labour. In the next two extracts, Rebecca and Ericka observe that there is a differing relationship between women and doctors as opposed to the one between women and midwives:

> Sometimes you wonder whether doctors and obstetricians have the same closeness in their dealings with women...Women relax a lot more with a midwife...(here) the doctor is a professional, the midwife is a friend. Women don't think of the doctor as their friend. That is the difference I

> think...
> Rebecca, Case Study 1, Int.1, refer page 156.

> It's a difference in relationship that you have (as a midwife) with the women. And it's how they see you and it's how they see the doctor...Like...when I asked Betty how she was feeling today. She said "Oh I'm browned off with being kept in here"...When the doctors came...and asked Betty how she was she said "I'm fine".
> Ericka, Case Study 4, Int.2, refer page 201.

The differences observed highlight a more distant relationship between doctors and women than between midwives and women. This relationship is, in the next excerpt, concomitant with patronising and aloof relationships with midwives. As Jessica explains:

> A high percentage of doctors can be quite patronising in their behaviour and in what they say to the woman and to the midwife. They can actually tell you a particular way they want the labour handled and it will be such a basic thing we would have thought of it anyway. They can make a big deal out of it...I think some of the doctors want to be seen in front of their 'patients' to be calling the shots, deciding the way things are going to go. I don't think they want the midwives to get any of the limelight, so to speak. That sort of attitude can be reflected in the way they behave after their women have...delivered. There are some doctors who may not have been around much at all during the labour and will give no acknowledgement or thanks for the hard work you've put in.
> Jessica, Case Study 3, Int.2, refer page 187.

Jessica thinks that some doctors want to be seen by women to be "calling the shots" or "deciding the way things are going to go" to maintain their personal and professional image of superiority over the midwife. Such a dominant position negatively effects the learning environment for midwives. As Jessica explains:

> They can be more patronising to the new midwives and less so to more established midwives who have been there for a long time...This is undermining your confidence...so you don't learn much. Another thing is that when you're being patronised by someone it is actually a lot harder to perform at your best.
> Jessica, Case Study 3, Int.3, refer page 187.

The confidence of new midwives is undermined when their personal and professional capabilities are judged by those, and in this case

doctors, who have more professional status. That midwives also undermine the personal and professional capabilities of new midwives is illustrated in the next two excerpts. The first is from Jessica in my fieldnotes; the second from the first interview with Jessica:

> Many of the older midwives are not concerned with passing on their knowledge or sharing knowledge.
> Jessica, Fieldnotes, July, 1990, refer page 188.

During the first interview Jessica adds:

> ...it happens with the new and generally younger midwives as well as with woman (in their care). I think sometimes they (the older more established midwives) think it's easier to keep the woman ignorant so they can control the labour the way they want it to go. I mean it's quite a generalisation but I think they have a set idea about the way things should go and they don't like to deviate too much from their perception of the norm.
> Jessica, Case Study 3, Int.1, refer page 188.

Jessica notes that some midwives withhold knowledge from women in their care and from the newer midwives on staff. This is also noted by Rebecca, (refer to page 161) Ingrid, (refer to page 173) and Sarah (refer to page 219). Rather than empowering women through sharing knowledge, these midwives adopt a controlling approach toward those in their care, an approach which is extended over to their interactions with the newer midwives. As Ingrid explains:

> ...(some midwives' approach) tends to get caught up with the medical model and technological intervention. The midwife can forget to give women choices where ever possible and forget who their colleagues are. And at the same time put-down other midwives...These midwives aren't interested in passing on their knowledge...**Do you mean passing on their knowledge to other practitioners or to women?** Both...They are not teaching others including women themselves. For some midwives it is just a job. They think routinely and don't think about what it is they're doing or how the situation could be changed for the better ...There are a lot of midwives who think that medical knowledge is superior to theirs. Whereas the knowledge in each field is different and complementary.
> Ingrid, Case Study 2, Int.2, refer page 173 & 174

By routinely following a medicalised interventionist approach, these midwives do not offer women choices or alternatives. Labour and birth,

for example, will be 'managed' according to the midwife's perception of the way birth should be rather than that of women in their care. When midwives do not account for women's needs and concerns, their relationship with women is one of detachment rather than one which is actualised through engagement and reciprocity. By thinking this way, midwives are not thinking about "what it is they're doing or how the situation could be changed for the better..." In the next excerpt, Ingrid explains how some midwives accept the dominant medical ideology without question:

> The midwives from other cultures, such as Malaysia and China...never question doctors orders. They follow doctors' orders to the red letter because they accept that the doctor knows what is best for a woman. Their practice is based on a different philosophy. I find these attitudes frightening. They won't question the system because they're more concerned with getting it right or fitting in.
> Sarah, Case Study 5, Int.2, refer page 218.

Midwives from Asian cultures working in New Zealand adopt a different philosophy toward midwifery practice from that which is accepted by Sarah. Rather than being accountable to mothers, babies or themselves, they "follow doctors' orders" on the assumption that "the doctor knows what is best for a woman".

SUMMARY

In the preceding discussion, two disparate approaches to midwifery emerge - an authoritarian approach and a women-centred approach. These approaches illuminate different cultural values and beliefs centred around the way 'power' is conceptualised and acted out. For example, where power is in limited supply or withheld, the practitioner's relative power is enhanced over and above women and midwife. This is authoritarian since knowledge, and therefore power, is not shared with women or those immediately involved in a woman's care. Alternatively, where power is shared, as in a partnership which develops between the midwife and women, the approach is women-centred. Here authority and decision making, concerning an appropriate course of action in midwifery, is reflexive. It reflects a non-hierarchical relationship whereby two parties work together to achieve common or mutually

accepted goals. Such a partnership is empowering for women and midwives who are prepared to invest their own personal identity into the relationship. This has a positive affect on the ability of a woman to determine her own experience of pregnancy and childbirth as well as on the learning experience of the midwife.

It is argued that the issue here may not rest so much on practitioners having more power, because doctors and midwives have authoritative power by virtue of their knowledge and skills beyond that of their clients, but on the way power is interpreted. 'Power with' is interpreted as knowledge which is shared in dialogical relationships. This is in conflict with 'power over' which is knowledge withheld and maintained in a relation of dominance associated with a position of advantage. A final word on the way human agency functions to maintain a position of advantage in midwifery belongs to a research participant:

> Maybe a lot of people slip into a (dominant) power relation because it happens when people give them that power and if you are handed power on a plate you tend to take it.
> Rebecca, Case Study 1, Int.2, refer page 160.

The next theme to be discussed is the competing discourses indicative of a counter-hegemonic struggle in midwifery.

CHAPTER SIX

COMPETING DISCOURSES

This chapter is centred around competing discourses in midwifery. These discourses are rooted in the distinction midwives make between empowering practice and authoritarian or instrumental practice. Such a distinction reveals a counter-hegemonic struggle in midwifery practice and education. It is therefore an important theoretical domain as it is one in which there are critical moments of contestation and socially transformative action.

Polarities In Practice

The midwives in this study experienced discrepancies between the practices within clinical settings and those derived from their education-based principles. They referred to their own educational experiences as having influenced the ways in which they think, act and reflect on their practice as graduate midwives. They held values, beliefs and ideals in common which set them apart from other midwives who did not hold similar beliefs and thus did not realise the same priorities and goals. As Jessica explains:

> There are two groups of midwives here. The first group are younger and have recently completed a midwifery programme. They are open-minded and pro-midwifery...These are the ones who are trying to bring about more change for the better in midwifery. The second group are into letting doctors control everything. They'll ring the doctor over the simplest management problem...This is not to say that the other midwives don't want women to have a good experience but they are not focused on that so much. They seem to be focused on providing care by the book which was written twenty years ago.
> Jessica, Case Study 3, Int.1, refer page 189.

The "two groups" of midwives described have differing values and beliefs manifest in their action and interaction with women and other practitioners. The first group view midwifery knowledge as complementary to medical knowledge. They comprise some experienced

midwives and midwives who have recently graduated from a midwifery course. These midwives question and discuss midwifery practice and socio-political issues in an open forum. They therefore keep themselves and others informed about the current changes affecting midwifery practice. This places them in a better position to strengthen and critique their own beliefs and mobilise power to challenge the status quo prohibitive of women's control over their own pregnancy and birthing experiences.

The second group comprise midwives who have generally been educated in a different paradigm from the first. These midwives typically occupy senior positions to 'manage' childbirth according to prescribed procedures. Rather than a women-centred approach essential to their practice, they promote their own perspective of the way birth should be. This perspective conforms to ideological and pervasive dogma of an unequal power relation. That is, ultimate responsibility for their own practice is transferred to another group (doctors) irrespective of the Nurses Amendment Act 1990. As a consequence of this, these midwives uncritically accept hierarchically organised social relationships and knowledge. They resist making clinical decisions which are legally within their jurisdiction. For these reasons some midwives support doctors over and above their colleagues. As Jessica explains:

> Some midwives will support the doctors above midwives...When a midwife challenged an obstetrician's unprofessional manner ...some midwives wouldn't support her on the grounds that the doctor had been here a lot longer than she had, and therefore he should not be challenged.
> Jessica, Case Study 3, Int.1, refer page 188.

Here traditional medical authority is beyond contention. But in the above extract it is not medical knowledge that is in dispute but longevity of tenure. The midwives in question support what they perceive to be <u>legitimate</u> authority of a doctor who "had been here a lot longer...and therefore... should not be challenged." The legitimacy of the obstetrician's authoritative position leads these midwives to conform to an established order. This suggests that some midwives may pay lip service to new knowledge but are firmly entrenched in traditional values rather than open to new

possibilities. Jessica reiterates this when a woman is transferred into 'her' unit:

> The charge midwife thought that the woman had the right to doctor's care although everything about the labour was quite normal...
> Jessica, Case Study 3, Int. 2, refer page 194.

Here a midwife exercises positional power to reinforce medical authority which means that midwifery practice is dependent upon medical knowledge. Here a hegemony (refer to **Chapter Three**) is apparent in which the dominant culture of medicine exercises social and political control over the subordinate culture of midwifery whose practitioners accept this without question. In this way, some charge midwives subscribe to a 'received' view of knowledge and practice. An uncritical acceptance of this knowledge illustrates how personal and professional identities have been dictated and diminished by others. Lovell (1980:78) conceptualises this situation in terms of 'possession', 'control' and 'deception'. She challenges caregivers to enter into a politics of care that is not encumbered by deception which exercises subtle control. Here a power relationship "constitutes oppressive violence because it objectifies and therefore dehumanises."

Lateral Violence

Rebecca, (refer to page 162) Ingrid, (refer to page 173) Jessica (refer to page 189) and Sarah give anecdotal evidence that some midwives, who are more established in the system, oppress newer midwives and others with the result that the status quo is maintained. As Sarah explains:

> Some midwives put-down other midwives...They (some charge midwives) make sure that midwives go along with their ideas which is usually a medicalised approach to midwifery...it is oppressed people who put-down members of their own group...they make you do things through...control in getting people into line.
> Sarah, Case Study 5, Int.3, refer page 219.

By withholding knowledge, allocating too many women to the new midwives, criticising procedures that do not conform to the charge

midwives' expectations, and leaving new midwives to their own devices, charge midwives maintain a position of dominance over other midwives. Thus, professional socialisation legitimates the exercise of power through hierarchically organised social relationships which are oppressive. Where it is seen as 'natural' for everyone to fit into hierarchical relationships, everyone is rendered either superior or inferior to someone between two extremes of the hierarchy. This is illustrative of a hegemony perpetuated by midwives who judge themselves through the eyes of the oppressor (doctors) which makes them think they are inferior. They are submissive in their negotiations with doctors who are perceived to be superior and therefore unchallengeable. In this way it becomes normal to use authoritarian power and abnormal not to use it. Thus, midwives learn to internalise a strong feeling of inferiority and to value themselves negatively. They may develop group feelings of self-hatred. And to make themselves feel superior, they project aggression onto members of their own group as a target for releasing frustration. As Jessica reiterates:

> Some midwives are aggressive to other midwives. This does not serve midwifery well to be like this.
> Jessica, Case Study 3, Int.1, refer page 189.

With the exception of Ericka, all participants give similar accounts of charge midwives who use positional power to oppress new midwives and others so they will conform to prescribed practice. Rebecca, Ingrid, Jessica, and Sarah observe that oppressive violence is mirrored in relationships with women. As Rebecca explains:

> ...the midwives who mistreat women tend to mistreat their workmates as well.
> Rebecca, Case Study 1, Int.3, refer page 162.

By taking an authoritarian approach midwives subject women to a power relation and dupe women (who are ostensibly in their care) to conform to a dominant culture.

An Invisible Culture

The invisibility of midwives' practice is part of the counter-hegemonic struggle. Through their lack of awareness of the status, authority and practice of a midwife, women are unable to legitimise midwifery knowledge and therefore subscribe to it. All participants believe that the sphere of midwifery practice is generally unknown to women. As Ingrid says:

> Midwifery is not a known choice...And therefore not an acceptable choice. I think that has got a lot to do with the public's attitudes than anything else.
> Ingrid, Case Study 2, Int.2, refer page 177.

The reasons for women's general lack of awareness of the practice and responsibilities of midwives are complex but are related to the cultural roots of **care** and **cure** practices and the devaluation of care provided by women. Rebecca reflects on the history of midwives:

> The survival of the races always depended upon women because they're the gatherers...of...herbs...It was easy not to see their work because they were boiling down tinctures and making remedies...(for) healing, (they were) women who were involved in childbirth...
> Rebecca, Case Study 1, Int.3, refer page 162.

The history of midwifery is inextricably tied to the history of women. Women in every society developed care activities related to healing the body, feeding and childbirth to assure the maintenance of life and its continuity (Colliere, 1986). However, women's traditional healing/midwifery work was usurped by male medical practitioners who suppressed women healers and midwives by creating a hierarchy of practice (Oakley & Houd, 1990). Instead of birth being a normal event in a life process, childbirth was redefined within a medical model which is, according to Ingrid, "...normal only retrospectively, or after the event" (Ingrid, Case Study 2, refer page 172).

Women were also barred from universities (Oakley & Houd, 1990). Their knowledge was therefore seen as inferior to the academic knowledge of doctors. Midwifery knowledge and skills were taken-for-granted as it was considered that midwives' practice required lower skills and

scanty knowledge of 'know how' rather than 'know that'. Ingrid, Jessica and Ericka make a connection between women's oppression and stereotyped sex roles. Jessica describes this connection in the following terms:

> If they're men it's natural to be superordinate to women who are expected to be submissive in relation to their husbands. It is not in the men's interests to change. This situation has parallels in midwifery. **How?** The majority of doctors are men and the older group of midwives are submissive to them.
> Jessica, Case Study 3, Int.1, refer page 190.

Where normative beliefs about a situation are perceived to be "natural" they are also perceived to be inevitable and therefore unchallengeable (Perry, 1985). It is "not in the men's (doctors) interests to change." According to Geuss (1981:87) this implies that "in **this** social order it is well to have as much normative power as possible." It does not imply "that members of a dominant group do not want to change." In the following extract Ericka comments on the value of women's work:

> Areas of work that are predominantly governed by women such as midwifery are traditionally not highly valued. They are mandatory for survival of society but don't carry much kudos.
> Ericka, Case Study 4, Int.1, refer page 205-206.

Where women's work is given lower value in relation to men's, there exists a hierarchy of knowledge. It is argued that this has contributed to the oppression of midwives as women. Ingrid conceptualises this oppression in terms of a patriarchy:

> A lot of paternalistic ideas are culturally ingrained in midwifery and these may be imposed on to people 'for their own good'...There will always be medical personnel who don't wish midwives to be autonomous.
> Ingrid, Case Study 2, Int.1, refer page 175.

The notion of 'hegemonic masculinity' (Connell, 1987; Fleming, 1991) in midwifery is related to the rise of the medical profession in New Zealand before the turn of the century. The way doctors, who were predominantly men, redefined childbirth was as a medical event. This pervades the dominant medical ideology today. As Sarah points out:

> A lot of women are not familiar with what your skills actually are...They have never been socialised to think that birth is a normal process...
> Sarah, Case Study 5, Int.1, refer page 218.

Pervading ideological beliefs, involving women's "faith" in the power of medicine, have meant that women are socialised to trust the doctor as specialist in childbirth care. As Jessica elucidates:

> They (women) just believe that the doctor is going to be wonderful to them and give them the exact care that they want. They seem to have this implicit childlike trust, like a sort of faith that this person is going to look after them and just do exactly the right thing. We see that just doesn't work all the time.
> Jessica, Case Study 3, Int. 2, refer page 190.

Women reinforce medical ideologies in various ways. One way is to have an "implicit childlike trust" in the doctor. Another way is to advocate private medical care as the "best" care. To be able to afford an obstetrician's fee for service, for example, is seen by some women as a status symbol. As Ingrid explains:

> When women are able to have their own doctor or obstetrician, that is seen as a status symbol...It seems to be based on a premise that the best care they are going to get is private medical...
> Ingrid, Case Study 2, Int. 1, refer page 176.

Women's belief that the "best" care is private medical care is mirrored in some midwives' beliefs about obstetric care. As Ingrid explains:

> I've seen a lot of midwives who have had babies recently...All except one have chosen a general practitioner or an obstetrician. So I wonder how much midwives believe in the predominantly midwifery care model themselves.
> Ingrid, Case Study 2, Int.2, refer page 174.

Some midwives believe in the prominence of medical care over midwifery care. In this way they devalue midwifery knowledge and skills. As exemplified earlier, midwives may give lip service to the 'new' way but their everyday actions contradict what they espouse. Where this occurs it is reflective of a transitory struggle. Sarah (refer page 215) and Ingrid think that this struggle is related to fear, or more

accurately the issue of safety. As Ingrid says:

> ...women want to be in hospital under a doctor because they feel safer...But that fear is misplaced.
> Ingrid, Case Study 2, Int. 2, refer page 178.

The deception and myth which surround childbirth deter women, and midwives themselves, from retrieving power. Malinowski (1926) explains how myths are related to uncertainty. He observed that magical beliefs and practices tend to cluster about situations where there is an important uncertainty factor and where there are strong emotional interests in the success of action. Pregnant women who purchase medical services may well fit this description. The use of myth and the threat of danger that women may fear regarding childbirth gives doctors coercive power. Ingrid believes coercive medical power is illustrated by the use of technology:

> ...through the use of technology the medical profession got a great deal of power. They could say that with this technology...there was a greater chance of ensuring that the baby was going to be fine.
> Ingrid, Case Study 2, Int.2, refer page 176.

The use of technology facilitated the process of establishing and retaining a dominant medical ideology. Medical technology has permeated the maternity services to increase doctors' control over women in pregnancy and childbirth. At the same time the commonly held view that "there is nothing normal about childbirth...its normality consisted in its potential pathology...is a dangerous fallacy" (Oakley & Houd, 1990:25). Many women may be readily deceived into believing that a doctor's presence is crucial to the success of childbirth. The central tenet upon which this argument rests points to the issue of safety, and how safety may be used as dogma to reinforce compliant behaviour and the dominant medical ideology (Clare, 1991). However, some women will question medical intervention, as Sarah notes:

> The doctors wanted to do a few more scans during her pregnancy but she wouldn't let them. She had two scans during her whole pregnancy. That is really unusual in the management of placenta praevia, very unusual. She refused cardiotochographs too because she does not trust medical opinion.
> Sarah, Case Study 5, Int. 1, refer page 217.

A few women refuse technological intervention. They therefore do not bestow power on the medical profession because they do "not trust medical opinion." While these women retain control of their situation in this way, some women retain control in other ways. As Jessica explains:

> There are some women that obviously go to some lengths to find out how skilled their doctor is or they will go to a number of different doctors to discuss how they want their labour to go and the sort of birth plans they have in mind.
> Jessica, Case Study 3, Int. 2, refer page 191.

Even though some women "go to some lengths to find out how skilled their doctor is", some have pointed out (Bassett-Smith, 1988:50) that "doctors...did not provide accurate information about when he would be there (at the hospital) and who would be caring for them (the women) throughout most of their labour." Bassett-Smith (1988:50) draws the conclusion that doctors, by emphasising their practice, socialised women "to believe that their doctor would see them through the whole birthing event." Women therefore lack an awareness that it is a midwife who actually cares for them during labour and birth. In addition, women often do not differentiate between a midwife and a nurse who are both held to be subordinate to doctors. As Jessica (refer to page 187) and Sarah have pointed out. Sarah explains here:

> A midwife is sort of like a helper-nurse who helps the doctor by carrying out his or her orders. That's the general view.
> Sarah, Case Study 5, Int.1, refer page 218.

There are differing perspectives between a midwife's view of herself, and a woman's view of a midwife. From a woman's perspective, the midwife may be perceived to be a "helper-nurse" who merely carries out the doctor's orders based on an assumption that a nurse is dependent upon them. As with 'the doctor-nurse game', (Stein, 1968:105) the midwife is seen to indirectly "communicate recommendations without appearing to do so" which "effectively supports and protects a rigid organisational structure with the physician in clear authority". Alternatively, a midwife may perceive herself to be self-determining and autonomous in practice based on the assumption that midwifery is a

separate profession from medicine and nursing, all of which require their own body of knowledge and skills. The "general view" makes no differentiation between midwifery and nursing and extends to the vast cadre of female caregivers whose work continues to be culturally invisible.

Science And Knowledge

From the narratives of the midwives in this study it is evident that personal knowledge is a central way of knowing in midwifery practice. But this knowledge is sometimes devalued in relation to "a rational viewpoint." As Ericka explains:

> ...it (intuitive personal knowledge) often doesn't hold much water when it clashes with a rational viewpoint. That's not because it isn't as valuable, it's more because it isn't valued. Rational logical scientific knowledge has the kudos in society. Intuitive knowledge is seldom acknowledged ...whereas a balance of both is needed.
> Ericka, Case Study 4, Int.2, refer page 204.

A hierarchy of knowledge is identified. Knowledge that is rational, logical, or analytical generates propositional knowledge which is given higher status than knowledge produced through experience. Experiential knowledge is not legitimised. Thus, intuitive, nonrational knowledge is not seen as different and equal to logical, rational knowledge, but different and inferior. This coincides with the values of a traditional male culture. As Ericka explains:

> As a generalisation males are often rational and females are often nurturing. The traditional nurturing female roles are devalued and so are the principles upon which these roles rest. All the masculine principles, like the logical and the rational, are what gets the kudos. The scales aren't equal between these principles, between the logical or rational and the nurturing or nonrational, so that they do not complement each other.
> Ericka, Case Study 4, Int.1, refer page 206.

The male-defined occupation of medicine is given higher status in relation to the female-defined occupation of midwifery. The predominantly female profession of midwifery is subordinated to the predominantly male medical profession in much the same way as women

have been subordinated to men. The hegemony lies in what knowledge is emphasised or included - the objective and measureable realities of social life - and what is excluded - feelings and emotions. This situation is reinforced by rewarding practices and discourse which support the dominant way of knowing and denigrating those that don't. In the following extract, Ericka discusses two research proposals, one proposal is from a doctor, the other from a midwife:

> It was very interesting to see the difference between the two proposals. The midwife thought the medical proposal was detached or impersonal. It set objectives that were measureable and quantifiable as problems in a statistical arrangement. Whereas the midwifery proposal endeavoured to examine the meanings and issues inherent in what counted as problems for the women concerned...This was viewed as rather emotive by the medical profession.
> Ericka, Case Study 4, Int.3, refer page 205.

The midwife and the doctor identify with a different set of second-order beliefs about what is acceptable or unacceptable ways of knowing, and how these beliefs can be shown to be acceptable. Geuss (1981) describes these second-order beliefs as 'epistemic principles'. Two contrasting epistemic principles or epistemological orientations are posited by Belenky, Clinchy, Goldberger, and Tarule (1986). These are: a 'separate epistemology', based upon impersonal procedures for establishing truth, and a 'connected epistemology', in which truth emerges through care. It is the identification with an agreed set of epistemic principles that gives each group (midwives and doctors) its sense of authority or beliefs about what ordinarily constitutes knowledge.

A 'separate epistemology' is evident in the medical proposal which appeals to objectivity, detachment, hierarchy and 'science' as a cultural activity taking priority over women's more individualised concerns. On the other hand, a 'connected epistemology' is evident in the midwifery proposal which appeals to subjectivity, involvement, complementarity and science based on an understanding of women's feelings and concerns in the others terms (rather than in their own terms). From the prism of the doctor's "rational viewpoint", the midwifery proposal may be relegated to 'non-data' as it does not "hold

much water." Whereas, from the midwife's point of view, a balance of both forms of knowledge "is needed." Taking the latter perspective, midwives legitimise their knowledge by sharing it with the dominant group. As Rebecca illustrates when she constructively criticises the competency of house surgeons:

> If they want to catch babies they have to have some idea of how the women is working, how she's coping with the situation...They're rushing off to someone else...they can't be all things to all people. But they miss the subtle changes in people and they need to be aware of that...they...need to take on board what they've been told by the midwife.
> Rebecca, Case Study 1, Int.4, refer page 160.

As already illustrated in **Chapter Five**, medical practice is not facilitative of doctors 'being with' women. Traditional medical education has been couched in 'scienticism' whereby the woman's experience is objectified and the birth process culminates in a "statistical arrangement". This has meant that doctors adhere to the empirico-analytic tradition, claiming a dominant role on the same basis as the natural sciences. Therefore, science has provided doctors with the means for legitimisation by arguing that medical science is neutral and value-free. Historically, by utilising science as ideology, doctors were able to replace myth with scientific rational action or appeals to reason. From this perspective, the midwife's knowledge may not be seen as legitimate knowledge. As Ericka explains:

> The house surgeon was seeing all the women in that four-bedded room. She continually came in and interrupted the interaction that I was having with those particular women...I was supposed to sublimate what I was doing so she could see them...it is just assumed that what she's got to do is more important.
> Ericka, Case Study 4, Int. 1, refer page 207.

The midwives believed that a collaborative approach, in medicine and midwifery, would go some way toward fostering enlightenment and mutual respect within and between both professions. However, Sarah suggests that the midwives' belief that their knowledge is complementary to medicine as knowledge develops, is not a belief that is shared by the dominant culture:

> Some doctors expect you to drop what you're doing and carry out their instructions because they don't consider that what you're doing is as valuable as what they want you to do. They do not see midwifery knowledge as valuable. They often see us as just carrying out their orders...But I've learned to value my knowledge and skills...which is complementary to theirs.
> Sarah, Case Study 5, Int.2, refer page 215.

By taking a "detached" theoretical approach doctors are unable to take on the perspective of 'the other'. Belenky et al., (1986:115-118) who encourage new ways of thinking about what constitutes knowledge, make a distinction between two groups of knowers. The first group are 'separate knowers' who use the lens of a discipline to view reality. Authority for these knowers rests on objectivity (since feelings cannot shape scholarly judgement) and involves technical rationality. The second group of knowers are 'connected knowers' who use the lens of another person, as their knowing, in this case, is through empathy. Authority of a connected knower rests on the commonality of experience and involves receptive rationality. This gives the knower an ability to take on the perspective of 'the other'. As Ericka explains:

> Some doctors are very detached from the data and from their practice. But as a midwife you utilise values and experiences in your practice and research.
> Ericka, Case Study 4, Int.3, refer page 205.

Whereas it appears that medical practice is shaped by the fundamental belief that an objective and systematic understanding of their work will naturally lead to the 'correct' solutions, midwives here assume that certain phenomena have many potential meanings and the particular interpretation of meaning will depend upon the context in which the phenomena are perceived. From this perspective, to be able to fully understand a phenomenon, it has to be viewed from a variety of angles. This is not possible from a consistently "detached" and "impersonal" approach, as Sarah explains:

> Doctors only believe objective tests. This is similar to their disbelief of a woman's dates (of last menstruation). A woman can be sure of her dates but the doctor will believe the scan before her opinion.
> Sarah, Case Study 5, Int.3, refer page 216.

By consistently distancing oneself from a woman's experience there is a loss of subjective meanings. According to Gadow, (1984:64) "the body is treated as a neutral object free of demeaning social or emotional values" so that the subjective experience of both women and doctor is replaced with objective data. Where objective data is unavailable, the problem is sometimes individualised. As Ericka illustrates:

> Sometimes if the medical staff are unable to solve a problem medically or scientifically they throw it back onto the woman concerned thereby negating her experience.
> Ericka, Case Study 4, Int.3, refer page 207.

Where there is no objective data which clearly identifies a physical origin of illness, medical practitioners sometimes look for an individualistic or a psychological cause for a given problem. The dominant orientation of doctors since the nineteenth century has been to treat disease or disease-like entities in the individual in a 'scientific' manner. "There is the assumption that all conditions can be classified and diagnosed according to some discrete, specific cause or mechanism (such as an infective agent) and that, once this diagnosis has been carried out, treatment and prognosis naturally follow" (Davis, 1981:13). The effect is to individualise the problem, that is, to locate the source of this problem in women themselves, in their lack of capacities to adjust to the demands of life. The limitations of a reductionist approach to women in midwifery is apparent in Sarah's description:

> Midwives have noticed that when women with placenta praevia go for a scan they have a moderate to severe bleed two days later. One midwife...says you can predict it by the clock...that ultrasound probe...may be dislodging it (the placenta).
> Sarah, Case Study 5, Int.1, refer page 217.

The value of technical knowledge is not in dispute. But what may be questioned is a bias that exists toward technological intervention that undervalues empirical observations. Here there is a relationship between knowledge and interests which an objectivist view of knowledge conceals. By an uncritical objectivist view of science, any ideological elements may be denied or suppressed. For where a doctor is able to impose rational action to which other reasonable (not

"emotive") people will accede, science may be utilised as ideology. The ascendency of rational knowledge misrepresents midwifery as a social science because ultimately rationality may be used as a tool of manipulation, repression and domination rather than as a means of enlightenment and freedom.

Prenatal Education

Part of the way midwifery is invisible to women is through the process of antenatal education. Within hierarchical relationships women are placed on the lowest rung of a 'ladder' with no power at all. This is not a conducive learning environment for women or midwives. Ingrid explains how an oppressive learning environment may be maintained by midwives:

> The outcome of antenatal education depends upon the educator's approach. If you present the class with an approach that gives them no clear alternatives, like "this is the way its done here", then the class itself can become a means of control. If you talk about what is hospital policy, as far as procedures go, then this is a means of control because it's not offering them any alternatives. I do say "At this hospital we tend to do such and such." But I don't think...it's done to control because I inform them that there are alternatives.
> Ingrid, Case Study 2, Int. 3, refer page 178.

Ingrid is conscious of the way a hidden agenda has socialised women into depending upon doctors who have maintained a dominant position as gatekeepers to the maternity services. Such a position has unwittingly, or otherwise, been reinforced by midwives themselves who accept a medicalised model of childbirth and legitimate its continuation as a taken-for-granted feature of midwifery education.

Rather than offering women choices about how they may want to prepare for their impending labour, some midwives take a systematic approach to education. Within this approach the task of education is to reproduce the dominant ideology and thereby emphasise the dependence of women upon medical authority. In this way the authority of the midwife as teacher "becomes a means of control" and is transformed into authoritarianism. As Freire and Shor (1987:36) state "...reality

is a fixed commodity only to be described instead of recognising that each moment is made in history and can be changed in an historical process."

Freire and Shor (1987:104-105) recommend a 'situated pedagogy'. Here the familiar is situated in their larger social and historical context to challenge the 'givens' and the "surrounding system dominating daily life" which 'limit acts' and situations. By way of contrast, a flexible approach to teaching and learning antenatally endeavours to liberate women by offering aternatives, as Ingrid illustrates:

> I inform them (women) of...things relating to normalisation...and the reasons why intervention is not always preferable because it often leads to more intervention in childbirth.
> Ingrid, Case Study 2, Int. 2, refer page 178.

A liberatory approach to education rests on a belief in the legitimacy of midwifery knowledge and practice to foster awareness, influence attitudes and help women to identify alternatives in an attempt to share the responsibilities of creating new possibilities.

Vested Interests

Although midwifery knowledge and skills may be invisible to women, midwifery has gained increasing acceptance from some members of the community over more recent years. Both on the grounds of cost and on the grounds of consumer choice, alternatives to a highly technologised birth are appealing. But midwives may not have gained the same degree of acceptance as competitors for what doctors may describe as 'the low risk market'. Whether the issue at stake is the "livelihood" of doctors, who may be threatened by a potential loss of clients as an entree into general practice, as Sarah (refer page 222) and Jessica (refer page 192-193) suggest, or "loss of income" as a result of this, as Rebecca proposes, the central issue revolves around 'power'. Rebecca makes this point:

> General practitioners probably more than obstetricians... feel threatened by midwives (autonomy) because they (are)... worried about...their loss of power. Money in midwifery is a trap midwives need to be wary of too.

Rebecca, Case Study 1, Int.2, refer page 166.

But power is not just economic, it is also ideological. Those who have produced the dominant ideas (doctors) have controlled the way the health system has been organised. The organisation of the maternity services are legitimised by traditional ideologies that mask the existing power relationships which perpetuate traditional authority and values. As discussed earlier, some midwives use their authority to reinforce hierarchical relationships and to retain control of knowledge. These relationships are reinforced by institutionalised mechanistic forms of knowledge which is the subject of the next theme.

Social and economic contexts are crucial determinants of power nonetheless. In the following extract Sarah sees a marked difference between the maternity services available to women in the urban communities where this study was undertaken:

> In one district the population is predominantly white and middle class and inclined to consider that to have optimal maternity care it is necessary to have a doctor...In this area the GPs are very reluctant to let midwives have any part in an autonomous midwifery practice. Whereas in the district which is predominantly working class and poor, the majority of births are attended by midwives...
> Sarah, Case Study 5, Int.2, refer page 222.

There is a relationship between the socio-economic status of an urban population and the autonomy acceded to midwives. Midwives are more widely utilised in a poorer community than in a more affluent one. It is questionable whether this is by choice, or whether the poorer area is as well served by doctors which would decrease their availability to women. Hart's (1971) 'inverse care law' may go some way to explain why this disparity occurs. This law proposes that the actual delivery of medical care is inversely related to need. There is evidence that this law is applicable to New Zealand (Salmond, 1975; Reinken, 1979). Hart's inverse law states that there are more doctors in affluent suburbs where the population can pay for their services compared with the suburbs that actually need medical attention but cannot afford to pay for them. Thus, where the population is affluent, doctors have a greater interest in retaining a monopoly since the population can

readily afford to pay for medical services. This suggests that the status of caregiving is intimately related to the status of the ones cared for. Based on a changing socio-political context in New Zealand, a context that may give rise to a larger working class, Sarah foresees no change for midwives, as she explains:

> ...midwives might end up looking after the poorer end of the scale, the ones who can't afford obstetricians...as has historically been the case.
> Sarah, Case Study 5, Int.1, refer page 222.

Although the socio-political environment may have changed, the prevailing social philosophies have not. The philosophy of extreme individualism that pervades Western societies effects professional attitudes to caregiving in the maternity services. Ingrid (refer to page 175) and Sarah allude to this point. It is suggested here by Sarah:

> It's...market forces that generally propels society. So people in private practice are likely to be driven by competitive self-interests that devalue collective interests.
> Sarah, Case Study 5, Int.3, refer page 222.

Benner and Wrubel (1989) point out that particular historical circumstances, power relations, and ideologies such as patriarchalism and individualism, have created the conditions under which health professionals organise their practice. This has facilitated the emergence of a professional identity in medicine and prevented it in others such as midwifery. Where social and economic infrastructures have rested on the assumption of stereotyped gender roles, midwives, for example, were expected to accept a duty to care for mothers and babies rather than demand a right to determine how they would satisfy this duty. However, competition for money and resources increases with rationalisation of services. Midwives are constrained by the lack of resources within the public health care system as a result of budgetary constraints. Sarah (refer to page 224) and Ericka reflected on their experiences of the effects of budgetary constraints. Ericka describes the effects of these constraints in the following terms:

> There is a definite lack of resources which is more noticeable with further budgetary constraints. Much of the frustration experienced in the work area is directly related to a decrease in the allocation of funds.
> Ericka, Case Study 4, Int.1, refer page 209.

A diminishing allocation of funds to Vote Health puts pressure on midwives which combine to decrease a midwife's autonomy. Sarah suggests that doctors have been advantaged economically by practice nurse subsidies:

> General practitioners would not employ practice nurses if the practice nurse subsidy wasn't there. They get 75% of the practice nurse's wages which means they pay one hundred dollars per week or 25% out of their profit for the practice nurse.
> Sarah, Case Study 5, Int.3, refer page 224.

Part of the way the system operates is for the government to pay a practice nurse subsidy to general medical practitioners. Thus, medical services are subsidised while alternative health care, such as a midwifery option, are not. Sarah believes that resources are also limited for midwifery research and journal publications:

> Midwives have only just started to have a journal, which is good, but that's a monetary thing too. It costs money as does research. Other professions, such as the medical profession, have a lot more money for publications and research.
> Sarah, Case Study 5, Int.3, refer page 224.

Doctors have a long history of State funding for scientific research as well as the means to publish their research findings. The reasons underlying the power of the medical profession to manipulate State funding toward their requirements is related to their power to impose a single scientific worldview within which midwifery knowledge is not considered to be legitimate knowledge. But a single worldview, as in the empirico-analtyic science tradition, takes reality as 'given' and therefore any interpretive elements which may be ideological are denied. In this way, doctors are characterised as acting in the interests of the common good of all citizens. But medical practices are run as businesses where money-making for profit may be rooted in self-interests. Self-interests are not necessarily compatible with

collective interests. Rebecca suggests that the hegemony of the medical profession is historically related to "power" and "money" making:

> ...historically doctors got into midwifery once they discovered what a great deal of power they could have over people, over women in general. So they discovered how much money they could rake in at the same time and it was too good to resist.
> Rebecca, Case Study 1, Int. 2, refer page 163.

Doctors have been politically active since before the twentieth century in New Zealand to advance modern institutionalised medicine into a position of power and to keep themselves there (refer **Chapter Two**). The hegemony of the medical profession is reinforced by subordinating midwives to them. Ericka reflects upon the effects of subordinating her experiential knowledge to a rational way of knowing in nursing:

> When you think about the original motives for going nursing...the altruistic stuff...the wanting to help people, the nurturing...this gets trained out of you...And in fact you can lose the motivation that you had for doing the job in the first place...you have to...procure the...logical rational stuff in order to survive in the system...whereas a balance of both is where you need to be.
> Ericka, Case Study 4, Int.2, refer page 204.

The ethic of caring, which is the basis of altruism, gets 'trained' out of caregivers in hospitals. In this way, not only is caring rendered culturally invisible, as the accepted everyday reality, it is also devalued. The extreme individualism of Western societies "makes caring suspect and subordinate to individual desires and needs" (Benner & Wrubel, 1989:368). Benner & Wrubel point out that a concern for others need not be competitive with self-interest if the concern is grounded in an ethic of care and responsibility. As Sarah says:

> ...part of the ethic of caring is to be responsible for your actions. **Is that altruistic** Yes it is...
> Sarah, Case Study 5, Int.3, refer page 222-223.

By viewing the history and the implications of the word 'altruism' as problematic, Benner and Wrubel (1989:367) see that "its roots lie in an oppositional view of self" so that "concern for others must always

be at the expense of the self, and therefore altruistic." But where a person is defined by social relationships, concern for others may bring about mutual realisation of personal understandings and meanings which are not neutral but are ethical and political. This is demonstrated by Jessica:

> If someone who's not actually involved in the direct care of the woman comes into the room without being invited...it can destroy the whole rhythm of labour and atmosphere in a matter of seconds... my attention is taken away from her and you've lost that trust in some ways...(it) just takes away from the woman's whole experience and lowers it down to something less important.
> Jessica, Case Study 3, Int.3, refer page 192.

Labour and birth are a personal experience, but it is more than that. When people enter a labouring woman's room uninvited, birth becomes a political issue since the natural rhthym of birth is disrupted and women are dehumanised.

A Potential For Conflict

With the expanded scope of midwifery, a midwife and a general medical practitioner have the same responsibility to seek specialist consultation when 'high risk' women are involved. A shared responsibility sometimes contribute to interprofessional conflict in a hospital setting, as Jessica illustrates:

> ...the midwife was the one that was there and did the assessment and she'd be the best one to communicate that to the obstetrician. But the general practitioner didn't want her to do that. I think he felt that if he let the midwife do it, that he would have lost some sort of control in the care of that woman.
> Jessica, Case Study 3, Int.2, refer page 193.

While doctors protect their position to maintain authority within a rigid organisational structure, midwives simultaneously battle for position intraprofessionally. In the following extract, the issue of safety is at the root of divisive relationships between midwives. Midwives who work in a hospital setting, for example, show overt lateral violence toward independent midwives because their technical skills are unknown. What is brought into question are the standards of

midwifery practice when clients are tranferred into hospital. As Ingrid explains:

> ...some midwives turn against other midwives' efforts. When women request epidurals and they are cared for by independent midwives, the way policy stands at the moment, the independent midwife doesn't have the right to do the epidural top-ups or care for women in this situation because they're not on the epidural register. And so the hospital midwife has to take over the care...This is where the safety aspect of practice can work against midwives because all independent midwives' practice will be suspect.
> Ingrid, Case Study 2, Int.2, refer page 173.

Safety is an issue that consistently reappears throughout the narratives. While not denying that technically competent midwives are essential for safe midwifery practice, the issue of safety may be used to change the social relations between midwives just as historically the issue of safety was used to change the social relations between doctors and midwives (refer **Chapter Two**). 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. That is, a midwife who is on an epidural register is perceived to be of a higher status than a midwife who is not. Ironically, rather than new technology having the effect of liberating midwives, it may have the reverse effect through an ideology of technique. For what can be detected, measured, manipulated and controlled in each situation dominates thinking with little or no consciousness of the socio-political context in which policy is made. Here agency is viewed in strategic terms, that is, in terms of success in achieving certain ends without an adequate consideration of alternative means to achieve these ends. Such an instrumental view of knowledge takes precedence over other ways of knowing. This results in the legitimation and objectification of technical forms of knowledge to the exclusion of others that endorse the importance of critique and contestation.

While the techniques that hospital midwives have 'over and above' other midwives may be elevated to give them a sense of superiority, a technique cannot produce the philosophy that directs it. When hospital policy, techniques, and the underlying philosophies are perceived to

be the 'natural' order of an institution, (as in the above extract) there results a divisiveness among midwives. Hegemony here is not so much about winning approval for the status quo, rather, what seems to be involved is the prevention of rejection, opposition, or alternatives to the status quo through deception.

In the context of clinical teaching Clare (1991:142) points out that "the issue of safety may be used as a controlling mechanism" for clinical practice to justify authoritarian relationships. In the sense that flexible midwifery practice, which is responsive to ethical and cultural concerns as well as safety, gives way to mechanistic action, practice is subsumed by the dominant ideology. Thus ethical questions may be reduced to a matter of safety and are one of the ways in which practical rationality gives way to technical rationality. But where there exists a hierarchy of knowledge, with a bias toward technical rationality which is reinforced by narrow policy, it is at the expense of other forms of knowledge essential for professionhood. As Smyth states:

> ...ways of thinking and acting that have to do with controlling the physical world, may have little or no relevance for the social world we inhabit.
> (Smyth, 1986b:8)

Aside from the issue of safety, Ingrid foresees conflict arising between independent midwives and hospital midwives:

> Midwives in private practice will be constrained by how much time they can put into it...so obviously once women are in hospital they are going to be looked after by the hospital midwives and that is where a breakdown in relations between midwives can happen. It's a 'them' and 'us' sort of situation and it shouldn't be so.
> Ingrid, Case Study 2, Int.1, refer page 174.

When midwives who work in two different settings (hospital and community) meet, there is the potential for conflict. For there will be differences in the work context in relation to decision making and autonomy in each practice setting. These differences may be prohibitive of collaboration. Those who work in a hierarchically organised environment may have less autonomy, for instance, than those

midwives working in the community. But the similarities among midwives have much to do with collective interests or common goals. These may be masked by dominant power relations and ideologies so that the differences between midwives justify the boundaries between them.

SUMMARY

This chapter reveals a competing discourse in midwifery practice and education which represents a struggle and counter-struggle as two groups of midwives seek to define their own limits. The first group represent a renaissance view of midwifery. By taking an active interest in controlling what counts as knowledge in their field, by creating new knowledge, and by utilising knowledge in appropriate ways, these midwives resist the dominant medical ideology. The second group of midwives accept power relationships and forms of knowledge uncritically and in so doing show deference to medical authority. These midwives are resistant to autonomy in midwifery practice in their lack of a perception or belief in the existence of alternatives to the status quo. In this way the dominant hegemony (conservative) or structures and relations of power are legitimised and therefore serve to sustain dominant social practices and oppressive hierarchically organised social relationships. Rather than values and beliefs being open to debate and contestation, values are tacit and deceptive. Through lateral violence, midwives align themselves more closely with medicine and perpetuate the conditions of their domination. Within this dialectic, midwifery culture has its own inherent logic and counter-logic which is simultaneously a structuring process and a transforming process. As a structuring process, human agency is accommodating to the dominant ideology. On the other hand, as a transforming process, human agency is resistant to the dominant ideology. The conflict lies in preconceived notions of what is considered to be reasonable and possible.

The chapter also portrays how women too perpetuate the status quo through their general lack of awareness of the status, authority and practice of midwives. In this way women are unable to legitimise midwifery knowledge and therefore subscribe to it. Part of the way the

the dominant medical ideology functions, is through a hegemonic process of antenatal education as an important vehicle in maintaining the established order. Midwives themselves reinforce a medicalised view of childbirth by adopting a systematic approach to antenatal education which legitimises its continuation as the taken-for-granted feature of the maternity services.

The status quo is further reinforced through a dominant technical rational view of knowledge and science. Rather than midwifery knowledge complementing medical knowledge, a midwife's way of knowing may be devalued in relation to a doctor's. Here medical knowledge is considered to be naturally superior to midwifery knowledge and therefore unchallengeable. The evidence suggests that there are vested interests in the health care system which serve to keep doctors in a dominant position, a position which is perpetuated by uncooperative intraprofessional relationships between midwives. This theme therefore raises a paradox: midwifery is simultaneously accommodating to the dominant ideology as it is resistant to it.

The next theme to be discussed in **Chapter Seven** is the contradictions between belief and action in midwifery education and practice.

CHAPTER SEVEN

CONTRADICTIONS BETWEEN BELIEF AND ACTION

This chapter focuses on the ways in which participants in this study experience contradictions between beliefs and action in the everyday practice world of midwifery. The structural contraints which may have resulted in a separation of knowledge from the accompanying practice are explored.

Midwifery Education

Anecdotal evidence suggests that some midwives are moving toward determining their own personal and professional interests in education and practice. These midwives endeavour to create a positive learning environment where "learning can be extended rather than inhibited". As Rebecca explains:

> ...some people will try and help by trying to give a person...a positive experience where they can learn in a non-threatening environment...where learning can be extended rather than inhibited. There are others who...won't make it easy for the learner, who...don't look for ways to foster learning. It's almost as if they're obstructive to learning.
> Rebecca, Case Study 1, Int.5, refer page 164.

While some midwives aim to "foster learning", others are "obstructive" to learning. By trying to give people a "positive (learning) experience", a learner-centred view of education is taken. A learner-centred view is not apparent when people "don't look for ways to foster learning" or when "they're obstructive to learning." In the following extract, Ericka believes that the theoretical approach taken by teachers in her own general nursing apprenticeship was deficient as it was acritical of the social and political context in which learning ostensibly occurs:

> The people who trained us at the hospital...carried with them deeply rooted attitudes that were quite firmly implanted in...theories that were not critical of the social

> and political circumstances.
> Ericka, Case Study 4, Int.3, refer page 206.

Attitudes of teachers' of past nursing programmes were "deeply rooted" in 'given' assumptions that did not encourage students to keep abreast of changes. This has contributed to a theory-practice dichotomy. Past 'training' as an obstetric nurse is identified by Ingrid and Rebecca to be a particular source of frustration relating to teaching and learning, or more specifically what amounts to the deficiencies of a 'numbers curriculum'. This curriculum was adopted for the education of midwives and obstetric nurses within the former hospital-based apprenticeship system. Ingrid reflects upon her experience and observations as an obstetric nurse:

> ...the place was so regimented. We all had to do strict procedures, such as four-hourly feeding (of the babies) and these were timed strictly. We had to do four-hourly perineal toilets and so many rectal examinations. The knowledge seemed to be one-sided as it was based on procedures which were done in a step-by-step or task orientated manner. And the knowledge was not related to the whole picture.
> Ingrid, Case Study 2, Int.3, refer page 179-180.

There is a difference between the orientation of past educational programmes for midwives and (obstetric) nurses and those undertaken currently. In past programmes students had "to do" a set number of procedures. This is indicative of an 'objectives curriculum' which is structured according to predetermined learning outcomes for obtaining and communicating knowledge. But the knowledge is "one-sided" or unrelated to the "whole picture." Such an approach to learning is behaviourist. It specifies learning outcomes of tasks which emphasise a "step-by-step" procedure, a procedure which is not placed within a social context. The assumption underlying this approach is that complex behaviour and learning is acquired through a linear process as each step in the procedure is a separate task, or behaviour to be observed. Knowledge is therefore instrumental, that is, a means to an end so that alternative ways of knowing are obscured and hence not legitimated. A focus on tasks accepts historic practices as 'natural' and fails to uncover the true nature of taken-for-granted procedures. In this way, education in midwifery and nursing is shaped by forms of technical control which arise from a dominant and frozen ideology of

technical (explicit) values which are reinforced in practice. Rebecca illustrates this in the following extract:

> In the past (midwifery programmes) midwives had to have so many specific techniques. This perpetuates the 'doing to' women. I don't want to have to do a set number of vaginal examinations or episiotomies or whatever. You can only get these skills through caring for someone throughout their labouring and birthing experience. It's not midwifery to check off so many techniques...(or) numbers from a list...To catch the baby is not the way to learn midwifery.
> Rebecca, Case Study 1, Int.4, refer page 163.

The set objectives to be accomplished (which are a prescribed number of specified observations, "techniques", or numbers that the student ticks off from a list set rigidly by the teacher, not the student) are incongruent with Rebecca's experiential knowledge. According to Rebecca, this perpetuates "the 'doing to' women" which is inconsistent with a women-centred approach in midwifery. However, a task-oriented approach is consistent with Freire's (1972:46-52) 'banking' education. Thus, the student midwife is "passively open to the reception of deposits" which they "patiently receive, memorise and repeat" as the scope of action allowed to students "extends only as far as receiving, filing and storing the deposits." By "banking" deposits of knowledge, which are 'given' rather than created by them, midwives "adapt to the world." The "ideological intent" (often unperceived) is to indoctrinate midwives to "adjust" to the interests of a dominating group (doctors), and in the last analysis it is midwives who are "filed" away.

The 'numbers curriculum' is also described as a "masculine modality" (Daly in Bevis & Watson, 1989:179-180). It is a 'received' view of knowledge which amounts to a technical form and was institutionalised as the only way to organise a curriculum. Such "methodolatry (where methodology is taken to the point of tyranny) hinders critical thinking because it prevents students raising questions or introducing content that does not fit into preestablished objectives." The notion that students come from different histories, embody different experiences, linguistic practices, cultures, and talents is ignored in this approach and consequently so is the learning needs of each

student. From this it follows that a procedurally orientated programme in midwifery functioned to serve interests supportive of existing hierarchical social structures whereby students conform to the status quo. In addition, hierarchical relationships maintained by midwives working in clinical practice reinforced this situation. As Ingrid recalls from her experience as an obstetric nurse:

> When I did my obstetrics...I found that the midwives were extremely bossy in the way they interacted with other midwives and also with women.
> Ingrid, Case Study 2, Int.3, refer page 179.

In the clinical agency a midwife may 'train' those below her to conform to the established order by being "extremely bossy." A narrow selection of pursuits and interests are portrayed which do not foster autonomy, responsibility for individual learning, or the development of a social and political consciousness. Rebecca believes that this "autocratic" approach to learning is perpetuated by some midwives today:

> If they trained that way many years ago and in a particularly hierarchical system...then they're still there. They still have that hierarchical autocratic sort of approach to everyone...
> Rebecca, Case Study 1, Int.3, refer page 161.

Manipulative "hierarchical autocratic" relationships in education and practice ensure the "inherited and 'official' shape of knowledge as hegemonic controls enforce compliant behaviour" (Freire & Shor, 1988; Clare, 1991). This is the hidden curriculum and is the hegemonic consequence of a dominant ideology. That is, students, new graduate midwives and others are socialised into conformity and passivity which amounts to hegemonic forms of control. In this way, midwives are unable to engender a socially critical attitude in order to challenge structural constraints inhibiting an autonomous midwifery practice. Freire (1972) describes education of this nature as a "domesticating discourse." For as Sarah states in the following extract, the set objectives that the student has to accomplish "becomes the main thing to achieve" regardless of what is appropriate for individual learning needs:

> When the student has a concern with getting a number of tasks completed this becomes the main thing to achieve. Energy is not devoted to reflective and critical thinking because you're too busy just coping with the demands of the tasks or assignments.
> Sarah, Case Study 5, Int.3, refer page 220.

Where reflective and critical thinking is not promoted, the student is "too busy just coping with the demands of the (prescribed) tasks." Hence students are prevented from raising questions or introducing content that does not fit into preestablished objectives. The end result is a separation between thought (theory) and action (practice) which may go some way toward explaining why there has been little theory development in midwifery. Such a logic undervalues the transformative potential of practice in favour of instrumental procedures that are 'given', rather than in dialectical relation with practice.

In contrast to past midwifery programmes, midwives in this study had the opportunity to reconcile their personal knowledge with interpretation based on experiential learning. In this way, their midwifery course fostered autonomy and responsibility for individual learning with the aim of developing an awareness of the student's own values. As Sarah states:

> The emphasis in our midwifery curriculum was on attitudinal change rather than technical tasks...you were forced to think about what your attitudes and values are and develop an awareness of where you are coming from...If you don't examine these you just operate out of what you've always done, or been conditioned to do, and you don't know the rationale for doing it.
> Sarah, Case Study 5, Int.3, refer page 220

Rather than accepting the dominant ideology as 'given', the midwives in question engaged in formal self-reflection through an examination of their own professional attitudes and image. This gave them the capacity to perceive contradictions between beliefs and action in everyday practice within the hospital and technical institute, and to understand how constraints on personal and professional values are at a social level rather than at a personal or individual level. Their midwifery course therefore fostered a 'dialectical imagination'. In

the following extract, Ericka sees a dialectic between cultural values and the interests behind them:

> The culture of a hospital...(is) often accepted as people are socialised into it. Take a simple example of uniforms. The epaulettes are symbolic of rank and the whiteness of purity...Many attitudes are deeply rooted in long-standing sexism.
> Ericka, Case Study 4, Int.4, refer page 206.

Ericka believes that the symbols of epaulettes and white uniforms represent historical "sexism" as the mediating ideology at the root of an oppressive culture in midwifery. Epaulettes are seen to represent the ranking order of a hierarchical system which upholds and reinforces a status distinction between midwives. Such a distinction separates midwives from midwives as it does midwives from women in their care. Similarly with white uniforms. These are seen to be a symbol of an oppressed group. It is when symbols are perceived to be 'natural' that they may be "used to define the situation encountered in various 'roles' and as yardsticks for the evaluation of leaders and followers" (C. Wright Mills, 1959:48). In this way, midwives may be socialised into accepting 'roles' which they take-for-granted and which they unconsciously reinforce through symbols that deny them cultural potency. Hence they are prevented from reconstructing a professional identity.

In their own education course, midwives in this study were introduced to the history of midwifery which proved to be particularly valuable in the development of an awareness of the socio-political context in which midwifery care is given. As Ingrid explains:

> We had the history of midwifery in our midwifery curriculum...Now I'm working (as a graduate midwife) I have developed that political awareness in a clinical context.
> Ingrid, Case Study 2, Int.3, refer page 180.

With a historical perspective midwives are able to emerge with a critical consciousness. It is this process which Freire calls 'conscientization'. C. Wright Mills (1959:11-12) argues that this is the central task of a 'sociological imagination' which "...enables its possessor to understand the larger historical scene in terms of its

meaning for the inner life (or)...to grasp history and biography and the relations between the two within society. That is its task and its promise." Freire, (1972:61) argues that the task of a critical consciousness is not only to understand the socio-cultural and historical reality which shapes human life, but to "name the world." By imagining the world differently and naming it, new existential modes (ways of being) and structural forms are possible. But for Freire, a critical consciousness is not brought about through intellectual effort alone, but through praxis - through the authentic union of action and reflection. That is, critical reflection is also action. Sarah explains how a group of newly graduated midwives brought their new attitudes and concepts into a clinical setting:

> ...a lot of the attitudes that we came into the clinical area with were new and challenging, particularly to some of the older practitioners who had been in the system a long time. Things like empowering women and informing them of the choices available...was actually quite new.
> Sarah, Case Study 5, Int.1, refer page 221.

Concepts, such as 'empowerment', and existential modes, such as offering women 'choices', are counter-hegemonic and challenge midwives to individually and collectively put aside dogma and enter discourse as full and equal partners: where midwives negotiate in an 'ideal speech' situation and engage one another in an ongoing dialogue. This for Freire is an ongoing concern or what he calls "problem-posing" practice. Once the world is named, the "world in turn reappears to the namers as a problem that requires renaming. Men (sic) are not built in silence, but in word...in action reflection" (Freire, 1972:61).

Leadership

Traditional theories guiding educational administration in large teaching hospitals may have failed to recognise and promote it's distinctively educational features. Ingrid illustrates this when a manager takes a narrow view of her practice:

> I was speaking to a manager...who was having a performance review and who was asked: "Are you a manager first or a midwife first?" And she said that she was a midwife first and a manager second. She said that this was obviously not

> the 'right' answer.
> Ingrid, Case Study 2, Int.3, refer page 180.

As managerial strategies in two institutions are basically supportive of the status quo, "the 'right' answer" may be according to the tenets of a bureaucratic organisation rather than professional needs. Under these conditions managers are better able to ensure that the hospital remains an instrument of social control. Jessica and Ingrid both believe that a midwife's "thinking" often changes when a midwife makes the transition from expert clinician to charge midwife or a unit manager. Ingrid says (refer page 180) that although the thinking of a practitioner and a manager should "marry, they (often) don't". This is substantiated by Jessica:

> When a midwife goes from working with women...to becoming a charge midwife or a manager of a unit, her whole frame of reference changes...She's thinking in terms of money or how she's going to meet the budget, how she's going to keep doctors (and)...midwives happy...it's an intermediatary sort of role but...It's not focused on women...
> Jessica, Case Study 3, Int. 2, refer page 193.

According to Codd (1989:159-160) "the educational administrator is more than a facilitator of learning or an agent of socialisation; he or she is a person who embodies fundamental educational values". Smyth (1986a, 1989) and Schon (1983) give weight to Codd's argument in their observation that applying specialised knowledge to resolve particular problems is out of step with the changing circumstances of practice. Rather than applying discipline-based knowledge (i.e. based on verified rules, laws and prescriptions) that is generalised to other cases, they advocate the application of practitioner-based experiential knowledge acquired from previous cases. Smyth (1989) sees this view of leadership as sense-making, where greater attention is given to the 'playfulness' of knowledge and to job-embedded ways of learning that acknowledge the fundamental importance of questioning, criticising and reformulation of taken-for-granted assumptions about the nature of work. Viewed in this light, there is a prima facie obligation involved in midwifery leadership which rests on making community life more rational. However, Ingrid suggests that bureaucratic values (such as efficiency and productivity) may be

reinforced over and above professional or educational values:

> ...when many midwives go into management they...are made to become managers first to the detriment of the midwifery service that is provided...And while...we should be able to work within our budgets, silly things or backward steps are being made that prevent midwives from giving professional care...
> Ingrid, Case Study 2, Int. 3, refer page 180.

Rather than a commitment to values and principles for professional practice, the midwife manager may be committed to principles of the institution. This is a 'traditional' mechanical view of leadership as opposed to an avant gard 'organic' view. An 'organic' intellectual or leader for Gramsci (1971) is capable of both leading and representing groups of people who are dominated by social structures. Unlike 'traditional' intellectuals, these new 'organic' intellectuals refuse to join the privileged elite. In preference to a mechanical style of leadership as practised by 'traditional' intellectuals, an 'organic' style of leadership would mean supporting midwives who ought to be able to practice as autonomous self-directed practitioners. Then midwives would be constrained only by moral concerns which pervades the service orientation of a profession. But the midwife in clinical practice is constrained by a requirement to be accountable to the hospital hierarchy, a position that is problematic when adhering to a philosophy that holds midwives are accountable to women in their care. As Sarah says:

> In a hierarchical organisation you are constrained by protocols that make you fit into the system. There are so many protocols to follow...
> Sarah, Case Study 5, Int.2, refer page 223.

Midwives may be coerced to adhere and apply institutional protocols that no longer suit professional interests. For while it is acknowledged that explicit protocols and policies are important substitutes for tacit understanding, they are not the same thing. Rebecca makes this differentiation in practical decision making that circumvents rule-governed behaviour:

> Every birth is going to be different so how can you apply rigid rules to every birth when a lot of women don't want to do things in a particular way or may have particular

> approaches that they want?...the...thing...is to be flexible about what you do...
> Rebecca, Case Study 1, Int. 2, refer page 167.

Midwives have substantial knowledge about what they do which may not always comply with "rigid rules" imposed by managers who accept management theory uncritically. As a consequence of this, leaders in midwifery, much like Gramsci's 'traditional' intellectual, will prevent midwives from determining what their true interests are and hence acting in accordance with those interests. Leadership then becomes a distortion of vocation as managerial action is directed toward oppression rather than liberation. But if leadership is defined in terms of Gramsci's 'organic' intellectual, leaders and followers together reconstruct knowledge and history through a dialogical process. Here leadership is thought of as something that is not inherent in people, nor in positions, but in relationships which are constantly open to definition and redefinition (Bates, (1989). Thus, the concept leadership and the power which accompanies it may be redefined as the ability to act with others to do things that could not be done alone (Blackmore, 1989). Leadership is therefore a form of empowerment and not of dominance and control (Ferguson, 1984:206; Burbules, 1986; Blackmore, 1989). "To lead is to be at the centre of the group rather than in front of the others" (Hartsock, 1983:8). From this perspective leadership takes an educative stance as it rests on the ideals of critical reflection, personal autonomy and collective deliberation as a form of "philosophy in action" (Codd, 1989:157).

Performance Appraisals

The nature of the discourse which dominates the thinking of hospital administrators may be to control midwives to fit into the established order. Part of the way midwives conform to the established order is through the process of performance appraisals (where midwives are expected to write an appraisal of their own practice, as well as peer review). While individual evaluation of practice is meant to be a positive learning experience to foster excellent standards in midwifery practice, Jessica, Rebecca and Ingrid are suspicious of this process. As Rebecca explains:

> There's something I do not trust about Q.A. (quality assurance)...It is open to abuse in its present form...While the whole idea of Q.A. is to encourage excellence in practice it might be just another bureaucratic attempt to keep midwives in their place. If you happen to be in an area where you don't get on with the person who has authority over you, then you can be in deep trouble...
> Rebecca, Case Study 1, Int. 2, refer page 166.

When practice is evaluated by a "person who has authority over" a midwife and who chooses to use her positional power to a midwife's detriment, the quality assurance programme is "open to abuse". Upon further reflection on a past experience as a staff nurse in a general hospital, the root of Rebecca's current suspicions of performance appraisals is revealed:

> ...(the performance appraisal) was written by the charge nurse...She just didn't like me or my approach. She was old school or autocratic...She assessed me without asking anyone elses opinion...I didn't see any bad qualities in what she'd said...but it was couched in such a negative fashion. I thought if it goes on my record...they will...try and beat me into shape.
> Rebecca, Case Study 1, Int.2, refer page 167.

In light of past experience, Rebecca's fears are well grounded. By requiring her to conform to largely unstated expectations of those in authoritative positions, there is an insidious exercise of power which serves to reinforce compliant behaviour within a hierarchy of social relationships in the name of competent or safe practice. Where observations about personal characteristics of midwives are subjectively evaluated and entered into a personal file, practical knowledge is open to scrutiny and has the potential for "abuse." Although Rebecca's negative experience of quality assurance was in the past, Rebecca, Ingrid and Jessica continue to distrust the evaluation process. This is echoed here by Jessica:

> ...I have learned never to bring up the negatives in a review because people might pick up on them and use this against me...it can be something that controls you...
> Jessica, Case Study 3, Int. 1, refer page 194.

While appraisals of a midwife's performance are part and parcel of a programme that ostensibly assures competency, they can be a means of

social control by stipulating what is relevant for professional development. As Ingrid explains:

> ...the standards of safety are something we need to maintain but on the other hand, you have to use the jargon (which) is a language that they want you to use in particular ways. They (administrators of quality assurance) send it back to you (if you don't). So rather than maintaining quality care it becomes an academic exercise.
> Ingrid, Case Study 2, Int.2, refer page 181.

Rather than fulfilling the purpose of maintaining quality care, performance appraisals can become a means by which existing power relations are constituted and perpetuated. In this way, they are part of the hegemonic process which keeps the oppressed in their place. There is a similarity here with the procedural curriculum used in past education programmes for midwives and obstetric nurses. This similarity is illustrated by Ingrid who is referring to performance goals but may well be referring to rigidly prescribed learning objectives:

> ...if you...are forced to cover everything there will be some that you're not even going to achieve. If you concentrate on goals that you choose, then you've got a lot more chance of achieving them than if you'd put ones down that aren't really relevent to you...what's the point of making a goal up to please someone else because that's the requirement...If there is a problem then goals should be set by the midwife and the appraiser together.
> Ingrid, Case Study 2, Int.2, refer page 181.

To reiterate, performance appraisals which require midwives to conform to the expectations of those in authoritative positions over them are a means of control. This is reinforced by the use of technical-administrative knowledge in the process of evaluation. The hegemony of such procedures lies in its presumed neutrality of evaluation. In this way compliant behaviour is reinforced through a rationality which, in Codd's (1983:12) words, "drives a wedge between the executive and the contemplative dimensions of human action, positing a logical gap between theory (thinking) and practice (action)..." Hence, the development of a profession based on praxis (refer to **Chapter Three**) is thwarted.

Work Constraints

There are other forces within the hospital institution where the midwives work which constrain their practice. Budget constraints were identified as exacerbating the difficulties that Ericka and Sarah experienced. As Ericka explains:

> There is a definate lack of resources which is more noticeable with further budgetary constraints. Much of the frustration experienced in the work area is directly related to a decrease in the allocation of funds.
> Ericka, Case Study 4, Int.1, refer page 209.

The resources that were identified to be "short" were: time to take an active part in the education of women, equipment, and staff. As Sarah explains:

> A lot of the equipment gets stolen too I think...But it is sometimes expected that midwives should preceptor while at the same time take quite a heavy workload with the shortage of staff the way it is. The staff are just getting exhausted.
> Sarah, Case Study 5, Int.3, refer page 224.

Midwives are "sometimes expected to preceptor while at the same time take quite a heavy workload with the shortage of staff..." This adds to work stress they experience which in turn directly effects the quality of midwifery care. As Jessica explains:

> If it's my sixth shift in a row then it's easy just to do the bare minimum. Those are the days when I don't put much love into my work...You don't want to know where the woman is coming from the same...When my energy level is low I just want to get through it.
> Jessica, Case Study 3, Int.1, refer page 195.

Fatigue affects midwives' work so that they "do the bare minimum" and therefore favour their own needs rather than the women's. However, where this situation is unrelieved, work fatigue may reach a level of burnout. This is acknowledged by Jessica:

> I was burned out...in the postnatal area...because of the sheer volume of work that was expected of me. I wasn't able to enjoy what I was doing...
> Jessica, Case Study 3, Int.1, refer page 195.

In the context of caring for women postnatally, Jessica literally loses the ability to care so that she feels compelled to avoid the woman's situation. This is consistent with burnout, where burnout is interpreted as "the general feeling of loss of connection and commitment" as "a late effect of exhaustion" (Benner & Wrubel, 1988:297). This literature shows how social support is the most effective way to reduce distress through burnout. Jessica had little social support when working in the postnatal area:

> I didn't feel that I had people of a similar mindset working with me...I was working mainly with staff nurses and enrolled nurses who didn't have the same philosophy as me and they didn't approach care the same way that I did. That just made it difficult...the midwife is better at assessing the dynamics of the whole family situation and all the ramifications that go with the care of women and their babies.
> Jessica, Case Study 3, Int.2, refer page 195.

The stresses of midwifery are intolerable when the demands of the situation prevent midwives from performing with a maximum level of skill and commitment. The work situation may become more stressful when working with staff who do not have a similar "mindset". When Jessica worked with midwives, the "thinking was the same way and things went a lot smoother." This is indicative that social support from colleagues make a difference in reducing distress leading to burnout. Common meanings, insights and perspectives can be shared with an insider. This cannot happen when working with staff who do not have the same background knowledge and skills. These factors contributed to Jessica and Sarah's recommendation that the postnatal area be fully staffed by midwives. As Sarah explains:

> The postnatal wards...are not considered to be an area where you actually need to be a midwife...This is reflected in medical attitudes as well. A lot more interest is paid to antenatal and intrapartum women. And postnatally, the problems of breast feeding or mothering skills are not considered to be as important...women (who) feel positive and confident about their mothering skills...are going to bring up children that feel like that too. This area needs to be staffed by midwives.
> Sarah, Case Study 5, Int.1, refer page 223.

With early discharge it is more imperative that the postnatal area be staffed by midwives who have the necessary knowledge and skills appropriate to care for postpartum women and babies. For as Sarah and Jessica point out, how women are treated postnatally is directly related to women and children's mental health. They therefore suggest that when women do not have access to midwifery care postnatally, this area is undervalued to the detriment of women, babies and the community.

Care-delivery

Although the attitudes of some midwives are "new and challenging", midwives experience a number of structural constraints that prevent them from fully utilising their new knowledge and skills. One of these constraints is intermittent care-delivery within the hospital system. Rebecca explains how the "fragmented" or intermittent nature of care-delivery in the hospital system presents a particular difficulty for midwives and women to achieve mutually defined goals:

> The difficulty with fragmented care is that you have to raise issues whenever you meet them...rather than in a relationship that is built up between woman and midwife (antenatally)...You also can't raise (some) issues in front of the woman...
> Rebecca, Case Study 1, Int.2, refer page 165.

The opportunity for midwives to give ten to fifteen women continuing care throughout their pregnancy, childbirth and early parenthood arose in their midwifery course. As midwifery students, they found continuity of care to be facilitative of a flexible approach to practice. This was thought to be an efficient use of knowledge and skills in contrast to intermittent care-delivery. This distinction is evident in the following extract as Rebecca describes what was missing in her experience as an obstetric nurse:

> ...it was the personal touch, the rapport, or the way that you lost something with someone who you had a relationship with after eight hours, or the way the doctor would wander in and do the delivery and leave. As a midwifery student we wouldn't do that. We took a participatory role in the labour process...Continuity of care was a very valuable experience in my midwifery programme because you were 'with women'...

> antenatally...until they delivered...and after.
> Rebecca, Case Study 1, Int.4, refer page 164.

In contrast to the impersonal nature of intermittant care which "lost something", continuity of midwifery care gave midwives job satisfaction through enhancing holistic relationships built up between midwife and women. While the intermittent nature of care-delivery presents a particular problem for midwives, it also presents a difficulty for some women, as Rebecca says:

> When women don't see the same person in clinic they feel like a lump of meat moving along a conveyor belt of antenatal care.
> Rebecca, Case Study 1, Int.2, refer page 165.

The unfamiliarity of the hospital situation makes it difficult for women to provide meaningful cues as to their real needs and wishes. Bassett-Smith (1988:49) found that when pregnant women had knowledge of how the hospital system worked, they were accommodating to system inadequacies and even made "excuses in advance for the care the midwife or doctor might fail to provide." Jessica alludes to how the system presents difficulties for some women:

> A women can end up in hospital in labour...not on her own ground and she's not as powerful as she was before, and she's in pain, and she's less likely to be able to put her point across then...
> Jessica, Case Study 3, Int.2, refer page 191.

The lack of opportunity for a midwife and a woman to share their histories and to learn something about each other before entering the hospital system may mean that the first time the parturient women meets the midwife is likely to be in the active phase of labour. This is less than ideal circumstances in which to establish rapport, a situation which Ericka says "compounds the power structure against women":

> The system compounds the power structure against women...Like a woman arrives in the ward and it's a process of getting to know her as a person. That process may take quite a long time and if she's subjected to lots of brand new faces every few hours then it may never happen.
> Ericka, Int.3, Csae Study 4, refer page 208

Ingrid explains how the intermittent nature of care-delivery presents a particular difficulty with conflicting advice postnatally:

> Women say that they come out of hospital not knowing what to do because every nurse they come across had a different idea on how they should breast feed and I think that that can be a problem.
> Ingrid, Case Study 2, Int.3, refer page 177.

Women who may choose to have their babies in hospital have no alternative but to accept intermittant care-delivery. The system is therefore imposed upon women rather than created by them. Ericka, Rebecca and Jessica believe that the maternity services could be organised differently to facilitate continuing midwifery care within a hospital structure. This is afterall "what women want" (Ericka) and is suggested here by Jessica:

> ...a midwifery (team) scheme should be made available to any women who...is...a low risk type pregnancy...If a total midwifery care scheme was operating...(it) would change women's perceptions (of midwives)...they could see the alternative approaches working and learn to understand and accept what midwives are doing...A proposal for a team midwifery scheme was submitted to management. The idea was not viewed favourably.
> Jessica, Case Study 3, Int.1, refer page 192.

Two different proposals for a midwife team scheme were initiated between 1990 and 1991 by two different midwives in two different hospitals. Despite the overseas literature, (Flint, 1986; Kitzinger, 1988; Frolich & Edwards, 1989; & McIntosh, 1989) and the New Zealand studies (NZNA Consumer Survey, 1989; Smythe, 1989) which emphasise an empowering effect gained in the knowledge and experience which continuity of care offers women and midwives, both proposals were rejected without dialogue. This is an example of midwives renaming their world but prevented from recreating it through anti-dialogical relationships (refer **Chapter Three.**

When proposals are submitted and midwife managers uphold the status quo without dialogue and debate, their leadership is the result of superior power which is hegemonic. The only grounds on which reality is constructed lies solely on the manager's terms. If managers are to

move beyond the narrow functions of socialising midwives to conform with the status quo, they must cognitively appraise the socio-political context in which midwifery care is given. That is, midwife managers themselves are not separate from the dialogical process of creating the world of midwifery. They too, need to combine a critical reflective dimension with an executive dimension in decision-making. This may mean rejecting narrow technical-administrative interests, that rigidly follow the 'official' business line, in favour of professional interests of midwives.

SUMMARY

Historically, cultural activity in midwifery has been essentially a one-way process of domination in education, practice and management. This has resulted in cultural forms and knowledge which are represented as homogeneous but are a reflection of the dominant culture. By reducing midwives to homogeneous groups, whose only difference is whether they exercise or respond to power, there is a one-sided view of ideology. Dominant ideologies are transmitted formally through education and informally through practice settings. However, midwives in this study view dominant ideologies as contrary to their own interests and either resist them openly or conform to them under pressure from the hospital authorities. Past and present limitations on midwives' practice in this study include: past education programmes for obstetric nurses and midwives; symbolic representations of historical sexism, such as epaulettes and white uniforms; midwifery leadership; performance appraisals; budget constraints; staffing levels; care-delivery; and a lack of collegiality among midwives. These structural constraints reduced the midwives ability to exercise autonomy and therefore to be self-determining in practice and education. The hegemony here functions both by winning approval for the status quo and by the prevention of alternatives to the status quo. Thus hospitals are not simply static institutions that reproduce the dominant ideology, they are active agents in its construction as well.

The mismatch between midwives' experiences of structural constraints and the positions they occupy in professional practice, provide the conditions for reflexive thought which may give midwives human agency to change the circumstances that serve to perpetuate a separation of theory from practice.

In the next chapter, which concludes **Part Two** of the thesis, personal experience and contextual factors are acknowledged and integrated before some of the limitations and implications of this study are discussed. The chapter also suggests areas for future research.

CHAPTER EIGHT

DISCUSSION, RECOMMENDATIONS AND LIMITATIONS

This chapter is divided into three sections. In the first section personal experience and contextual factors of this study are integrated and discussed. In the second section the findings of the thesis are discussed in relation to midwifery education, practice and future research. The third section which concludes this chapter considers the limitations of social critical theory and this study.

SECTION ONE: CRITICAL REFLEXIVITY

Gossip

During the process of inquiry, I was involved in many informal discussions involving several midwives. Just as some women, who are admitted into hospital during their pregnancies, make sense of their new situations by talking with other women, midwives talk with other midwives to make sense of their own experiences. The following extract from my fieldnotes pertains to a conversation involving myself and several midwives who shared with me their perceptions of medical practice:

> A group of three midwives discussed their perception of doctors' preferences, their skills or the lack of them. One comment was about a doctor who panicked easily or readily. I thought this was like 'gossip'. When I mentioned this to Jessica she said: "It is like that. Discussing doctors' capabilities is all part of a midwife's work."
> Fieldnotes, July, 1991, Case Study Three.

Through gossip, midwives are primarily operating with their own and women's interests in mind. For example, it is in their vested interest to know doctors' capabilities. They are not therefore operating outside their value system but precisely within it. Chinn (1990:319) points out that "gossip was originally the noun for the woman who

attended the birth of a child with a midwife, and who gave support and comfort to the woman during labour. After the birth, this woman was sent out to broadcast what had happened." Similarly, in midwifery practice, gossip becomes the medium by which midwives broadcast to each other the images and interpretations that they accept and those they know to be missing in midwifery practice. Midwives make sense of experiences and personal relationships in an attempt to bring together values and actions within their group. Such dialogical relationships are essential for gaining new self-understandings which reshape our sense of the possibilities for what we do in the name of midwifery.

Common sense

While gossip reformulates values and actions within midwifery and is therefore a transformative art, the outcome of such dialogue may be referred to as 'common sense' or 'self-evident' reality. When reality is thought of as self-evident there is a certainty of opinion which is suggested in the following extract from my fieldnotes; a charge midwife has formulated an opinion of Rebecca's practice:

> Rebecca is a good midwife to follow as she has a lot of common sense.
> Charge Midwife, Fieldnotes, May, 1991.

It is assumed that midwives adopt subject positions or definitions of practice that are 'self evident' or 'generally accepted'. This demonstrates how the social order is often typified and unquestioned. While common sense ways of looking at the world permeate meanings, and therefore reflect the way midwives think and feel about their practice, these meanings simultaneously may be distorted to sustain their disempowerment. Thus "common sense knowledge structures group consciousness in ways which mask and mystify the existing power relations and social arrangements" (Codd, 1989:172). This casts some doubt over the supposition that common sense has universal application in midwifery. To avoid the imposition of a dominant discourse, midwives need to be skeptical of appearances and "common sense" to render the 'good sense' embedded in their practice into a coherent and systematic worldview, free from hegemonic ideological distortions.

Reflection-in-action

During fieldwork, I observed that each midwife had a coherent, systematic, conception of the world manifest in her own individual way of approaching practice, a theory-in-use. The notion that within practical activity "there is implicitly contained a conception of the world, a philosophy" derives from Gramsci (1971:344). Schon (1983) calls this "reflection-in-action" and sees it as an inseparable part of ongoing practice. Reflection-in-action is illustrated here by Rebecca in the context of childbirth:

> A lot of what you're doing is intuitive...(This means) the observations made in practice...and includes listening to the way women sound, watching the way women act, and maintaining therapeutic touch for the assessment and reassessment of change. This allows the midwife to think about what is going on at the time, and, apply this knowledge to what she can expect is happening physiologically in the process of labour, for example, cervical dilatation.
> Rebecca, Int. 3, Case Study 1, refer page 168.

Technical and practical reflection in ongoing practice is portrayed. Rebecca blends her theory-in-use to her knowledge of the physiological process of giving birth. Thus tacit (subjective) knowledge is interwoven with formal propositional (objective) knowledge both of which are mutually informing as an integral part of midwifery practice. That is, objectified theory is not translated or integrated and then applied to practice as an after thought, but rather, elements of theory and practice exist in the other. In addition to technical and practical reflection, it is argued that critical reflection is necessary to render tacit knowledge and extant theories conscious and explicit.

Critical Reflection

The dialogically reciprocal stance of this study provided the conditions for critical self-reflection. This is illustrated in the final interviews with all midwives after they had read the transcripts and reflected upon their experience of participating in the present study.

All participants said that by conceptualising and articulating what they did as midwives, they reformulated an awareness of the 'what' and 'why' of midwifery practice. Both Ericka (refer to page 210) and Sarah (refer to page 225) thought that it was a "positive" or a "valuable" experience to be on the "cutting edge" of midwifery research. Not only has it "disseminated interest in midwifery", but it gives midwifery theoretical power because it "shows this or that".

However, it was the 'why' of midwifery that enabled participants to uncover the extent of their own habitual practice. Ingrid and Rebecca, for example, said that it was being aware of the rationale for their own practice that threw into relief the differences between their practice and other people's. For Rebecca this was expressed in terms of different "attitudes and beliefs" (refer to page 168). For Ingrid it was "philosophical differences" (refer to page 182).

Ericka and Jessica thought that it was through having an avenue to conceptualise and articulate midwifery practice that they became more aware of the possibilities for change in their own practice. Jessica said that the study made her ask questions about practice which she thought was an "ongoing thing" (refer to page 197). While Sarah saw the study as an opportunity to reflect upon the conditions surrounding practice, Ingrid extended this beyond the artifical boundaries of this study by making the "time to get involved in discussions about social and political issues related to midwifery" (refer to page 182).

Thus, there is evidence that involvement in the research process reoriented, focused and energised participants toward knowing reality in order that they may transform it in an ongoing process.

Praxis

The extent to which midwives' self-understandings are translated into praxis (refer to **Chapter Three**) during the process of this study is addressed. Part of the midwives formal curriculum included a module on 'the midwife as a change agent'. This resulted in a perception of themselves as change agents within the hospital system where they

work. As Rebecca says:

> Midwifery is in a state of flux and a midwife at this point in time needs to see herself as a change agent for change within midwifery...
> Rebecca, Case Study 1, Int.5, refer page 168-169.

However, according to Weedon, (1987:25) midwives **are** agents of change, rather than authors of change, who "serve either hegemonic interests or challenge existing power relations." In the following extract, Jessica appears to adopt the latter position without imposing her views onto midwives who have "entrenched attitudes" which perpetuate hegemonic interests:

> I think I'm bringing about change where I work by being an example to the midwives who have entrenched attitudes...Any change that is brought about must be done in such a way that people don't take it as a personal slight on their behaviour.
> Jessica, Case Study 3, Int.4, refer page 197.

In addition to being an example, which is thought to have a reality-altering impact, some midwives consciously channelled their self-understandings by openly exploring with others alternative ways of viewing reality. This is illustrated by Ingrid, when asked how she would change midwives who are aggressive toward other midwives:

> Through education and example and by questioning and bringing issues out into the open so that they can understand why they feel that way and then change their ways.
> Ingrid, Case Study 2, Int.2, refer page 182.

By challenging the social arrangements which are generally assumed to be 'natural', social knowledge may be produced which reveals possibilities for action. In the following extract, Ericka reflects on the structural constraints to organising continuity of care-delivery for women in the hospital setting:

> ...it's amazing that there have been so few initiatives to begin to even look at providing continuity of care in the system for women...That's the system...
> Ericka, Case Study 4, Int.1, refer page 209.

Ericka's amazement at the lack of initiatives to provide a midwifery

team scheme to give women continuity of care, demonstrates her ability to partially penetrate hegemonic structures. While elsewhere she identifies the root of her polemic to be "long-standing sexism", which she says "compounds the power structures against women", the hospital "system" appears to be a 'fait accompli' - a fate of human nature - rather than as a result of a socially constructed system that may be deconstructed. For Habermas, (1979:178) who writes that "legitimacy means there are good arguments for a political order's claim to be recognised as right and just...", one of the important consequences of legitimacy is stability. This consequence has been taken to mean preservation of the status quo but it is more correct to associate stability with adaptive capacity. However, by challenging the system, even in incomplete ways, midwives challenge the system's capacity to adapt and so "provide entry points for the process of ideology-critique" (Lather, 1986:268).

Despite the liberating potential of ideology-critique inherent in this study, some midwives obviously have ongoing difficulties practising within a hierarchically organised system. This is illustrated by Sarah:

> It's hard to be a change agent within the hierarchy...The bureaucracy is a way of keeping people in line...I don't see myself as an effective change agent as much as just coping with the system.
> Sarah, Case Study 5, Int.4, refer page 221.

By "just coping with the system" Sarah reveals a contradiction between beliefs and action since her awareness of forms of social domination is not translated into praxis. As explained in **Chapter Three**, praxis is a form of practice in which the enlightenment of the actor comes to bear directly in their transformed social action, the central aim of which is action at a socio-political level. Sarah's inability to challenge the bureaucratically and hierarchically organised system produces a separation of theory from practice.

Discourse

Midwifery practice, like any other work, cuts channels in discourse, creating certain clusters of meanings, concerns and definitions that sustain a linguistic pattern. Sometimes midwives, who believe midwifery to be predominantly "looking after healthy people", slip into a dominant medical language pattern when describing medical practice even with reference to a normal birth. As Jessica illustrates:

> I don't think they (doctors) want the midwife to get the limelight, so to speak. That sort of attitude can be reflected in the way they behave after their women have...delivered...
> Jessica, Case Study 3, Int.3, refer page 187.

Jessica's reference to "their women" denotes medical ownership of a 'patient'. To have a woman "delivered" connotes that the doctor is active and the women passive during childbirth. This is in direct contrast to the language Jessica uses when describing midwifery practice:

> Midwives...want women to birth the way she wants to...
> Jessica, Case Study 3, Int.2, refer page 184

References to "give birth" or "to birth" are semantically equivalent to "she gave birth to her child" which is a women-centred view of childbirth. Such a position may be contrasted to a medical view of childbirth denoted in the use of the phrase "the doctor delivered her child". The verb "deliver" is an active transitive verb which, when used in the sentence "she was delivered of her child", might have been uttered several hundred years ago; but the sentence "he delivered her child" is an invention of late nineteenth century obstetrics (Treichler, 1990:129). Whereas the medical language pattern makes clear that the doctor is the one who has delivered the child, the midwifery language pattern leaves ambiguous the presence of birth attendants.

As with the above example, discourses about childbirth are constructed not only in multiple ways but sometimes in contradictory ways. This is

further illustrated by Rebecca when she refers to midwifery practice in a way that seems to contradict her belief about midwifery practice elsewhere:

> When those charge midwives are not practising everyday on the floor they may let their techniques get out of date. Rebecca, Int.4, Case Study 1, refer page 161.

Personal "techniques" is semantically equivalent to "a set of skills" which encompass ritualistic or behavioural approaches to childbirth. Such a routinised task oriented approach to women is contradictory to Rebecca's belief that midwives "are there to assist and help the woman deal with her own experience."

These examples illustrate that discourses in midwifery practice are situated within dominant social relationships which serve to define midwives in terms of them. In Habermasian terms, a discourse is synonymous with a 'speech act'. For Habermas (1979) statements made by those in power are a type of speech act. As such, these statements contain implicit claims to being valid by subscribing to conventional linguistic rules, and most importantly, to being correct in relation to social 'norms'. By subscribing to conventional medical linguistic patterns, midwives adapt to the 'correct' pattern in relation to social norms. In the words of Kirkham, (1986:45) "midwives, as much as patients, (sic) lack an appropriate language and in adopting the language of obstetrics they adopt too its values and its limitations." Thus, there are competing subject positions offered to women in childbirth, the social meanings of which are dependent upon a 'discursive field'. What childbirth means at any particular moment depends upon the "discursive relations within which it is located" (Weedon, 1987:25) and which cannot be viewed in isolation from this context.

SECTION TWO: IMPLICATIONS OF THIS STUDY

Implications For Midwifery Practice

This study is grounded in the ability of each individual midwife to engage in a process of becoming increasingly conscious of their own

actions and situations in the everyday practice world of midwifery. The study therefore has implications for an ongoing critique of midwifery practice. It has opened institutional processes to scrutiny and thereby provides critical moments which identify practices and constraints inherently supportive of the politics of the status quo, a status quo which upholds the tenets and ideals of a system which constrains midwifery practice and 'women-centred care'.

The participatory nature of the research process reaffirms values which are empowering for participants by resulting in a deeper understanding of their own particular situations. Thus the research process has implications for those midwives who may wish to adopt a transformative agenda. It may exemplify possibilities for enlightenment and action within midwifery which will increase intersubjective understandings and allow preconceptions of midwives current situations to be reshaped and reformulated. This is particularly pertinent at a time of rapid restructuring within the health care system.

The participants believed that the health services could be reorganised to include a midwifery option within hospital settings so that women may be offered continuity of midwifery care. Some participants regarded a team scheme as vital to autonomy in midwifery if midwives are to fully utilise their knowledge and skills and if women are to have alternatives within the hospital system.

This study also points to the need for midwives to value community and cooperation among practising midwives irrespective of where they practice. By promoting collegiality, the collective interests and common goals between midwives may be realised so that midwives can work toward the benefit of mothers, babies, families and the communities they serve. It is argued that collective interests in midwifery may be masked by dominant power relations and ideologies that perpetuate divisiveness among practising midwives. By becoming socially critical, midwives may be enabled to transform their practice world through collective political action. As shown in this study, the first step toward building supportive relations and institutional

structures in midwifery is a critique of ideologies that mask common interests among midwives. To begin this task midwives must start with self-critique before engaging one another in dialogue to identify common interests and seek out the hidden limits to autonomy and rationality that constrain and shape everyday practice and understanding.

Ideology-critique by midwives in this study revealed that some of the participants were constrained by oppressive leadership. Middle managers, for example, were supportive of the tenets and needs of the bureaucratic organisation rather than the professional needs and interests of practising midwives. To provide intellectual and moral leadership (as opposed to merely reproducing the cultural values of the status quo) midwife managers must also start with self-reflection in order to critically examine their own currently held assumptions. These assumptions may restrict the development of autonomy and self-determination of practising midwives. Thus dialogical relationships must include a collaborative search by all midwives in order for collective political action to be effective.

This study demonstrates that established institutional power structures deny midwives the opportunity of self-determination in practice. Performance appraisals, for example, serve to reinforce compliant behaviour in those appraised. The appraisals may merely fulfil the expectations of quality assurance administrators while simultaneously exposing more of midwives' personal life to public scrutiny. While ostensibly assuring competency and professional development through peer review, quality assurance and quality of service programmes may become a means of control. By stipulating what is relevant and requiring midwives to use particular jargon in specific ways, midwives are constrained to fit in with those in authoritative positions above them. The use of technical-administrative knowledge in the process of evaluation sustains the dominant ideology and the distribution of skills needed to reproduce the social division of labour. This in turn reinforces a dominant form of knowledge. The hegemony of evaluation procedures lie in their presumed neutrality.

The midwives drew parallels between the ascendency of a rational viewpoint and stereotyped sex roles established historically through an oppressive regime. Here the notion of 'hegemonic masculinity' relates the oppression of practising midwives as women to the ascendency of the medical profession as men. To expose the interests of practitioners and move beyond it, ideology-critique must also extend to the discourse that accompanys midwifery practice. Tacit knowing is embodied in language as much as it is embodied in practical activity. By exposing the interests and values of discursive practice, midwives provide themselves with both critique and alternative possibilities for action and thus set limits on their own practice rather than collude in a new orthodoxy.

In addition to all of the above, the midwives identified budget constraints as exacerbating their work. Heavy workloads, limited resources and staffing shortages added stressors which prevented them from performing with a maximum level of skill and commitment. This in turn diminished the quality of care which they could provide and the level of satisfaction they derived from their work. Work satisfaction was also said to be reduced, and, in turn, the level of stress leading to burnout increased, particularly in the postnatal area when not staffed entirely by midwives. It was suggested that where postnatal wards are staffed by people who are not midwives, this may compound the health problems of women, children and midwives, and, in particular, problems associated with postnatal depression.

Implications For Midwifery Education

Past education programmes for midwives have used a numbers curriculum which has constrained midwives to conform to the requirements of the education system. In addition to a formal component of the curriculum, midwives were inducted by the informal curriculum. This hidden curriculum socialised them to conform to the expectations of those in authority to perpetuate the dominant culture. However, the new midwifery course, which the midwives in this study experienced, fostered self-reflection and an awareness of the socio-political context in which midwifery care is given. This gave these midwives the

ability to perceive how existing organisational arrangements in a hospital setting could be reorganised differently to better suit the needs of the women they serve. It thus laid the foundation for a counter-hegemony.

In order to avoid attachments to technical forms of knowledge and to explore alternatives, it is argued here that an 'ideal speech situation' is necessary in educational and practice settings. This requires communication which is undistorted by ideological or value positions so that a democratic flow of ideas and arguments is maintained between midwives, between midwives and other professionals and between midwives and women. This also means that there needs to be a continuing dialogue between midwives and the different professional and interest groups such as the Women's Health Council; the Maternity Services Consumer Council; the Direct Entry Midwifery Taskforce; The Home Birth Association; The New Zealand College of Midwives; The New Zealand College of General Practitioners; and the Obstetricians and Gynaecological Society, to name a few.

This study demonstrates that a democratic flow of ideas and arguments need to occur between midwives already working in hospital settings, neophyte midwives, and student midwives. Rather than dismissing their ideas out of hand, their initiatives and innovations are worth listening to, as the midwives of this study demonstrate. Learning environments therefore need to be created which promote the exchange of student ideas and initiatives which question and challenge existing power structures and social relationships. In this way educational institutions may create a liberating learning environment which promote a democratic flow of ideas between the educational and practice institutions. Thus midwives in any setting will have the opportunity to enter into discourse as full and equal partners.

Such educational practices also have relevance for prenatal education within the health care system. A liberatory approach would foster awareness, influence attitudes and help women identify alternatives in an attempt to share the responsibilities of creating new possibilities together - midwives and women.

Implications for Research

This study has demonstrated that theory in midwifery is not translated or integrated and then applied to practice as an after thought, but rather, elements of theory and practice exist in each other. This is the dialectic - the interpenetration of theory and practice. It is argued that critical reflection is necessary to render the essence of this dialectic conscious and explicit. There is therefore a need for similar studies in a variety of settings.

The midwives in this study exposed two contrasting epistemic communities which have relevance for research in midwifery. The first views knowledge as neutral, objective, value-free, or 'separate'; a view which typically constitutes a medical epistemology. The second views knowledge as non-neutral, subjective, complementary, or 'connected' and typically constitutes a midwifery epistemology. As already noted in **Chapter Six**, while midwives may view medical knowledge as complementary to their own way of knowing in midwifery, the medical profession generally does not view midwives' beliefs about what constitutes knowledge as legitimate. It is argued that knowledge which is viewed as neutral and value-free, is self-deceptive since interest-free knowledge is logically impossible. In this way, medical science adopts an ideological position which promotes a dominant rational form of knowledge while at the same time undervaluing the nonrational, personal or experiential knowledge of midwives. By way of contrast, this study is exemplary of an interpretive approach to research in midwifery. It shares the postulate that practical understanding in context cannot be reduced to a system of categories defined only in terms of their relations to each other. The study therefore reinstates the value of a 'connected' epistemology for further research in midwifery. Research is then firmly situated within a historical context.

The study has highlighted the importance of language as a constitutive process in midwifery practice, a process that remains largely unrecognised. There is therefore a need for research in midwifery which illuminate how linguistic processes intersect with social

structures and professional authority to produce particular representations of childbirth. Resting on the assumption that the ways in which experiences are understood and expressed is never independent of language, (Weedon, 1987) it is proposed that a poststructuralist approach to research would unpackage the linguistic patterns which surround childbirth. From such a perspective the linguistic patterns which surround the issue of 'safety' in childbirth, for example, may be rendered explicit. Such a study may be an important phase in the reversal of hierarchical relationships between doctors and midwives by disrupting and displacing dominant (oppressive) knowledges.

SECTION THREE: LIMITATIONS

Limits To Critical Social Theory

Critical social theory is wedded to the concept of 'human agency' which gives an activist conception of human beings as shapers of their world. However, this position, according to Fay, (1987:166) "overstates the power of reason" and warns of the limits of clarity and autonomy that have to be continually challenged and worked against. For Fay, "no narrative of actual human lives can ever be characterised as **the** genuine one." In the following extract, Ingrid suggests that there is a genuine narrative when she teaches house surgeons to "take on board...alternative methods" rather than medical intervention:

> Some house surgeons...will really take on board what you teach them...(which is) alternative methods of pain management, such as massage, rather than using epidurals and other interventions, and to be comfortable with using a hands on approach with good communication skills...If I get a chance I usually ask them what they've done before. It's a good to...know where they're coming from...
> Ingrid, Case Study 2, Int.1, refer page 178.

Ingrid conveys a belief in the 'rightness' of new knowledge over other kinds of knowledge. It is as if she assumes that her knowledge expresses a reality of experience that labels a 'real' world to which she is the author. That is, she speaks as if language is transparent, as if she is in control of meaning, or that meaning is rational,

unified, the source rather than the effect of language. But meanings are always socially and historically located in discourses that are continually being constructed and reconstructed rather than having fixed universal meanings which enable us to understand the 'truth'. Taking into account that history is open-ended because its direction is a function of the choices of those who make it, one can only speak of "anticipatory narratives" (Fay, 1987:168). Thus, narratives are inherently fragmentary and tentative. Childbirth is the subject of competing discourses which give meaning to it in ways which serve particular values and interests rather than speak the genuine 'truth'. The meaning that these "anticipatory narratives" have will vary according to the discursive position from which narratives are interpreted and can constrain or facilitate movement toward autonomy and responsibility in midwifery.

Limitations Of This Study

Although this study has identified some of the ways in which institutional practices and dominant ideologies constrain personal and professional action in midwifery, it nevertheless does have some limitations.

The study is limited by the artificial end point which is imposed by the time constraints of a project of this nature. It is anticipated that the reflexive process, which commenced with the case studies, will be continued beyond the boundaries of this study. Thus what is captured here is a snap shot of a much more dynamic ongoing historical process than can ever be imposed by any reflexive critique.

The time constraints of the study posed particular frustrations for the researcher. In particular, it was felt that the historical sources used, although fulfilling the basic requirements of the thesis, nevertheless could be explored more fully. Hansard, as one historical text, for example, was not consulted in the review of historical source material.

A further frustration imposed by a combination of time constraints and the methodology used was in the researcher's inability to dwell on what the midwives in this study were doing well. Thus studies which explore more fully this aspect of midwifery practice would complement studies committed to "research as praxis" (Lather, 1986) and thus provide a necessary balance.

Although social critical theory is closely aligned with feminist theory, its potential value for theorising gender is limited. In particular, the way midwives, as women, experience oppression by, and resistance to, patriarchal prescriptions could be explored more extensively from a different theoretical perspective to illuminate the genesis of institutional power relationships.

Finally, it is not proposed that the findings of this study may be generalised to a larger population or other situations. Instead, it is proposed that readers will recognise aspects of descriptive accounts, interpretation of the experiences, and the critical reflection of these five midwives. This may illuminate aspects of their own experiences.

CONCLUDING STATEMENT

This study has demonstrated some of the ways in which socio-political forces constrain and shape personal and professional choices for action in the context of midwifery practice and education. If midwives are to give the quality of care to women and babies in ways that reflect the professional ideals of autonomy and accountability, they must encorporate a "philosophy in action" which is committed to critical reflection and ongoing dialogue. It is imperative that midwives individually and collectively think beyond the technicalities of their own practice to be able to expose and change the socio-political conditions which prevent them from being autonomous practitioners.

Part Three concludes the thesis by presenting the five case studies. As explained in **Chapter Four**, midwives' protocols are labelled with a pseudonym and the interview number. The interviewer's comments are typed in bold.

PART THREE

THE CASE STUDIES

ONE: REBECCA, TWO: INGRID, THREE: JESSICA, FOUR: ERICKA, AND FIVE: SARAH

CASE STUDY ONE: REBECCA

General Introduction

Rebecca had practiced as a midwife for a period of eighteen months before participating in this study. Prior to graduating as a midwife, she had studied history at university and had experience in nursing practice. At the time of the first interview Rebecca had worked in the labour and birthing area for ten months. As explained in **Chapter Four**, all midwives were pakeha (white).

This study demonstrates Rebecca's understanding, experience and knowledge of midwifery practice. The themes that appear in **Part Two** of this case study are therefore grounded in Rebecca's personal and professional knowledge as she engaged in reflexive dialogue with the researcher.

Contextual Knowledge

Technical rationality (see **Chapter Three**) is an essential part of Rebecca's practice to insure safety throughout labour and birth. This is illustrated in the following extract as Rebecca explains:

> Midwives are responsive to the situation so they know when the need for intervention is there...(for example) when to give an episiotomy or not...Midwives need the knowledge and skills for safe practice. That's all part of constantly assessing and reassessing women in labour and knowing when to intervene...you have to look at things in order of priority and intervene with discretion.
> Rebecca, Int. 2

Rebecca demonstrates that she is "responsive to the situation" and to women so that she "knows when the need for intervention" arises. For Rebecca timely intervention is part of competent practice. Here the technocratic legitimation of knowledge is apparent and justifies decisions made in the name of 'safety', a rationale which is as important for midwives as it is for women in the midwife's care. As Rebecca explains:

> There has to be a time when your midwifery knowledge and skills take over. You have to know and foresee a situation where you think you'll have to do an episiotomy here or...give an ecbolic right now. In both these situations you haven't got the time at that particular moment to discuss the merits of a particular intervention...You need to use midwifery knowledge to intervene when necessary, when non-intervention would be negligent practice given your knowledge and skills.
> Rebecca, Int. 3

By being responsive to the situation Rebecca demonstrates that she is able to fulfil the mandate society bestows upon her to be responsible and accountable in practice. From time to time and for specific reasons, Rebecca consults with the medical profession which sometimes leads to an interventionist approach in childbirth:

> ...at times we recognise that this is not going right and that we need medical intervention. It is a team approach and part of that team is the medical model when it is indicated. The thing to keep in mind is <u>when it is indicated</u>, so that we don't leap the boundaries.
> Rebecca, Int.2

Although Rebecca acknowledges that technical rationality is essential for safe midwifery practice, she sees that there are times when the issue of 'safety' provokes paternalistic attitudes which supercede ethical concerns for a woman's autonomy. Autonomy in this sense involves a respect for the individuality of women and a recognition that they are defined by their own values and desires rather than by somebody elses. As Rebecca explains:

> This woman came in and wanted a natural third stage. The consultant said to the midwife that she could have fifteen minutes for the placenta to separate and to give the ecbolic if the placenta was not out in this time...That was his idea of a natural or physiological third stage, that is, fifteen minutes. I mean it can take up to half an hour at least, some-times longer, before the placenta separates which is within the realms of normal, depending on blood loss and whether the baby is fixed to the breast and feeding or not. I mean, what's his knowledge of a natural third stage and why is he so scared of it? Women have natural third stage constantly at home without haemorrhaging.
> Rebecca, Int. 2

By way of comparison, Rebecca's approach to a woman wanting a natural third stage of labour depicts a more flexible approach:

> In the situation where a woman wanted to have a natural third stage I would first of all ask her what she knew about this. I would find out her knowledge and then fill in the gaps so that decisions made are based on informed consent. I would also point out that there was possibly a time after the birth that she may need to have an ecbolic...like if she was haemorrhaging.
> Rebecca, Int. 3

Rebecca elucidates two different approaches to women who request a natural third stage of labour. While she takes a judicious approach to intervention, making sure a woman understands the process involved in a natural third stage as well as the rationale behind it, the doctor denies a woman's active participation. Rebecca suggests that the doctor's decision may be based on the assumption that a natural third stage is unsafe, an assumption which is contrary to her beliefs derived from empirical observations. Here Rebecca demonstrates that she is able to go some way toward transcending the technicalities of medical practice. If a women requests, but is denied a natural third stage of labour, she will question the rationale for this decision. It is by questioning or rendering practice problematic that Rebecca is able to critically reflect upon it. Rebecca demonstrates this:

> Personally speaking I have a problem with the word 'professional' because it tends to restrict practice to certain bounds. I'm not saying that midwives can do everything, we need to work collaboratively with other health professionals, but the concept 'professional' is elitist because it lends itself to the idea that the professional knows best! This in turn puts the professional above the person she is attending which is hierarchical and goes against the grain of midwifery 'being with' women. The rules and regulations of a professional body encourage uniformity rather than diversity. Therefore there is a tendency towards conformity and to be less responsive to the situation for change.
> Rebecca, Int. 5

Rebecca perceives the social order to be arbitrary or, as only one possible order among others. By questioning the legitimacy of 'self-

evident' reality, Rebecca exposes the socially 'given' patterns of understanding (ideology).

Going Against the Grain - A Conflict of Ideologies

From Rebecca's perspective, she has observed caregivers who do not share knowledge with pregnant or labouring women. This is contrary to her personal and professional beliefs about what is an acceptable approach to women in her care. Rebecca questions the quality of antenatal obstetric care during field observations of her practice. This is recorded in my fieldnotes:

> A very apprehensive woman was admitted in prelabour. Rebecca said "I wonder if this woman had (antenatal) midwifery care whether she would be in such a state."
> Rebecca, Fieldnotes, May, 1991.

During the interviews Rebecca adds:

> You see women come in (they have generally gone to particular doctors) who really want an epidural before their labour is established. They are often nervous, to say the least. Often they have gone to antenatal classes. You expect them to be prepared in a sense but they are not. They are not at all prepared and the moment labour starts it is all over for them. You think to yourself that they are not able to deal with what is happening. It is like the strength of the experience overpowers them before they have really had a chance to come to grips with it. And you wonder why it is...I wonder how much antenatal information/education they get from their caregiver. They may be told that their blood pressure is fine, that their baby is moving well and growing well, but are they talked to through all their antenatal visits...about how they want to approach labour, what they expect from it, what they want to do, what they don't want to do...to keep the labour moving and increase their control over the situation?
>
> **What is the difference with a midwife?**
>
> The difference with a midwife is that...she is there to complement what is going on. She is there to help the woman deal with her own experience. It is her experience. Some times you wonder whether doctors and obstetricians have the same closeness in their dealings with women...Women relax a lot more with a midwife...the doctor is a professional, the midwife is a friend. Women don't think of the doctor as their friend. That is the difference I think.

Well, there seems to be a pattern that you have noticed with predominantly obstetrical care. The GP or obstetrician does not prepare the woman for the birth...

Yes, and they are not there helping the woman through it...I've seen husbands of wives who have had obstetric care get really up tight and scared stiff that they are going to deliver in the car or in the lounge because they don't know anything either...They've both worn themselves out pacing around the house all night with these initial contractions so that as the contractions get stronger and stronger, the couple get more and more tired. But they're actually only just in very early labour, like that woman who came in the other night.

Doesn't this happen with predominantly midwifery care as well?

No. I don't think so, not in my experience...Women relax a lot more with a midwife than with a doctor...They have more information to start with. They can contact the midwife by phone and discuss what's happening and what to do easily.

I noted the different body language of practitioners as they interacted with women...I don't know what I'm seeing here. I wonder whether it's got something to do with status or gender or some other factor.

I think that a lot of what it has to do with is the fact that you are a woman (the midwife) and are in a non-threatening position...(whereas) with some doctors there is that whole gender thing, or not so much even gender, its sort of the power role, you know, I'm the expert the person who knows what's going on and the woman is the person to whom it's happening. There's that sort of I'm up here and you're down there. There's a fair few obstetricians and GPs - there's not a lot of difference between them - who don't sit on the bed (to maintain face-to-face contact at eye level), who don't sit a woman up before they talk to them after they've examined her, who would leave them lying down if someone didn't sit them up...there's that whole sense of vulnerability.

Are you saying that they treat women in an objective manner rather than as a person who has concerns and issues relevant to them?

Yes. They deal to the process of what's going on and the person involved in that process is on the periphery.

Does the technology further impair this process?

Yes. Because they end up looking at the technology and not the person.
Rebecca, Int. 1

Rebecca has observed caregivers who she says adopt a hierarchical position which has traditionally exemplified a "professional" approach to pregnant and birthing women and which "goes against the grain of midwifery 'being with' women."

Meshing

In contrast to what Rebecca says is "hierarchical" or "elitist" she descibes midwifery practice as a working partnership in which midwife and women are empowered through mutuality. As Rebecca explains:

> Midwifery care is looking out for women and babies...you can't separate the two...so they have the best possible outcome.
>
> **What does 'looking out for them' mean to you?**
>
> It's giving women information (knowledge) and the ability and strength to make an informed choice so that there is an increased chance there will be an outcome she is happy with ...It's not making a decision for them, but about allowing them to make their own decisions that they feel is correct for them in the situation at the time...Mm...If a woman says to me "This is what I want" then first of all I would make sure that she knew just exactly what it was she wanted and then (if necessary) I would explain very carefully to the medical side of the team who were involved in her care what she wanted and I would do my best to support her in this.
> Rebecca, Int. 3

Rebecca describes an approach which empowers women to "make their own decisions that they feel is correct for them in the situation at the time". This is an approach which is encapsulated for Rebecca in the concept "meshing":

> Meshing is a sort of being on the same wave length as a woman, it's being with her and moving along with her from here once you have established rapport. It is a joining together for that brief intimate time to help women feel that birth is something they've done, not something that's done to them...You have to be able to empathise with how a particular woman is feeling and suss out what's right for her.
> Rebecca Int. 4

Rebecca's approach is characterised by reciprocity and rapport which is continued throughout the birthing process as she "meshes" with women in her care. Meshing means that she is "on the same wave length as the woman" as she strives toward developing a harmonious relationship.

Power and authority

Rebecca explains the way she sees power to work for women and midwives in clinical practice:

> If you're in a situation where you are dealing with a woman who is having her first birth and as such is unsure of the way it's going to go, she doesn't know what's going to happen or how she's going to deal with it, then, there's a lot of power there that can be given away to the person who's caring for her. It's up to you whether you choose to share power or to take that power and withhold it. I think that birth should be empowering for the woman and the family - the woman, the husband, and whoever else is involved in it - far more so than it should be for the midwife. The midwife shouldn't get power out of it. She may get pleasure or joy or whatever, but certainly not a feeling of dominance or control...It's not up to the midwife to orchestrate it. It's up to the midwife to go along with it and help it, but not be the one that determines what happens when.
> Rebecca, Int. 3

For Rebecca, the concept of 'power' is synonymous with the concept of 'knowledge'. To 'empower' those she is "working with", Rebecca shares knowledge with women and their significant others. To "take power and withhold it" signifies that the practitioner retains power or control of events by withholding knowledge. However, Rebecca is aware that the authority which underwrites practice may be associated with a restricted understanding on part of women in her care. She therefore consciously tries to counteract the feelings of powerlessness which her authority may engender. As Rebecca explains:

> Looking after someone denotes dependency on behalf of the woman...I try to 'work with' someone not 'look after' someone. I try to be involved in the situation to an extent that I don't detract from it and run the risk of our relationship developing into one of dependency. When I go into the room of the woman I say "I'm working with you today" not "I'm looking after you today."
> Rebecca, Int.4

The way human agency functions to maintain a position of advantage is stated by Rebecca:

> Maybe a lot of people slip into a power relation because it happens when people give them that power and if you are handed power on a plate you tend to take it.
> Rebecca, Int. 2

Legitimising Midwifery Knowledge

Rebecca takes an active part in teaching house surgeons midwifery practice. However, this sometimes gave rise to conflict between a different understanding of what is possible in a situation. As Rebecca explains:

> The midwives who are there all the time see changes and may say to the house surgeon "Look this is a big baby and this is a small woman and she's been labouring for sometime and what's the point of starting syntocinon to make this baby come down when this woman has been contracting for...ten hours with good contractions. All you're going to do is drive them both into distress" (mother and baby). Mm...And you see that happening over and over again...Someone who is not there all the time can miss the subtle changes, like the house surgeons.
> Rebecca, Int. 3

Rebecca demonstrates the importance of tacit understandings of the nuances in interpretation, a kind of communication that takes place amongst familiars. Thus, she sees the "subtle changes" which a practitioner "who is not there all the time can miss." This kind of knowledge is not possible when one lacks a background of familiarity. As Rebecca points out:

> That's why I don't think house surgeons are good at actually delivering babies...because they aren't there to see the woman work so they don't have the same meshing. It' harder for them to join in with the woman when she's actually working really hard. If they want to 'catch' babies they have to have some idea of how the woman is working, how she's coping with the situation. They're rushing off to someone else and then they're coming back...they can't be all things to all people. But they miss the subtle changes in people and they need to be aware of that...but they also need to take on board what they've been told by the midwife.
> Rebecca, Int. 4

Rebecca illustrates an ability to constructively criticise the practice of house surgeons and to take an active part in sharing her midwifery knowledge with them. She explains that house surgeons' practice is not facilitative of midwifery practice "because they aren't there to see the woman work so they don't have the same meshing." As Rebecca states, it is the 'being with' that constitutes the "meshing" as central to a women-centred approach in midwifery.

Midwives Who Oppress Midwives

While Rebecca believes midwifery to be based on a partnership model with women, these values and beliefs were not shared by some of the midwives working in the labouring and birthing area. She demonstrates this by discussing how authoritarian values have been internalised by midwives themselves:

> There are some midwives who do oppress students or new people to the hospital...It's students, new students in the area, and I suppose it's even people that they take a dislike to. When some people take a dislike to you then you are given the hardest workload, the fartherest away rooms. They can make life hell for you until you end up leaving.
>
> **You've said that some midwives who trained a long time ago are stuck in their ways and can't change?**
>
> If they trained that way many years ago and in a particularly hierarchical system...then they are still there. They still have that hierarchical autocratic sort of approach to everybody..Some are brillant...while others will just criticise your practice. There are some who do share their power with women and midwives. There are others who don't hand over power and who make women that come in without ringing up first feel like dirt.
>
> **So some midwives are oppressive to women?**
>
> Yes they can be...When those charge midwives are not practising everyday on the floor they may let their techniques get out of date. It depends on what effort they put into their midwifery practice. When they do not deal with women on a daily basis, or on a personal basis, they may let their interpersonal skills go by the wayside. This accounts for them being rude to labouring women that come in without telephoning first. They don't get involved with women in their practice.
>
> **What do the other midwives do that is different?**

They help.

Are you saying they establish a humanistic relationship with people?

Yes they do. The midwives that sometimes treat people like dirt are more likely to be overtly rude to women if they're brown and working class. If they're white and middle class they'll mutter under their breath, but the way they feel is less likely to be communicated face-to-face. Why do they do that? What's the point? What does it achieve? It embarrasses the people or the woman that are coming in and it embarrasses the midwives who are to care for the woman.

When this type of conflict occurs between you and those midwives, you have said that some midwives are known to give you a hug and tell you not to worry about it. Is this part of a humanistic approach?

Yes it's the same thing because the midwives who mistreat women tend to mistreat their workmates as well. They are not the sort of people you can trust to be your back-up.
Rebecca, Int. 3

Rebecca identifies two groups of midwives: those that "share their power with women and midwives" and those that "don't hand over power." The second group, who she says occupy charge midwife positions, are "stuck in their hierarchical ways" and have a "hierarchical autocratic sort of approach to everybody". Rebecca says that these midwives let "their interpersonal skills go by the wayside" which "accounts for them being rude to labouring women" and "their workmates" and which leads her to perceive them as "not the sort of people you can trust to be your back-up."

Reflection On The Past

Rebecca has revealed lateral violence in midwifery. By reflecting on past events she makes the connection between womens oppression and that of midwives:

The survival of the races always depended upon women because they're the gatherers of herbs. They were boiling them down to make tinctures and remedies for healing. They were more likely to be women who were involved in childbirth. Well, why did medical men get involved in it? I think it was around the time of the burning of the witches in the fourteenth century when women were accused of being witches probably. They lived on their own and managed extremely

> well. They were independent women who aroused the jealousies of the rest of the community, both men and women, but more likely men, who then whipped up the public fury at a particularly superstitious time anyway, a time when you had to blame things on faith, or spirits or magic, bad magic.
> Rebecca, Int. 3

Rebecca recalls that medicine (herbal) was part of midwifery's female heritage in autonomous health work before their suppression and subordination to the male medical profession in medieval Europe. Rebecca links the advance of modern institutionalised medicine with men's acquisition of power:

> I'm sure historically doctors got into midwifery once they discovered what a great deal of power they could have over people, over women in general. So they discovered how much money they could rake in at the same time and it was too good to resist.
> Rebecca, Int. 2

Midwifery Education

By reflecting upon her time as an obstetric nurse, Rebecca situates the source of her personal subordination in the educative deficiencies of a 'numbers curriculum'. This curriculum was used in past education programmes for midwives and obstetric nurses. Obstretric nursing was part of the former hospital-based system of education within a three year general nursing programme. As Rebecca explains:

> In the past (midwifery programmes) midwives had to have done so many specific techniques. This perpetuates the 'doing to' women. I don't want to have to do a set number of vaginal examinations or episiotomies or whatever. You can only get these skills through caring for someone throughout their labouring and birthing experience. It's not midwifery to check off so many techniques. If there is a certain number you have to get, then sooner or later you will do one (episiotomy for example) that's not necessary. That's inflicting a wound on to someone. Ticking off numbers from a list is not midwifery. You learn a whole lot more 'being with' someone. To catch the baby is not the way to learn midwifery. Knowing how to deliver helps but you need to learn that as part of the whole experience...
> Rebecca, Int. 4

Rebecca has highlighted a difference between the orientation of past educational programmes for nurses and midwives and those undertaken currently. She suggests that there are different theoretical approaches influencing learning and contemplative dimensions of midwifery practice within clinical agencies:

> In a hierarchical organisation, such as a hospital, some people will try and help by trying to give a person, whether they're a student or a new graduate in a learning situation, a positive experience, where they can learn in a non-threatening environment. That is, where learning can be extended rather than inhibited. There are others who are into that power situation and who won't make it easy for the learner, who makes them feel uneasy or uncomfortable from the start, who see the negative first rather than the positive, and don't look for ways to foster learning. It's almost as if they're obstructive to learning. They'll just stand at the end of the bed and criticise other people's practice.
> Rebecca, Int.5

Continuity of care versus Fragmented Care

In contrast to being dissatisfied with the impersonal nature of intermittent care-delivery in her time as an obstetric nurse, Rebecca found continuity of care to be "a very valuable experience" in her midwifery course. Rebecca reflects upon what was missing when she was an obstetric nurse:

> ...it was the personal touch, the rapport, or the way that you lost something with someone who you had a relationship with after eight hours, or the way the doctor would wander in and do the delivery and leave. As a midwifery student we wouldn't do that. We took a participatory role in the labour process...Continuity of care was a very valuable experience in my midwifery programme because you were with women ...antenatally...until they delivered...and after...Women empower midwives. Without women what are midwives?
> Rebecca, Int. 4

Rebecca states that "rapport" or the intimacy of the relationships are enhanced between women and midwives during continuity of midwifery care. This is in direct contrast to the intermittent nature of midwifery care within hospitals. As Rebecca explains:

> When women don't see the same person in clinic they feel like a lump of meat moving along a conveyor belt of antenatal care.
> Rebecca, Int. 2

Rebecca is aware that the unfamiliarity of the hospital situation makes it difficult for women to provide meaningful cues as to their real needs and wishes. In Bassett-Smith's (1988:49) study, she found that when pregnant women had knowledge of how the hospital system worked, they were accommodating to system inadequacies and even made excuses in advance for the care the midwife or doctor might fail to provide. Rebecca explains how the intermittent nature of care-delivery presents a particular difficulty in achieving mutually defined goals:

> The difficulty with fragmented care is that you have to raise issues whenever you meet them...rather than in a relationship that is built up between woman and midwife (antenatally)...You also can't raise issues in front of the woman, (concerning a conflict of interest) unless the person was being offensive or causing the woman undue pain.
> Rebecca, Int. 2

To overcome the externally imposed constraints on care-delivery in midwifery, Rebecca suggests how the maternity services could be organised differently:

> Team midwifery is a scheme that attempts to overcome the difficulty of organising continuity of midwifery care in a hospital setting. It is good in principle but difficult to organise as midwives themselves have their own lives to lead. To have continuity you really have to have a team midwifery scheme.
> Rebecca, Int. 1

Rebecca reveals the underlying bureaucratic structures and policies which prevent midwives organising a team scheme facilitative of continuity of care-delivery in midwifery:

> One of the student midwives...proposed a scheme for continuity of care and found that it was rejected out of hand by management. And in actual fact the midwife actually did do that without being paid...She was there as support...Midwives would be keen to be involved in

> continuity of care if they could do it without losing themselves in the process.
> Rebecca, Int. 2

The Future of Midwifery

Rebecca speculates on the future of midwifery practice:

> As the knowledge about what midwives can do and what their experience can involve is known, the more women will want to have midwifery care and will ask for them.
> Rebecca, Int. 1

Underlying Rebecca's statement is the assumption that midwives are active participants in their interpretation and creation of their practice world.

Vested Interests

Rebecca suggests that there are some with vested interests in maintaining the status quo:

> Doctors, that is general practitioners probably more than obstetricians, feel threatened by midwives (autonomy) because they threaten their livelihood as they can...take away that part of their income from normal deliveries...In many ways I think that general practitioners are worried about their loss of income...(and) their loss of power. Money in midwifery is a trap midwives need to be wary of too...
> (Rebecca, Int. 2

Performance Appraisals

Through critical dialogue, Rebecca reveals externally imposed structural constraints in the clinical area where she works:

> There's something I do not trust about Q.A. (quality assurance)...It is open to abuse in its present form...While the whole idea of Q.A. is to encourage excellence in practice it might be just another bureaucratic attempt to keep midwives in their place. If you happen to be in an area where you don't get on with the person who has authority over you, then you can be in deep trouble...I feel that the way people are assessed for their levels is still very dependent on who they work with. What I'm saying is, if there's a clash of temperament or work methods or...if there's a personality clash, and if that person you are having the difficulty with is superior to you then they can actually affect your record.

Rebecca, Int. 2

Rebecca uncovers the source of her suspicion by reflecting upon a past experience as a staff nurse in a general hospital. Rebecca's practice was appraised by a senior member of the staff:

> It (the appraisal) was written by the charge nurse. We were like chalk and cheese...she'd say things like "vivacious but boisterous" or "is familiar with patients and staff" or "treats the students as friends" or "treats the patients as friends"...She just didn't like me or my approach. She was old school or autocratic. The fact that I called the people by their christian names (when applicable) and they called me by mine...was unacceptable to her...She suggested I go and work in a psychiatric area where she thought would be more suitable to my approach...She assessed me without asking anyone elses opinion...I didn't see any bad qualities in what she'd said...but it was couched in such a negative fashion. I thought if it goes on my record and if somebody looks who doesn't know me and who hasn't a clue of what I'm like or what my work is like, they will wonder who this woman is and will try and beat me into shape.
> Rebecca, Int. 2

In the past Rebecca's practice has been circumscribed by a charge nurse who has delegated authority over her.

An Individualised Approach

In more recent practice as a midwife, Rebecca reports that she circumvents rule-governed behaviour:

> Every birth is going to be different so how can you apply rigid rules to every birth when a lot of women don't want to do things in a particular way or may have particular approachs that they want? I mean the whole thing about that is to be flexible about what you do...You don't say "Oh sorry there is a rule here". I mean we do, we say "Oh it is hospital policy to give an ecbolic" or "We'd like to give your baby some vitamin k"...but basically you do what they (women) want.
> Rebecca, Int. 2

Rebecca legitimately rejects hospital policies which may not be congruent with a woman's preference in relation to her care.

Reflection and Action

In the process of assessing women throughout labour and birth, Rebecca

demonstrates a reflexive approach to practice which incorporates technical, practical and critical knowledge (refer **Chapter Three**). Technical retrospective reflection on practice occurs in a deliberate and calculated way as it is concerned with problem solving. Rebecca gives an example of technical reflection:

> Sometimes in a tense situation, such as labour, you miss the subtle changes because you are too close to the woman. Therefore the midwife needs to leave the room to assess change in the woman's condition. This highlights the value of birth attendants because the woman needs someone constantly there for comfort. A midwife needs to withdraw at times to maintain an objective eye toward subtle changes in the woman's condition as well as staying in touch with their (the woman's) subjective experience.
> Rebecca, Int. 4

In the following excerpt, Rebecca exemplifies practical reflection, or a concern with moral rightness of actions in a given social context:

> A lot of what you're doing is intuitive...(This means) the observations made in practice...and includes listening to the way women sound, watching the way women act, and maintaining therapeutic touch for the assessment and reassessment of change. This allows the midwife to think about what is going on at the time and apply this knowledge to what she can expect is happening physiologically in the process of labour, for example, cervical dilatation.
> Rebecca, Int. 3

Rebecca's experience of participating in this study is revealed in the following extract:

> It's been a useful participation...It gave me a chance to reflect on things that I'm still...learning about. It's not just while I'm being interviewed but in the practical situation. That is, not just during the follow-through, which makes you think about your practice, but also afterwards...when the researcher is not with you...It's made me reflect on how other people affect my practice both negatively and positively. It's reinforced the value of some of the attitudes and beliefs I already had so that I'm able to progress on that line and to have the courage of those convictions so that I'm able to pass this knowledge on.
> Rebecca, Int. 5

Rebecca's ideology-critique enabled her to see the dialectic between cultural values on one hand and interests behind action on the other:

> Midwifery is in a state of flux and a midwife at this point in time needs to see herself as a change agent for change within midwifery, with students generally, with doctors and with women. For example, in medicine, through teaching house surgeons the basis of midwifery practice, with women, who need to know the different birthing options that they have and the skills midwifery can offer. There are also some midwives already in the system who need to be encouraged to act as independent practitioners, to regain the skills they've let go. Some of that is the confidence to be able to ask for a second opinion. Like if you're doing a palpation, or if you think the baby hasn't grown very much. Students generally need to be reminded of the normality and wellness of birth compared with the illness that is more apparent in general nursing and medicine.
> Rebecca, Int. 5

Interpretive Summary

Through critical self-reflection Rebecca gives anecdotal evidence of socially dominant relationships that are antithetical to her personal beliefs of 'good' midwifery practice. For Rebecca, midwifery is based upon a women-centred approach that entails 'being with' women "to help women feel that birth is something they've done, not something that's done to them." When midwifery is "elitist" and "hierarchical" it is "something that's done to" women which "goes against the grain of midwifery 'being with' women."

Rebecca illustrates how the issue of safety may be used to justify paternalistic attitudes and authoritarian relationships in midwifery. She describes how authoritarian values are internalised by midwives themselves as they "mistreat their workmates" and women. This in turn perpetuates the "doing to" women. Rebecca suggests that dominant technical-administrative forms of knowledge have been perpetuated in the hospital situation by their emphasis in past midwifery programmes and courses for obstetric nurses.

Although Rebecca works in a system which gives midwives the authority to act autonomously, she believes the intermittent nature of care-delivery impedes the full utilisation of her midwifery knowledge and skills. Structural constraints are also seen to be embedded in evaluation procedures used for assessment of midwifery practice. Those with vested interests may act against an autonomous midwifery practice

by working toward maintaining the status quo. By uncovering a critical notion of human agency in her analysis of 'power' Rebecca reasserts the informal educational value of midwifery leadership at the practical level, a leadership which acts with midwives and women to achieve goals that could not be achieved otherwise.

CASE STUDY TWO: INGRID

General Introduction

Ingrid had practiced as a midwife for a period of eighteen months before participating in this study. Prior to graduating as a midwife, Ingrid had studied education at university and had experience in nursing practice. At the time of the first interview Ingrid had worked in the labour and birthing area for eight months.

This study demonstrates Ingrid's understanding, experience and knowledge of midwifery practice as she engaged in reflexive dialogue with the researcher. The themes that appear in **Part Two** are therefore grounded in her personal and professional knowledge.

Empowerment versus Disempowerment

The concept of 'control' is central to the way Ingrid visualises and describes practice in midwifery. Where women are given the opportunity to participate in actions and decisions regarding their labouring and birthing experience, the women are able to have control. As Ingrid explains:

> the woman should have the control and if she doesn't want the control then that is okay too...I feel that they should be able to conduct it (the labour and birth) the way they want. So I generally give the woman the opportunity to make decisions concerning the birth and support her in this...This midwifery model is empowering for the woman. A midwife usually starts from the assumption that birth is a normal event but she is also alert for the abnormal that can occur. How you interact with women can be a means of control.
>
> **What do you mean by interacting with women can be a means of control?**
>
> Sometimes a midwife does need to take control of the situation and it's appropriate to be controlling in some situations. But basically a woman has control and the midwife is there to support her so that she is her own leader rather than being lead by somebody else. But there's a fine line between empowering her by giving her options so

> that she controls it (the labour and birth) and the other way.
>
> **What is the other way?**
>
> Well you don't see other midwives practice so much and some doctors are good midwives...so I'm not decrying them, but by knowing more things the practitioner automatically has more control (or power).
>
> **So doctors and midwives have expert knowledge that automatically puts them in a more powerful position than their clients?** Yes. **What is the other way then?**
>
> Well the other way is when the practitioner influences the course of labour according to their own beliefs rather than the woman's. That is a controlling thing rather than an empowering thing. But you influence the woman by what you offer while at the same time it's the way you use your influence that is different...There are situsations in midwifery that call for a more controlling approach...This is for reasons of safety and is part of individualised care, whereas with the other way, the medical model, control is routine...because birth is normal only retrospectively, or after the event, and the practitioner tells the woman what they should do. This is disempowering as the woman is not given the opportunity to make decisions that affect her.
> Ingrid, Int. 1

Inrid interprets 'taking control' as an ability to make decisions. When the woman has control (in the decision making process) and the midwife is there to support her in this process, a labouring or birthing woman is thought to be empowered. That is, Ingrid believes that she is a resource person wherein knowledge is shared with the aim of achieving mutually defined goals. In this way there is a sense of cooperation, between Ingrid as the midwife and a woman in her care, characterised by a reciprocal relationship which develops between them. On the other hand, where practitioners do not involve women in actions and decisions surrounding their labour and birth, they are said to be "controlling" of events and are depicted as agents of control. Thus, Ingrid has identified two approaches which are differentiated according to how the practitioner influences the decision making process throughout labour or giving birth. Having said this, Ingrid sees that there are times when the midwife needs to "take control" of the situation which is illustrative of authoritative action derived from midwifery knowledge.

Midwives Who Put-down Midwives

While Ingrid's approach to midwifery is woman-centred, there is anecdotal evidence that this approach is not shared by other midwives working with labouring and birthing women. As Ingrid explains:

> There are a lot of midwives who put-down their own group.
>
> **What do these midwives do?**
>
> They work against other midwives as colleagues by criticising them and by supporting 'unmidwifery' things.
>
> **What are the unmidwifery things that they support?**
>
> They support a medical model as opposed to a midwifery model, even when it is inappropriate...Where there are a lot of 'at risk' pregnancies, the midwife's role changes as it tends to get caught up with the medical model and technological intervention. The midwife can forget to give women choices where ever possible and forget who their colleagues are. And at the same time put-down other midwives...These midwives aren't interested in passing on their knowledge...
>
> **Do you mean passing on their knowledge to other practitioners or women?**
>
> Both.
> Ingrid, Int. 2

Ingrid says that there is a group of midwives who "support unmidwifery things" and suggests that there is lateral violence in midwifery. In the extract that follows, hospital midwives "turn against" independent midwives because their technical skills are unknown. What is brought into question are the standards of midwifery practice when clients are tranferred into hospital. As Ingrid explains:

> We don't want to divide midwives, we want to be able to offer a service but some midwives turn against other midwives' efforts. When women request epidurals and they are cared for by independent midwives, the way policy stands at the moment, the independent midwife doesn't have the right to do the epidural top-ups or care for women in this situation because they're not on the epidural register. And so the hospital midwife has to take over the care because the birth has become medicalised. We know how midwives practice if they work in the hospital, but we don't know how the independent midwife practices. This is where the safety aspect of practice can work against midwives because all independent midwives' practice will be suspect.

Ingrid, Int. 2

Reflection On Future Developments in Midwifery

Ingrid foresees potential conflict inhibitive of supportive or collegial relationships among midwives in practice:

> If you are a midwife in private practice and you had a contract with the hospital to have so many midwifery beds, and you had so many women to look after in a month, it would be impossible to be there all the time and run a practice at the same time. The hospital midwife could get very narked about it if the midwife practised like the GPs as they are not able to be there all the time either...Midwives in private practice will be constrained by how much time they can put into it...so obviously once women are in hospital they are going to be looked after by the hospital midwives and that is where a breakdown in relations between midwives can happen. It's a 'them' and 'us' sort of situation and it shouldn't be so.
> Ingrid. Int. 1

A "breakdown in relations between midwives" may be reflected in the following extract as Ingrid explains:

> They (some midwives) are not teaching others including women themselves. For some midwives it is just a job. They think routinely and don't think about what it is they're doing or how the situation could be changed for the better. They are just not interested. I've seen a lot of midwives who have had babies themselves recently and who have worked in the delivery unit over the last year. All except one have chosen a GP or an obstetrician. So I wonder how much midwives believe in the predominantly midwifery care model themselves. There are a lot of midwives who think that medical knowledge is superior to theirs. Whereas the knowledge in each field is different and complementary.
> Ingrid, Int. 2

Whereas some midwives "think that medical knowledge is superior to theirs", Ingrid believes that "the knowledge in each field is different and complementary." Thus there are two epistemic communities in midwifery. The first believes in the legitimacy of midwifery knowledge. The second subscribes to the dominant culture by treating midwifery as "just a job" or thinking "routinely" and thereby lack "interest" in their thinking about "what it is they're doing or how the situation could be changed for the better" for future developments in midwifery.

Women and Oppression

According to Ingrid the circumstances that maintain and reproduce domination in midwifery are connected to the oppression of women generally:

> ...any woman in a medical profession will run up against opposition from men. Well, any woman in any job, whether it's business or whatever, runs into sexist attitudes. They are not going to go away in a hurry. They've been bred into a paternalistic society...Marriage vows stated that women had to obey their husbands...Women were controlled by men. A lot of paternalistic ideas are culturally ingrained and these may be imposed on to people for 'their own good'...Women in a medical profession...or in midwifery...will always run up against opposition from men...There will always be medical personnel who don't wish midwives to be autonomous.
> Ingrid, Int. 1

Ingrid uncovers the notion of 'hegemonic masculinity' in midwifery. (The concept of hegemony is explained in **Chapter Three**). This notion is related to the rise of the medical profession in New Zealand before the turn of the century. As Ingrid explains:

> I think that certain doctors saw there was money to be made out of obstetrics and as the population of doctors was growing there was limited avenues where they could specialise and so they turned to obstetrics. Normal births became the bread and butter for doctors. This still holds true today. They don't have to do much really, for a women who is having a normal birth, and they get paid an extra fee by the government to do it.
> Ingrid, Int. 1

Ingrid links the medicalisation of the maternity services to the notion of competition and self-interest in society:

> Society generally has the attitude that we are in for number one. The more money you can make the better off you're going to be sort of thing.
> Ingrid, Int. 1

Power Through Technology

According to Ingrid the medicalisation of the maternity services was facilitated through the use of medical technology:

> The medicalisation of childbirth has meant that there is a greater reliance on technology. Clinical skills, such as palpation may be lost through an increase in the reliance on

> scanning technology to give one example. Whereas with a more hands on approach, importance is placed on making observations of the whole person while doing a palpation. It is not just estimating the foetal size, the presenting part, the fundal height, or liquor volume, but a heap of associated observations about the woman which you make at the same time.
>
> **So technology has played a part in circumscribing midwifery practice?**
>
> Yes and it has affected the public's expectation of childbirth. As people's expectations have increased, with the use of technology, expectations have also changed. In days gone by women wanted a live baby and a good outcome. Today the expectation is not only that the baby will be alive but that it will be normal. In the past, people didn't have much choice about the matter. So through the use of technology the medical profession got a great deal of power. They could say that with this technology, take amniocentesis for instance, there was a far greater chance of ensuring that the baby was going to be fine.
> Ingrid, Int. 1

With the introduction of modern technology into obstetrics, public expectations have changed. In the United States of America, technological intervention in childbirth has led to an increase in intervention by practitioners to avoid litigation. As Ingrid notes:

> In the United States, to avoid litigation, practitioners readily use technology to account for safety of practice.
> Ingrid, Int. 4

Doctor as a Status symbol

While medical technology has permeated the maternity services to increase doctors' control over women in pregnancy and childbirth, their ascendency is reinforced by women's beliefs regarding the best maternity care. As Ingrid explains:

> When women are able to have their own doctor or obstetrician, that is seen as a status symbol...It seems to be based on a premise that the best care they are going to get is private medical but this is not necessarily so...it's only perceived to be so...
> Ingrid, Int. 1

Midwifery may not be an option because it is not a known choice. As Ingrid notes:

> Midwifery is not a known choice...And therefore not an acceptable choice. I think that has got a lot to do with the public's attitudes than anything else.
> Ingrid, Int. 2

Continuity of care

Ingrid thinks that midwives will be constrained by continuity of care:

> Midwives will have home and family and their own life to live and I'm sure that continuity of care does not mean being with women the whole time. So midwives will be constrained by how much time they can put into it (continuity of care).
> Ingrid, Int. 1

Continuity of midwifery care may be difficult to organise in relation to a midwife's personal life, but Ingrid explains how the intermittent nature of care-delivery presents a particular difficulty with conflicting advice postnatally:

> Women say that they come out of hospital not knowing what to do because every midwife they come across had a different idea on how they should breast feed and I think that that can be a problem.
> Ingrid, Int. 3

Prenatal Education

(Please note that in this thesis the terms 'prenatal' and 'antenatal' are used synonymously). While the intermittent nature of care-delivery in hospitals may not be an efficient use of a midwife's knowledge and skills, the public's lack of knowledge regarding midwifery practice may be perpetuated through prenatal education. As Ingrid explains:

> There are certain doctors who you know will intervene routinely. **Is this regardless of what a woman wants?** Yes but it goes back to pregnancy. I think that when they've looked after them antenatally they've never actually discussed what the woman wants in labour...it's never really been talked about. This is an important point and is one that I bring up in antenatal classes. I go over how important it is for women to discuss their expectations and things that they would like to know from their doctor prior to going into labour so they can assess if the doctor is able to help them or not, and if not, they may need to consider going to someone else.
> Ingrid, Int. 3

Ingrid actively educates women about midwifery practice:

> I don't think that people are always aware of what midwives do. One of the first questions I ask in the antenatal classes is whether people know what a midwife is and what a midwife does. So many of them have no idea. They know midwives are there to attend births, but they don't know what they are qualified to do...so I inform them of that...I carry a big envelope full of literature for them.
>
> **What is the literature you carry?**
>
> I have an article that is taken out of a midwife text that quotes certain things relating to normalisation...and the reasons why intervention is not always preferable because it often leads to more intervention in childbirth. I think that women want to be in hospital under a doctor because they feel safer...But that fear is misplaced.
> Ingrid, Int. 2

Ingrid's consciousness of the way a hidden agenda has socialised women into depending upon doctors in pregnancy and childbirth has resulted in a flexible approach to antenatal classes which fosters the development of women's initiatives. As Ingrid explains:

> The outcome of antenatal education depends upon the educator's approach. If you present the class with an approach that gives them no clear alternatives, like "This is the way its done here", then the class itself can become a means of control. If you talk about what is hospital policy, as far as procedures go, then this is a means of control because it's not offering them any alternatives. I do say "At this hospital we tend to do such and such." But I don't think that it's done to control because I inform them that there are alternatives.
> Ingrid, Int. 3

A standardised view of prenatal education "becomes a means of control" because it does not offer women choices about how they may want to prepare for the present birth. This view reinforces women's dependence upon a medicalised system. A renaissance view held by Ingrid, is more democratic as it liberates women from structural constraints by fostering awareness, influencing attitudes and identifying alternatives in an attempt to share the responsibilities of creating new possibilities.

Legitimising Midwifery Knowledge

Ingrid's approach to prenatal education was translated into the clinical setting as her practice rested on a belief in the legitimacy of midwifery knowledge:

> Some house surgeons...think that their medical knowledge is superior to the midwife's knowledge but I...don't accept that. As far as I'm concerned, whether they are a consultant or house surgeons, we collaborate because our knowledge is complementary. And so my knowledge is just as valid as their knowledge...But other house surgeons will really take on board what you teach them.
>
> **What do you teach them?**
>
> Alternative methods of pain management, such as massage rather than using epidurals and other interventions and to be comfortable with using a hands on approach with good communications skills...If I get a chance I usually ask them (house surgeons) what they've done before. It's good to know where they're coming from, how they feel...there are some who are very good midwives...
>
> **What makes the difference?**
>
> The difference is that the care is more cohesive for the woman. It's not sort of this bit or that bit, you know fragmented, it's flowing.
> Ingrid, Int. 1

Ingrid legitimises midwifery knowledge. There is a danger that the 'rightness' of new knowledge may be imposed over other kinds of knowledge.

Midwifery Education

Ingrid's midwifery course fostered personal and professional interests in education and practice. This is in direct contrast to past education programmes for midwives and nurses which is reflected in the following extract as Ingrid recalls her experience as an obstetric nurse:

> When I did my obstetrics...I found that the midwives were extremely bossy in the way they interacted with other midwives and also with women. And the place was so regimented. We all had to do strict procedures, such as four-hourly feeding (of the babies) and these were timed strictly. We had to do four-hourly perineal toilets and so many rectal examinations. The knowledge seemed to be one-sided as it was based on procedures which were done in a

> step-by-step or task orientated manner. And the knowledge was not related to the whole picture. In midwifery we were taught the whole picture, not just the procedure. For example, a vaginal examination gives valuable information of a woman's progress in labour but it stretches up the cervix to release prostaglandins. There is a hormonal link to various body mechanisms which are connected to a psycho-sexual-social side of a woman that has a rhythm to it...
> Ingrid, Int. 3

Ingrid was able to gain a historical perspective of midwifery in her midwifery course albeit possibly politicising her in the process. As Ingrid explains:

> We had the history of midwifery in our midwifery curriculum. Now I'm working (as a graduate midwife) I have developed that political awareness in a clinical context.
> Ingrid, Int. 3

A Conflict Of Values

Dominant worldviews in education and practice may be currently reinforced through management values and philosophies. As Ingrid explains:

> I think that a lot of the managers in midwifery are managers who have previously been expert midwives but they...have to get into a management way of thinking. I was speaking to a manager...who was having a performance review and who was asked "Are you a manager or a midwife first?" and she said that she was a midwife first and a manager second. She said that this was obviously not the right answer but for her she couldn't see any other way...I think when many midwives go into management they...are made to become managers first to the detriment of the midwifery service that is provided...
>
> **What is the management way of thinking?**
>
> Well I think the management side of things is driven by money, by economics, you know, what the budget can afford or cannot afford. People change their thinking when they go from being a clinical person to a management person, often the two don't marry, they should do, but they don't. And while I believe that we should be able to work within our budgets, silly things or backward steps are being made that prevent midwives from giving professional care...When midwives go into management positions it often means that their allegiance changes. Expert midwives go into management. It's the only pathway for them to go career wise in respect of remuneration and life style changes. **Or teaching?** Yes, we lose valuable people or role models in the clinical setting.

Ingrid, Int. 3

Ingrid suggests that there is a conflict between the philosophy of management and that of midwifery practice.

Jargon as social control

Performance appraisals of midwifery practice can be a means of control according to Ingrid:

> I think the standards of safety are something we need to maintain but on the other hand, you have to use the jargon and I think that this is unnecessary. **What do you consider to be jargon?** It's a language that if you look at a performance appraisal form or the standards of practice they're written in a certain way. It's just particular words that they want you to use in particular ways. **And what happens if you don't?** They send it back to you. So rather than maintaining quality care it becomes an academic exercise.
>
> **That's a means of control isn't it?**
>
> Yes it is, it sure is...I showed you my performance review. That was the one that got sent back to me because I had not filled in my goals in the area of communication...because I had no real goals for that particular area. I considered that I was practising in a manner that I was happy with...in that respect. All I wrote was to maintain the present standard that I'd been working to.
>
> **So you think that you should be able to decide what's applicable for your own professional development?**
>
> Yes, I think that if you...are forced to cover everything there will be some that you're not even going to achieve. If you concentrate on goals that you choose, then you've got a lot more chance of achieving them than if you'd put ones down that aren't really relevent to you. I think everything has to be relevant to you and if it's not then you may as well forget about it...If you communicate well with people and have no difficulty with this, what's the point of making a goal up to please someone else because that's the requirement. That seems a bit ridiculous to me...If there is a problem then goals should be set by the midwife and the appraiser together.
> Ingrid, Int. 2

Ingrid is required to conform to the expectations of those in authoritative positions over her.

Reflection and Action

The collaborative involvement of Ingrid in this study provided the conditions for critical reflection. In the final interview, after she had read the transcripts, Ingrid reflected on her experience of participating in this study:

> It's made me more aware of how I practice, particularly in the area of informed consent...But I'm also aware of who is controlling who. Things that you might not be aware of otherwise. I like to discuss how other people practice and what they think is necessary to 'good' practice. I make the time to get involved in discussions about social and political issues related to midwifery. I'm also aware of the philosophical differences in people's practice.
> Ingrid, Int. 4

Ingrid goes some way toward critical reflection or awareness of the socio-cultural reality that shapes the practice world. Ingrid is prepared to explore alternative ways of viewing reality to open up possibilities for choice and action. This may be seen when she is asked how she would change midwives who are aggressive toward their colleagues - practising midwives:

> Through education and example and by questioning and bringing issues out into the open so that they can understand why they feel that way and then change their ways.
> Ingrid, Int. 2

Through dialogue, Ingrid suggests that critical reflection would be translated into praxis, the central aim of which is action at a socio-political level. But despite the emancipatory interest of critical reflectivity, Ingrid found that she had difficulty practising within a hierarchically organised system:

> **Do you think midwives practice autonomously in New Zealand?**
>
> No, I don't think we do because we have to rely on institutions for a job to a certain extent. Unless we go out on our own and do domiciliary practice we really can't be autonomous.
> Ingrid, Int. 1

Ingrid reveals that her self-determination in practice is a matter of degree which depends upon the work context.

Interpretive Summary

Ingrid has described midwifery practice to be empowering for herself and the women in her care. She identifies practices and intersubjective understandings in midwifery that she finds unacceptable. Where the practitioner's control is "routine", Ingrid believes this to be "disempowering" as women are not given the opportunity to make their own decisions. Ingrid describes how a "controlling" approach is adopted by some midwives who have internalised authoritarian values.

Through critical reflectivity, Ingrid uncovers a hegemonic struggle between the medical profession and midwifery. This struggle is thought to have a materialist foundation. Ingrid links this struggle more generally to the oppression of women in the wider society and thereby uncovers the notion of 'hegemonic masculinity'. This notion is related to the rise of the medical profession in New Zealand before the turn of the century, a process which Ingrid sees as further facilitated through the use of technology. Having gained a position of dominance in the organisation of the maternity services, Ingrid thinks that doctors have maintained this position through the transmission of knowledge. Midwives, who have internalised a "one-sided" view of knowledge through past midwifery programmes, had knowledge prescribed for them which was to be undertaken in a "step-by-step or task oriented manner." This was an instrumental view of knowledge. Furthermore, some midwives have reinforced a more interventionist approach in midwifery through the burgeoning medicalised focus in prenatal education.

In Ingrid's experience, assessment of her own midwifery practice has been reinforced through bureaucratic values over and above professional values. In particular, an institutional requirement to remain accountable to management's beliefs about professional development rather than to her own. The hegemony of hierarchically imposed evaluation procedures and technical-administrative forms of knowledge thwarts the pursuit of principles that are consistent with Ingrid's personal beliefs about acceptable midwifery practice so that she is unable to fully participate in shaping her practice world.

CASE STUDY THREE: JESSICA

General Introduction

Jessica had practised as a midwife for a period of eighteen months before participating in this study. Prior to graduating as a midwife, Jessica had experience in nursing practice. At the time of the first interview she had worked in the labour and birthing area for seven months.

This study is based on Jessica's understanding, experience and knowledge of midwifery practice. The themes that appear in **Part Two** are grounded in Jessica's personal and professional knowledge.

A Midwifery Perspective

Power sharing was a central feature in Jessica's practice as she strived to give women in her care information on which to base individual decisions about labour and birth. As she comments:

> Women should be able to determine the sort of care they receive. So...if you give them full and proper information the majority of women would make the right decision about the way their labour and birth should go...Midwives are guardians of the normal birth and want the woman to birth the way she wants to provided it's safe for her and the baby.
> Jessica, Int. 2

Jessica's emphasis is on giving women "full...information" so that they have the freedom to "determine" between alternatives in relation to their care. A midwife and a woman 'create' knowledge together rather than the midwife 'giving' knowledge according to her own interpretation of the situation. Thus there is a difference between 'giving' knowledge, which intimates that control rests with the midwife, and 'creating' new knowledge together, which implies reciprocity and a freedom to choose among possible alternatives in the developing relationship between midwife and women. Jessica learns about women's prior experience and understanding of childbirth so that her care takes this into account. As Jessica explains:

> I try to determine the woman's knowledge level. **What difference does this make?** If they're obviously very clued up on what they should and need to know for labour and birth, then what you're going to tell them...is going to be different. If I know where the deficit is in their knowledge it really determines what...you're going to give them.
> Jessica, Int. 2

Although in the above extract Jessica's care is individualised, there are times when her authority overrides a woman's desires concerning her labour and birth:

> It would be naive of a midwife, or any caregiver during labour or birth, to expect every woman to make the right decision all the time...So you have got to know when to intervene and make decisions for them when the situation becomes unsafe...
> Jessica, Int. 2

Jessica intervenes to influence the course of labour when a woman's decision would be detrimental to her outcome, that is, when the situation becomes "unsafe". This is illustrative of authoritative action derived from expert knowledge in midwifery practice. Included in Jessica's judgement about 'good' midwifery practice is a judicious use of intervention. Where doctors contravene this principle she takes an active part in critically appraising what she sees as unnecessary intervention. Jessica illustrates this in the context of frequent vaginal examinations:

> Some doctors think that their fingers are going to tell them everything and they'll totally ignore, or not see, the other signs of progress. They just seem to think that by doing a vaginal examination every ten or fifteen minutes they're going to get a proper picture of what's happening and I think that's because they're not confident in their practice. They are typically not at the labour.
> Jessica, Int. 2

Jessica states that doctors who do not spend time with women in labour may place a greater significance on vaginal examinations as an objective assessment of a woman's progress. This is in preference to a reliance on the midwife's knowledge of less tangible but salient signs of labour. It is inferred that an increase in objective assessment procedures is due to a lack of experiential knowledge.

Taking-On A Midwifery Perspective

In contrast to some doctors who appear to lack confidence in their practice, Jessica notes that some "take on a midwifery perspective":

> Some doctors are different in that they do sort of act more as midwives. They take on a midwifery perspective in a lot of ways...They have a different rapport with the women. They don't hassle them along...And the women...have a good knowledge base...One of the best consultants here...explains everything to the women about what is going on...has good communication skills, both with the women and with the midwives,...gives women options in their care and...will clean up after himself...If the midwives are busy and haven't had time for a teabreak, he will sit with the woman and take their recordings ecetera. He is also for midwifery autonomy and is not against homebirth. He says that that would not be his choice but he accepts that women have that choice.
> Jessica, Int. 1

Jessica observes that some doctors "take-on" a midwifery perspective by having "a different rapport with...women" and by emphasising womens freedom to have "options in their care". Having said this, a doctor's midwifery practice will be limited as it is not conducive to being 'with women' during the labouring process. And as Jessica explains, it is the 'being with' that constitutes midwifery practice:

> We get good at handling labours because doctors are typically not there...And some doctors put women off. I've had women say "I can't push when he's here." I think women sometimes hold back when the doctor is there. They won't always tell me this but I sense it...It's not enough for the doctor to just come in for the delivery. They need to spend some time with the woman during her labour too...
> Jessica, Int. 1

The Doctor Will Decide in The End

In contrast to some doctors who "take-on" a midwifery perspective, Jessica describes others who make decisions about the course of labour and birth regardless of women's preferences:

> Most women have clear ideas about their preferences in childbirth but it is often the doctor who decides in the end...The doctor steps in even in situations that are not always considered to be unsafe...An example of this would be when a doctor wants to deliver a woman only in a particular position...He just says that she's got to be sitting up in bed or whatever...There are also doctors who put time limits on...and want things to be over and done with. They don't even need to say anything, you can just sense it...(or) they

> say "Oh well I'll give you another fifteen minutes and then we're going to give you a forceps delivery." And the woman wants another...quarter or half an hour because she knows she can do it...Waiting for the cord to stop pulsating...is another one...
> Jessica, Int. 2

Jessica has observed that there is a lack of authority by women to influence medical opinion so that intervention based on medical decisions takes precedence over what a woman wants. Such an authoritarian approach to labouring and birthing women is concomitant with patronising and aloof relationships with midwives. As Jessica points out:

> A high percentage of doctors can be quite patronising in their behaviour and in what they say to the woman and to the midwife. They can actually tell you a particular way they want the labour handled and it will be such a basic thing we would have thought of it anyway. They can make a big deal out of it...I think some of the doctors want to be seen in front of their patients to be calling the shots, deciding the way things are going to go. I don't think they want the midwives to get any of the limelight, so to speak. That sort of attitude can be reflected in the way they behave after their women have...delivered. There are some doctors who may not have been around much at all during the labour and will give no acknowledgement or thanks for the hard work you've put in...
> Jessica, Int. 2

Jessica is aware that an authoritarian approach by a doctor is taken-for-granted and overrides the situation. Here professional action and interaction become an expression of power (knowledge) which needs to be struggled for as it is in limited supply. This interpretation of power is associated with 'privilege' and is a relation of dominance which has negative effects upon those concerned. Jessica explains how patronising attitudes negatively affect the learning environment for new midwives:

> They can be more patronising to the new midwives and less so to more established midwives who have been there for a long time...This is undermining your confidence...so you don't learn much. Another thing is that when you're being patronised by someone it is actually a lot harder to perform at your best.
> Jessica, Int. 3

Thus, an authoritarian approach negatively affects the learning environment for midwives as well as women.

Traditional Authority Versus Sharing Knowledge

While Jessica's midwifery practice is based on sharing knowledge with those in her care, this view of midwifery is not shared by some of her midwifery colleagues. This is captured in my fieldnotes in Jessica's words:

> Many of the older midwives are not concerned with passing on their knowledge or sharing knowledge.
> Jessica, Fieldnotes, July, 1991

During the interviews Jessica adds:

> it happens with younger midwives and with the woman. I think sometimes they think it's easier to keep the woman ignorant so they can control the labour the way they want it to go. I mean it's quite a generalisation but I think they have a set idea about the way things should go and they don't like to deviate too much from their perception of the norm. They're not as adaptable and there are quite a few of them who don't...share their knowledge with us. Maybe they feel threatened by us because we (the newer midwives) do discuss things more...Maybe they feel a bit left out and that they don't have a lot to offer. But they do because they've got years and years of experience.
> Jessica, Int. 1

Jessica notes that the experiential knowledge of some more experienced midwives is not shared with other midwives or with labouring women. As a consequence, these midwives adopt a controlling or authoritarian approach; their practical knowledge is not shared with others. Furthermore, Jessica sees that some midwives support medical staff above their colleagues:

> Some midwives will support the doctors above midwives...When a midwife challenged an obstetrician's unprofessional manner toward her...some midwives wouldn't support her on the grounds that the doctor had been here a lot longer than she had and therefore he should not be challenged.
> Jessica, Int. 1

Although it is not the doctor's knowledge that is in contention here, but longevity, the hegemony (refer to **Chapter Three**) of the status quo

is apparent. It is perpetuated by midwives who do not support their colleagues through an unquestioning faith in the doctor. They may even give lip service to midwifery knowledge but continue to practice according to prescribed medical authority. Accordingly, doctors are thought to be superior and therefore unchallengeable while the midwife, on the other hand, has learned to internalise a strong feeling of inferiority. To make herself feel superior, she may project aggression onto other midwives. As Jessica explains:

> Some midwives are aggressive to other midwives. This does not serve midwifery well to be like this.
> Jessica, Int. 1

But as Jessica says, the newer midwives, who graduated from a more recent midwifery course, generally do not take the status quo for granted and do not accept a subordinate position in relation to the medical profession. The newer midwives question and discuss midwifery practice in an open forum. Thus, there are two distinct groups of midwives working in the labouring and birthing area. As Jessica explains:

> There are two groups of midwives here. The first group are younger and have recently completed a midwifery programme. They are open-minded and pro-midwifery...These are the ones who are trying to bring about more change for the better in midwifery. The second group are into letting doctors control everything. They'll ring the doctor over the simplest management problem. They are happy to stay the same because it's easier as there is less energy involved and it's the way its always been. The thing is they're ultimately thinking of themselves and not the women. The pro-midwifery group want things to be improved for women and for women to have more choice. They focus on the woman's experience and want her to have a good experience. That is not to say that the other midwives don't want women to have a good experience but they are not focused on that so much. They seem to be focused on providing care by the book which was written twenty years ago. **So they've not kept up to date with changes affecting midwifery practice.** That's right.
> Jessica, Int. 1

On Jessica's account, there are "two groups of midwives". The first group are "younger", "open-minded", "pro-midwifery", "recently completed a midwifery programme" and are focused "on the woman's experience..." The second group are constrained by traditional authority as they let "doctors control everything." Their practice is

midwife-centred, rather than women-centred, as they are "ultimately thinking of themselves and not the women."

Stereotyped Sex Roles

Jessica makes the connection between stereotyped sex roles and oppression in midwifery:

> Doctors who work here have generally come from the generation of stereotyped sex roles. If they're men it's natural to be superordinate to women who are expected to be submissive in relation to their husbands. It is not in the men's interests to change. This situation has parallels in midwifery. **How?** The majority of doctors are men and the older group of midwives are submissive to them.
> Jessica, Int. 1

Midwifery As An Invisible Culture

As shown in **Chapter Two,** the medicalisation of the maternity services has increased medical control over women in pregnancy and childbirth which is reinforced by the dominant medical ideology. That is, women think they need a doctor present in order to give birth and they need to be in a hospital. As Jessica comments:

> They (women) just believe that the doctor is going to be wonderful to them and give them the exact care that they want. They seem to have this implicit childlike trust, like a sort of faith that this person is going to look after them and just do exactly the right thing. We (midwives) see that that just doesn't work all the time...
> Jessica, Int. 2

Jessica suggests that women do not understand the midwife's expertise and look to their doctor for guidance - guidance with which they may be disappointed. As Jessica explains:

> You hear women say "I went to so-and-so and I wouldn't go to him again. I wouldn't let him within ten miles of me."
> Jessica, Int. 1

Jessica comments that women often confuse midwifery practice with nursing:

> A lot of women see us as nurses. I often get called a nurse in front of the doctor. I usually explain the difference to the woman...**What is the difference?** Midwives are looking after healthy people who are responsible for their own care and have a better chance of determining the outcome. They're calling the shots. Someone who is sick is having things done

> to them. **But some women are sick at this time and midwives are with women throughout the wellness-illness spectrum.** The majority of women are well.
> Jessica, Int. 1

Jessica attempts to render the social roles of midwives and nurses as problematic. Midwives are said to "work with" clients rather than "do things to" them. Such reflection is limited as the structural constraints and social relationships which have dictated and diminished personal and professional identities of both caregiver and women is left unquestioned. However, Jessica says that some women make a considerable effort to choose doctors who they can "work with" :

> There are some women that obviously go to some lengths to find out how skilled their doctor is or they will go to a number of different doctors to discuss how they want their labour to go and the sort of birth plans they have in mind.
> Jessica, Int. 2

While some women have a greater knowledge of their doctor's preferences, they are required to fit into organisational arrangements that are imposed upon them rather than created by them. Part of the way the organisational structures are perpetuated is through a lack of information available as to who will actually be looking after women during labour and birth. In this way midwifery is rendered invisible.

Continuity Of Care

Jessica alludes to how the intermittent nature of institutionalised care-delivery can be a difficulty for some women:

> A women can end up in hospital in labour...not on her own ground and she's not as powerful as she was before, and she's in pain, and she's less likely to be able to put her point across then.
> Jessica, Int. 2

Midwives work in a system that fragments midwifery care so that the midwife is unable to fully utilise her knowledge and skills. Jessica comments on this point:

> I think continuity of care is the best way to care for a pregnant woman...
> Jessica, Int. 2

Jessica suggests that the maternity services could be organised differently to facilitate continuing care rather than intermittent care-delivery:

> I think that a midwifery scheme should be made available to any women who wants it. If she is normally a low risk type pregnancy, I think she's entitled to that care, she should have the option...If a total midwifery care scheme was operating, this in itself would change women's perceptions in the long term because they could see the alternative approaches working and learn to understand and accept what midwives are doing...A proposal for a team midwifery scheme was submitted to management. The idea was not viewed favourably.
> Jessica, Int. 4

A midwife team scheme was proposed by a midwife but this was unacceptable by management. Jessica thinks that if a midwife scheme was operative this in itself would help to change women's perceptions by giving them practical alternatives in their care. However, Jessica sees that continuity of care can be disrupted in other ways:

> If someone who's not actually involved in the direct care of the woman comes into the room without being invited...it can destroy the whole rhythm of labour and atmosphere within a matter of seconds. It can actually be very difficult to get that back again if you ever get it back. The woman is trusting you to be supportive and help her through and if someone just walks into the room my attention is taken away from her and you've lost that trust in some ways...Someone coming into the room looking for something or wanting to ask you a trivial question, which is usually something that can wait, just takes away from the woman's whole experience and lowers it down to something less important...
> Jessica, Int. 3

Labour and delivery are a personal experience, but, as Jessica demonstrates, it is more than that. When people enter a labouring woman's room uninvited, birth becomes a political issue since the natural rhythm of birth is disrupted and women are disregarded.

Vested Interests

Jessica has described midwives who have internalised hierarchical authoritarian relationships. She suggests that there are others with vested interests in maintaining the status quo:

> I think that GPs are threatened because there is a lot of money to be made in obstetrics because a lot of their

> practice is built up from having one pregnant woman and then if they deliver her and look after her during the pregnancy then they are set for the care of her whole family basically.
> Jessica, Int. 2

Jessica believes that the practice and responsibilities of the general medical practitioner and the midwife overlap:

> A woman with quite a few risk factors came to delivery suite and the consultant actually knew that she was coming in. We'd informed him. He said when she was admitted to ring him back and let him know what was going on with her so that he could know whether to keep an eye on her or not. So the midwife admitted this patient and did the initial vaginal examination and palpation and everything that we do on admission. Then she phoned the GP and told him what the results of her findings were from her full assessment. She said to the GP that the obstetrician did want to know and that she would give him a call. And he said "No" that he wanted to call and tell him what was going on himself. And really the midwife was the one that was there and did the assessment and she'd be the best one to communicate that to the obstetrician. But the GP didn't want her to do that. I think he felt that if he let the midwife do it that he would have lost some sort of control in the care of that woman.
> Jessica, Int. 2

Jessica has illustrated that with the expanded scope of midwifery practice, a midwife and a general medical practitioner have the same right to seek specialist consultation when women who are 'high risk' are involved (even though this may be denied by some GPs).

A Conflict in Values

Aside from vested interests that work against midwifery, there are structural constraints within the profession that reinforce a dominant ideology. That midwives are oppressive to midwives has been discussed. Jessica sees a conflict of values between midwife managers and midwife practitioners:

> When a midwife goes from working with women...to becoming a charge midwife or a manager of a unit, her whole frame of reference changes because she's not thinking in terms of caring for women the same. She's thinking in terms of money or how she's going to meet the budget, how she's going to keep doctors happy, how she's going to keep the midwives happy. And in a lot of ways it's an intermediatary sort of role but their whole focus changes. It's not focused on women any more, it's focused on management. I mean that's

> what it is.
> Jessica, Int. 2

Midwives who change from clinical practice to management positions may be socialised into accepting a position that is antithetical to midwifery based on a professional model of practice. A conflict between Jessica, as the midwife in clinical practice, and the charge midwife is evident in the following extract. As Jessica explains:

> The charge midwife thought that the woman had "the right" to doctor's care although everything about the labour was quite normal apart from the fact that there was failure to progress but there was no risk factor involved. She didn't need a doctor but a doctor was called. That really just undermines what we're doing. It's quite demoralising when your own charge midwife doesn't have confidence in her staff's skills.
> Jessica, Int. 2

A women is transferred into hospital with slow progress in labour. On admission the baby is born spontaneously and without the need for medical intervention. The charge midwife, who insists on calling a doctor regardless of the normality of the situation, does not foster the development of professional autonomy. Hence midwifery practice loses its significance which in turn reinforces a hierarchical dominator-dominated system.

Performance Appraisals

A hierarchical system may also be reinforced through assessment of midwifery practice. In the clinical area where Jessica works, her practice is individually assessed through performance appraisals. This process is meant to be a positive experience to foster excellent standards in midwifery practice. However, Jessica is threatened by this process:

> ...I have learned never to bring up the negatives in a review because people might pick up on them and use this against me...I think it can be something that controls you. I think if someone is in power with whom you are working and is aware that you think there is something negative about your own practice, then when your 'chips are down' they could very easily bring it up if they were unhappy with the way you were relating to them. It's more a personal thing. It may not be anything to do with your work, but they may not be happy with you.

Jessica, Int. 2

Jessica demonstrates how there is an insidious exercise of power which serves to reinforce compliant behaviour within a hierarchy of social relationships.

Work Constraints

The added stresses of a heavy workload directly affects the quality of midwifery care. As Jessica explains:

> If it's my sixth shift in a row then it's easy just to do the bare minimum. Those are the days when I don't put much love into my work...**How does this affect your practice?** Well on those particular days you probably don't put as much effort into getting to know the woman and her partner or family members as much. You just tend to treat them more like, you know, here's another patient, and hopefully this labour and birth will be over as quickly as possible. You don't want to know where the woman is coming from the same. You can choose to be like that...It depends on the amount of energy I have. When my energy level is low I just want to get through it.
> Jessica, Int. 2

Jessica illustrates how fatigue affects her work so that she balances toward her own needs in the situation, rather than the woman's. Jessica acknowledges that work fatigue has reached the level of burnout:

> I was burned out...in the postnatal area...because of the sheer volume of work that was expected of me. I wasn't able to enjoy what I was doing...
> Jessica, Int. 1

In the context of caring for women postnatally, Jessica literally lost the ability to care so that she felt inclined to avoid the women. This situation was compounded by a lack of social support when working in the postnatal area. As Jessica explains:

> I didn't feel that I had people of a similar mindset working with me...I was working mainly with staff nurses and enrolled nurses who didn't have the same philosophy as me and they didn't approach care the same way that I did. That just made it difficult. There were times when I was working with midwives on that particular ward and it was really good because we were thinking the same way and things went a lot smoother.

What do you mean by not having the same mindset?

Well the care was not individualised and they didn't seem to pick up on the differences between women the same...they didn't have expert knowledge on breast feeding or the things they really needed to know. It is one of those highly undervalued areas in midwifery.

It's an important area of midwifery. Unless it's handled sensitively, there is a propensity for postnatal depression.

Oh definately. I think the midwife is better at assessing the dynamics of the whole familiy situation and all the ramifications that go with the care of women and their babies.
Jessica, Int. 2

The stresses of midwifery became intolerable when the demands of the situation prevented Jessica from performing with a maximum level of skill and committment. Where Jessica worked with staff who did not have the same "mindset" or midwifery knowledge, the situation became even more stressful. Whereas when Jessica worked with midwives, the "thinking was the same way and things went a lot smoother." This is indicative that social support from colleagues made the difference in reducing distress leading to burnout because common meanings, insights and perspectives could be shared with an insider. This could not happen when working with general or enrolled nurses. This experience has lead Jessica to think that the postnatal area should be fully staffed by midwives:

I think the postnatal area needs to be fully staffed by midwives. I don't see any justification for having enrolled nurses or staff nurses working in this area, because postnatally women are cared for in such a short time now, and they are entitled to be fully cared for by a midwife so that when they are discharged from hospital they have more confidence in that knowledge.
Jessica, Int. 4

Jessica believes that the postnatal area is devalued since it is staffed by people who do not have expert midwifery knowledge. With early discharge, the problems of working with staff who do not have the necessary knowledge and skills are magnified.

Reflection and Action

The collaborative involvement of Jessica in this study provided the

conditions for critical reflection. In the final interview, after she had read the transcripts, Jessica reflected on her experience of participating in this study:

> It's good to be able to verbalise your experience because usually you are just living it and working it. When you are actually verbalising it you can see the things that maybe you need to change in your practice, things you hadn't actually thought about in depth before...It made me ask questions about what we're doing in practice...like why we practice like that or that way, and why we accept or don't accept certain practices. It's an ongoing thing. Sometimes we question it more than other times as the situation arises or changes.
> Jessica, Int. 4

Jessica signifies that she is aware of the importance of critical reflection and dialogue in producing change in the socio-cultural reality that shapes the practice world. In the next extract she demonstrates that her critical reflection is translated into praxis (refer to **Chapter Three**):

> I think people have a vision of greater changes than I do but I think I'm bringing about change where I work by being an example to the midwives who have entrenched attitudes ...Any change that is brought about must be done in such a way that people don't take it as a personal slight on their behaviour.
> Jessica, Int. 4

Interpretive Summary

From the collaborative interviews with Jessica, it is evident that she takes a women-centred approach to practice. She endeavours to create new knowledge with women by sharing information so that they are able to determine the direction of their care. She notes that some doctors "take on" this perspective while others will "decide in the end" about the course of a woman's labour and birth. This "patronising" approach is transferred to the way some doctors interact with midwives. This is said to be "undermining...confidence" which negatively effects the learning environment for both women and midwives.

Jessica also describes how some midwives fail to recognise the complementarity of midwifery knowledge with medical knowledge. These midwives identify with traditional medical values over and above those

of midwives. She believes that these differing values have given rise to the formation of two cultural groups in midwifery. The first group is "pro-midwifery" and discuss issues pertaining to midwifery in an open forum. The second group let "doctors control everything". Jessica suggests that these midwives manifest aggression, or lateral violence, against their colleagues due to a power imbalance. It is through lateral violence, or the threat of it, that some midwives in senior positions set limits on other midwives' practice and thereby maintain the status quo within the hospital system. Jessica also believes that women in the wider community lack an awareness of midwives' authority and responsibility. In this way women also perpetuate the dominant medical ideology.

Jessica exposes structural constraints which she believes are perpetuated by those with vested interest in maintaining the status quo. These constraints she identifies as intermittent care-delivery, performance appraisals, heavy workloads, and people with a different philosophy incongruent with her personal and professional practice consistent with women-centred care. In particular, Jessica identifies a conflict of beliefs and values between midwives in clinical practice and those in management. Midwife managers generally reinforced a hierarchical dominator-dominated system by adopting a narrow view of their position and reproducing the cultural values of the status quo through technical-administrative forms of knowledge evident in performance appraisals.

In combination, the structural constraints and hierarchical social relationships served to "demoralise" and "undermine" Jessica's personal and professional practice and thereby restrict the development of autonomy and self-determination in midwifery.

CASE STUDY FOUR: ERICKA

General Introduction

Ericka had practised as a midwife for a period of eighteen months before participating in this study. Prior to graduating as a midwife, she had experience in nursing practice and education. At the time of the first interview, Ericka had worked in the antenatal area for seven months. She provided antenatal care for women who were considered to have an 'at risk' pregnancy since they had developed medical and/or obstetric complications. She therefore worked closely with members of the medical team including physicians. This study is based on Ericka's understanding, experience and knowledge of midwifery practice.

A Practical Approach

Ericka's approach to midwifery is characterised by practical reasoning, as she explains:

> Sometimes with constraints of time it's not possible to do a full antenatal assessment at once. Of course that's negotiable on the day. The priority, if it's busy, is to ensure mothers and babies are safe whilst spreading your attention over a large area in a relatively short space of time.
> Ericka, Int. 1

Ericka describes a flexible style of practice which is effective in the specific situation of caring for women whose pregnancies are classified as 'at risk'. Due to the unpredictable nature of the everyday practice world, she has learned to prioritise objectives for reasons of safety. By knowing that the unexpected is a common occurance where she works, Ericka makes an efficient use of 'self' in the amount of time available. This idiosyncratic practice is dependent upon a skill in managing a wide and varying range of situations.

Restoring Meaning

During interaction with women, Ericka is a resource person who shares

knowledge with the aim of restoring meaning for those in her care, as she explains:

> Midwifery practice enjoys the privilege of a degree of intimacy that enables midwives to be with women as individuals. Effecting a standard course of action for a given situation won't always be appropriate for every woman. While it may restore meaning for one woman, it may completely destroy meaning for another.
> Ericka, Int. 3

Ericka articulates an orientation toward an individualised approach to midwifery practice, rather than a standardised, inflexible approach. Ericka becomes involved in the different experiences that pregnant women have and is able to interact appropriately based on this background knowledge. This is reiterated by her in the following extract:

> While the word 'autonomy' may serve to define midwifery as a profession, it may be misleading for midwifery in practice. Midwives work in partnership with women and their families and act according to their needs and concerns.
> Ericka, Int. 3

While Ericka believes that 'autonomy' may be the hallmark for professional work, she also thinks that practice is situated within a social context which cirumscribes decision making in midwifery practice.

A Women-centred Approach

Ericka's approach to midwifery practice may be said to be woman-centred. It is focused on an exchange of knowledge with the aim of sharing knowledge with the women in her care. In this way, pregnant women may be empowered to cope with the new situation they find themselves in. A women-centred approach is depicted in the following extract when Ericka describes a situation where a woman with toxaemia of pregnancy feels well but has to be admitted into hospital:

> You've got a women who is expected to have had a normal pregnancy and she's got plans to maintain her own power throughout her pregnancy and birth...and suddenly she gets hit with this terrible toxaemia and she comes in and you plonk her into a bed so she's down there (shows with hand) and you're up here (raises hand) telling them what's going

> to happen...and why she's here...she's immediately disadvantaged. She's in an environment that's completely unfamiliar to her for a start and you're the one with expert knowledge...But that knowledge and power implies that you have some responsibility as well...So you've got to try and give her power...You want to provide accurate information...But it's the 'way' you say something rather than 'what' you say.
> Ericka, Int. 2

Ericka describes a woman who is admitted into an alien hospital environment. She purposively seeks to empower her, based on the premise that her midwifery knowledge puts her in a more powerful position. In this way, Ericka is responsible for trying to counteract a sense of powerlessness which women may develop in an unfamiliar hospital culture. As Ericka explains:

> Even with assertive women that come into hospital, in hindsight, they felt bombarded by the system. So much so that they are in a powerless position to the extent that they don't actually ask and therefore get what they want. They aren't able to articulate their needs. In another situation they would be more than capable of doing so. That's an obvious constraint of the system though isn't it? It's a well documented problem.
> Ericka, Int. 3

As well as the powerlessness which women may experience when entering into an unfamiliar environment, gender stereotypes require a woman to be passive and submissive when hospitalised (Gillette, 1988). This is compounded by the 'sick role' which women may be expected to adopt in this environment. In the following extract, Ericka identifies a differing relationship between women and doctors as opposed to women and midwives:

> It's a difference in relationship that you have (as a midwife) with the women. And it's how they see you and it's how they see the doctor...Like Lynette who spoke to me for half an hour one morning. And then suddenly said "What's the time? I'd better go and clean my teeth because I don't like talking to the doctors when my teeth are unclean." And when I asked Betty how she was feeling today. She said "Oh I'm browned off with being kept in here." I suggested that she negotiate some leave with the doctors because the end of the issue was that she needed some time out of hospital. When the doctors came around and asked Betty how she was she said "I'm fine." So it's really important that you take on the

> negotiation for them sometimes...It's advocacy really isn't it? Being a mediator, if you like, for someone who feels they can't say something is right for them when you know that that is what they want.
> Ericka, Int. 2

Due to the different relationship that women have with doctors, compared with midwives, Ericka takes an active part in being a woman's advocate. That is, Ericka acts to ensure that a woman's needs and desires are taken into consideration and intervenes when they are not by negotiating with the doctor when it is appropriate. Ericka believes that the decision to negotiate for women in her care is based on their values, rather than her own. As Ericka explains:

> When the doctor came to see Lynette, it wasn't her wish that I would negotiate some leave for her. Without a doubt she didn't feel brave enough to do so on her own. But she also didn't want me to do it for her...This understanding was established before the doctor arrived.
> Ericka, Int. 3

Although Ericka becomes a mediator between a woman and a doctor, she is mindful of the woman's fundamental right to autonomy. She respects this position through identifying the values of each woman in her care. This enables her to discriminate between when it is appropriate to be a woman's advocate and when it is not, a position which reinforces a women-centred approach.

Two Approachs To Midwifery

As has been illustrated in the above discussion, Ericka makes a conscious effort to empower women in her care. However, she identifies an approach which is contrary to this:

> Women can be in a vulnerable position and need to retain power and dignity, much of which can depend upon the type of exchange you have and plan to have with them. **Whether it's 'with' women or hierarchical?** Whether it's a human-to-human relationship or a professional versus person relationship. Basically (in the professional versus person relationship) the professional wants to know a lot about the woman but there's not that reciprocation. The professional demands information, encroachs on physical space and makes all sorts of demands on a woman. There's only so much of that person that she's going to want to reveal. So it's profession versus person when it should be an exchange of knowledge (as

> with a human-to-human relationship)...It's the whole idea about the professional knows what's best for somebody else. On an individual level we potentially have an enormous amount of power over the women in our care. **And sometimes it's used...** Badly. What's failed to be recognised in a professional versus person relationship, is that the women themselves potentially have a lot of power (knowledge)... that they will exchange in a situation they feel comfortable with...If a woman doesn't want to tell you things, then she doesn't have an obligation to do so. It's similar to anyone who is building up a friendship.
> Ericka, Int. 3

Ericka identifies two approaches to midwifery. One is woman-centred and is based on power-sharing, the other is described as "professional versus person". Here the professional "knows what's best for somebody else" and therefore lacks empathy with women, a feature which characterises a women-centred approach.

Nonrational Versus Rational Knowing

In the above discussion it is evident that Ericka's practice is based on many forms of knowledge which are used in flexible ways. But it is Ericka's personal knowledge and experience which enables her to intuitively grasp the salient features of problems that arise in midwifery practice. This is articulated by Ericka in the following extract:

> Intuition forms an essential part of midwifery practice. It's a way of knowing that is often not acknowledged as it is a rather nebulous means of assessment for the otherwise logical mind. But it's mandatory.
> Ericka, Int. 1:1

Ericka states that personal knowledge or intuition is "mandatory" for midwifery practice. Despite the importance of this knowledge in practice, it is "often not acknowledged" as a legitimate source of knowledge. This is elucidated in my fieldnotes which enlarges on this point:

> Ericka entered the room at the same time as the house surgeon. The house surgeon systematically examined the four women around the room. Ericka saw that Mrs Jones needed attention and went to help her immediately. Later, Ericka commented on the house surgeon's lack of response to the woman's situation: "Doctors are scientists and don't always

> pick up on intuitive things." The woman was later diagnosed as being in cardiac failure.
> Fieldnotes, June, 1991

There is a difference between Ericka's practice and that of the house surgeon. Ericka demonstrates clinical judgement based on experiential knowledge which she calls "intuition" and which enables her to understand and grasp the salient aspects of the situation for timely intervention. Rather than an analytic, reductionist approach to midwifery, this approach is indicative of a synthesis of knowledge based on past experience. The house surgeon lacks personal and local knowledge to respond appropriately to a women in cardiac failure. In the following extract, Ericka explains how intuition is "seldom acknowledged" or is devalued by society:

> **You have said that intuitive judgement is mandatory in midwifery.** Yes it is. But it often doesn't hold much water when it clashes with a rational viewpoint. That's not because it isn't as valuable, it's more because it isn't valued. Rational logical scientific knowledge has the kudos in society. Intuitive knowledge is seldom acknowledged. **This is reflected in the rational logical subjects taken at school, like mathematics and physics which are given higher status than subjects such as...**Liberal arts...whereas a balance of both is needed.
> Ericka, Int. 2

Ericka notes that rational, logical, or analytical knowledge which generates propositions is given higher status than knowledge produced through experience. Ericka reflects upon the effects of this dominant pattern within her past experience as a nurse:

> When you think about the original motives for going nursing...the altruistic stuff...the wanting to help people, the nurturing, all that side of things, this gets trained out of you...And in fact you can lose the motivation that you had for doing the job in the first place. In the end, what you have to develop is the complete opposite. You need to procure the...logical rational stuff in order to survive in the system...whereas a balance of both is where you need to be...It's like a box of tissues, the box is no good without the tissues but the tissues don't have any form without the box. **You need the 'concern' as well as the ability to 'problem solve'?** Yes you do. The one complements the other as knowledge develops.
> Ericka, Int. 2

Ericka believes that the ethic of caring, which is the basis of altruism, often gets 'trained' out of midwives and nurses. But as she states, the rational and the nonrational ways of knowing are "complementary as knowledge develops." This means she will "draw upon" intuition as well as rational ways of knowing to develop knowledge in midwifery. This is reflected in her "experience as a woman as well as...a midwife":

> I...draw upon the knowledge that I've gained in my practice...But I have an enormous advantage because I'm a woman. I draw on my experience as a woman as well as the short amount of experience I've had as a midwife.
> Ericka, Int. 3

In the next extract, Ericka discusses two research proposals; one proposal is from a doctor, the other from a midwife:

> It was very interesting to see the difference between the two proposals. The medical proposal set objectives that were measureable and quantifiable as problems in a statistical arrangement. The midwife thought the medical proposal was detached or impersonal. Whereas the midwifery proposal endeavoured to examine the meanings and issues inherent in what counted as problems for the women concerned...This was viewed as rather emotive by the medical profession.
> Ericka, Int. 3

Ericka goes on to say:

> Some doctors are very detached from the data and from their practice. But as a midwife you utilise values and experiences in your practice and research. **So a practitioners underlying philosophy of science or worldview dictates how they practice?** Yes I would agree with that.
> Ericka, Int. 3

Ericka has highlighted two different approaches to research and practice.

Patriarchial Society And Gender Defined Occupations

The ascendency of rational knowledge is hegemonic and is perpetuated by a dominant ideology operating in a patriarchal society. As Ericka states:

> Areas of work that are predominantly governed by women, such

> as midwifery, are traditionally not highly valued. They are mandatory for the survival of society but don't carry much kudos....**The whole of society rests on it but it's awarded low status?** Well it's part of the stereotyped sex roles. As a generalisation males are often rational and females are often nurturing. The traditional nurturing female roles are devalued and so are the principles upon which these roles rest. All the masculine principles, like the logical and the rational, are what gets the kudos. The scales aren't equal between these principles, between the logical or rational and the nurturing or nonrational, so that they do not compliment each other.
> Ericka, Int. 1

Ericka thinks that knowledge in midwifery is based, in part, on the situation as women in a patriarchal society and, in part, as women involved in a female-defined occupation which is given low status in relation to male-defined occupations. This situation Ericka believes is perpetuated by "power structures" of the "hospital system":

> The 'system' is unwittingly perpetuated everyday. The culture of a hospital system has strong power structures...which are often accepted as people are socialised into it. Take a simple example of uniforms. The epaulettes are symbolic of rank and the whiteness of purity...Many attitudes are also deeply rooted in long-standing sexism. The question needs to be asked repeatedly: Is midwifery providing a service which women want? Are women having an effective influence over its direction?
> Ericka, Int. 4

Here Ericka identifies the mediating ideology of historical sexism to be at the root of an oppressive culture in midwifery. In the next extract, Ericka thinks that feminist theory, as a critical approach to midwifery, was deficient in her nursing education:

> The people who trained us (as nurses) at the hospital...carried with them deeply rooted attitudes that were quite firmly implanted in non-feminist theories that were not critical of the social and political circumstances.
> Ericka, Int. 3

By reflecting upon her nurse apprenticeship training within the hospital system, Ericka has revealed what she believes to be acritical attitudes of the teachers of her nursing course. Nurses were socialised into accepting a subordinate position in relation to the

medical profession and were not educated to question their social or political circumstances. Relations of domination were also reflected in the practice of preventing women from seeing their clinical notes and medical records. As Ericka suggests:

> **Up until quite recently women were not allowed to see their notes...**it's the whole idea that the doctor or professional knows what's best for somebody else.
> Ericka, Int. 1

Legitimising Midwifery knowledge

Some doctors assume that their practice is more important than the midwife's practice. Ericka explains:

> The house surgeon was seeing all the women in that four-bedded room. She continually came in and interrupted the interaction that I was having with those particular women. She didn't see my interaction as important. I was supposed to sublimate what I was doing so she could see them. She could have seen the women that I wasn't actually with. And whilst it's true, I could go back, it is just assumed that what she's got to do is more important. But the interaction that I was having with those women at that particular time was lost.
> Ericka, Int. 1

The house surgeon's actions indicate that she assumes her practice takes precedence over Ericka's. This assumption is not shared by Ericka as she explains when she reflects upon the house surgeon's practice:

> Sometimes house surgeons are unable to draw the line between what's okay and what's not okay. **Like in skill acquisition?** Yes. It's not 'cool' for them to ask for help.
> Ericka, Int. 3

Ericka notes that there is a dissonance between some house surgeons' expectations of practice and the actualities of practice as she sees them. Ericka goes on to reflect upon the medical way of knowing:

> Sometimes if the medical staff are unable to solve a problem medically or scientifically they throw it back onto the woman concerned thereby negating her experience. This seems to be particularly so for problems which don't imminently threaten the lives of mother and baby...
> Ericka, Int. 3

Ericka suggests that medical practitioners sometimes look for an individualistic or a psychological cause for a given problem when there is no objective data which clearly identifies a physical origin of illness.

Continuity Of Midwifery Care

Ericka experienced a number of structural contraints operating within the clinical agency where she worked that prevented her from fully utilising her midwifery knowledge and skills. As she explains:

> The system compounds the power structure against women...Like a woman arrives in the ward and it's a process of getting to know her as a person. That process may take quite a long time and if she's subjected to lots of brand new faces every few hours (as with intermittent care-delivery) then it may never happen...
> Ericka, Int. 3

Ericka is dissatisfied with the impersonal nature of intermittent care-delivery in midwifery as it impedes the development of humanistic relationships between women and midwives. Ericka explains how the system, as it is currently organised, presents a particular difficulty for midwives and women to achieve mutually defined goals:

> A lot of the difficulty comes from the actual system that is imposed upon women. You can feel pressured to make assumptions about the way women might feel...rather than get to know her...It's really a system that's inflicted upon her. A system where there is often no mutual exchange. It must be really difficult for women who are required to give a lot of information and personal stuff to different people all the time.
> Ericka, Int. 3

Ericka believes that the system is "imposed upon women" so that as a midwife she feels "pressured to make assumptions" about a woman's feelings and concerns rather than "get to know" what these feelings and concerns mean to her. Ericka identifies 'power' to be central to the way the hospital system is organised. As she says:

> What happens in that system rotates around power.
> Ericka, Int. 3

Ericka goes on to question the way the maternity services are

organised:

> I feel quite passionate about continuity of care and the Maternity Task Force (NZNA Consumer Survey, 1989) have seen that as a priority because that's what women want. Considering that's what women want and the legislation that makes midwives autonomous has come to fruition...it's amazing that there have been so few initiatives to begin to even look at providing continuity of care in the system for women...who don't choose to have a homebirth. That is the only other avenue...for women who want continuity of midwifery care...Choices have been really narrowed. Women who choose to have their babies in hospital should be...offered continuity in a similar way to women who choose to have their babies at home. Whilst some women do experience some continuity it's a bit hit and miss. That's the 'system'.
> Ericka, Int. 3

Ericka thinks that it is "amazing" that so few initiatives have been proposed to provide continuity of care for women within the hospital system. For Ericka, continuity of care is fundamental if midwives are to be self-determining practitioners:

> To be autonomous practitioners, midwives...need to practice continuity of care...to have an awareness of our sphere of practice...We loose out as professionals because we don't have continuity of care.
> Ericka, Int. 2

Other Structural Constraints

While intermittent midwifery care may disempower midwives and women, there are other structural constraints inherent in the clinical agency where Ericka works which she believes impedes quality midwifery care:

> There is a definite lack of resources which is more noticeable with further budgetary constraints. Much of the frustration experienced in the work area is directly related to a decrease in the allocation of funds.
> Ericka, Int. 1

The difficulties Ericka experience have much to do with lack of resources in midwifery, to budgetary constraints within a health care system which has a diminishing allocation of funds. Ericka reflects upon time constraints with the low staffing levels:

> Constraints of time is another frustration. Not being able to do the job you want to and are educated to do. I find

> that very difficult.
> Ericka, Int. 1

A diminishing health budget puts pressure on Ericka which conspire to decrease her personal and professional autonomy.

Reflection And Action

Ericka reveals her experience of participating in this study after the final interview when she had read the transcripts:

> You don't normally get that avenue to be able to articulate what you're doing. It questions and validates the things I believe in. It enables me to reflect on my practice. And because I have articulated it and put out in front of me in the open, I can see distinct possibilities for action. It's also been exciting to be on the cutting edge of midwifery research. It's been more time consuming than I thought it would be. It's been a positive experience. It's disseminated interest in all sorts of people both professionals and women. That is, women who came in contact with participants in the study were able to realise that midwifery was a profession in it's own right. It is important to be seen doing research.
> Ericka, Int. 4

Ericka states that by conceptualising and articulating her midwifery practice she sees "distinct possibilities for action".

Interpretive Summary

Ericka's practice is characterised by a practical reasoning which enables her to deliberate about the ends and means appropriate for women in the situations in which they find themselves. Rather than a routine application of propositional knowledge, her approach involves personal knowledge which she says is "mandatory" in practice as it "complements" rational ways of knowing. Personal or intuitive knowledge enables Ericka to make judgements which are specific to the particular practices and social context at hand. But, Ericka says, this knowledge is "often not acknowledged" as legitimate knowledge.

Ericka reveals a hierarchy of knowledge with propositional knowledge at the top and experiential ways of knowing, including women's knowledge, lower down the scale. As with midwifery, this is further

reflected by the greater "kudos" given to subjects such as mathematics and physics, or knowledge which is generated in a "detached and impersonal" manner, than subjects such as the liberal arts. Through critical dialogue, Ericka reveals power relationships which she believes are inflicted on to women by professionals who take an impersonal approach to midwifery practice. Rather than practice being an "exchange of knowledge" between women and midwife, she describes an approach where there is a one-way communication down to women from a "professional" who "knows what's best for somebody else." It is this approach which Ericka describes as "professional versus person" and which she believes is antithetical to developing a partnership with women.

Due to the differing relationship that Ericka believes exists between women and doctors as opposed to women and midwives, she adopts a mediating position between women and doctors when applicable. This practice rests on an assumption that women are powerless when they enter a hospital system and may be empowered through her mediating action. She suggests that both women and midwives would realise their own personal and professional autonomy through the organisation of midwifery team schemes which she sees as a priority to facilitate continuity of midwifery care.

Ericka believes midwives have been socialised into accepting, rather than actively creating, a hospital culture. She draws the conclusion that this is the reason why many midwives do not question a system imposing structural constraints on them. She upholds that there are symbols of power embedded in the system which serve to divide midwives from women and women from each other. However, while Ericka believes that hierarchically organised relationships and the hidden symbols reinforce dominant social relationships, hegemonic agency in the construction of the dominant ideology are not brought to task. In this sense Ericka is only partially able to uncover the power structures that function to impede her professional development and transformative action.

CASE STUDY FIVE: SARAH

General Introduction

Sarah had practised as a midwife for a period of eighteen months before participating in this study. Prior to graduating as a midwife, she had experience in nursing practice and completed a years full time university education. At the time of the first interview, Sarah had worked in the antenatal area for a total period of three months as a graduate midwife. This study demonstrates Sarah's understanding, experience and knowledge of midwifery practice. The themes that appear in **Part Two** of this thesis are grounded in Sarah's personal and professional knowledge as she engaged in reflexive dialogue with the researcher.

Midwifery In The Context Of A High Risk Pregnancy

In the area where Sarah worked during this study, pregnant women were admitted into hospital because they developed medical or obstetrical complications. As Sarah explains:

> Women in the antenatal ward need medical attention because they are there with a problem pregnancy...something is (medically and/or obstetrically) wrong.
> Sarah, Int. 1

Given the context of hospitalised antenatal care, Sarah explains how her midwifery skills enhances the effect of obstetrician or physician provided care:

> Women who are admitted into the antenatal area of the hospital are often long stay...They are often alienated from their husbands, families and communities...Their families may live a long way away. They've got to come to terms with the fact that there is something wrong and that they may not have a normal birth. This means they need a lot of support from the midwife. Rather than just going into their room and doing routine observations, like testing their urine or doing their blood pressure, you actually need to be skilled at counselling. The women are extremely sensitive to the situation they're in...and they need help to choose the best option from their particular situation. Just because they are going to have a highly technical approach to their pregnancy and birth does not mean that they have to lose their control in every situation. Their experience needs to

> be the best it can be for them. It's the way you handle the women in your care that makes a difference. Often you need time to spend with them.
> Sarah, Int. 1

Sarah articulates an individualised approach in her interaction with women who are experiencing isolation as a result of hospitalisation and medicalisation. Often women live a long distance from the hospital where Sarah works, and it is this distance which removes them from much of the strength derived from supportive relationships and familiar surroundings. Sarah's knowledge and skills make a difference to the way pregnant women experience and cope with their hospital stay. But women also help themselves by talking to other women. As Sarah explains:

> The women all talk amongst themselves...they're all comparing what's happening with each other. I think they need to do this to reaffirm themselves and to make sense of their own experience.
> Sarah, Int. 1

By sharing their own experiences with people who are experiencing a similar situation these women are able to find new meanings in a changed situation.

A Women-centred Approach

As a midwife, Sarah guides the taking on of new meanings. She therefore is a resource person who shares knowledge (power) with the aim of empowering women in her care. As Sarah explains:

> Working in this area...sharing knowledge is really important...When something is wrong women need to know what's available and they need to know what's going to happen to them. It's being alongside or 'with women' rather than above them. Midwifery is about sharing knowledge so that women are empowered because withholding knowledge is to be in a more powerful position.
> Sarah, Int. 2

Part of the way Sarah empowers women in pregnancy is through her 'use of self' as she interacts with women in her care. In the next extract, Sarah notes that women interact differently with midwives as opposed to doctors:

> Often women don't know what's happening. They don't ask the doctor what they are going to do. When you say to them "Why didn't you ask the doctor?" They say they didn't want to bother them. But they feel they can ask the midwife who mediates between the woman and the doctor when necessary.
> Sarah, Int. 2

Based on her observation that women interact differently with doctors compared with midwives, Sarah actively becomes an advocate for women in her care. She takes an active part in counteracting a sense of powerlessness which women develop as a result of being removed from support networks. This aspect of her practice is demonstrated in the following extract:

> A lot of women don't have basic assertiveness skills which narrow their options. They don't feel they can disagree with their care as prescribed by the doctor. If I'm there then there is a different dynamic. I can interpret and support the woman and say things like "Is there anything you'd like to ask?" or "Do you understand what the doctor has said?" A lot of the time women just don't ask when they're not sure what has been said by the doctor. Whereas if I'm there I can make sure they understand. It's a bit like being their advocate really.
>
> **Is this what being an advocate means to you?**
>
> Yes. It's making sure they understand what's going on. Sometimes they don't understand the medical terms or the language that the doctor uses. How can they make an informed choice if they don't have the knowledge about it?
> Sarah, Int. 2

'Advocacy' is interpreted as a woman's right to make decisions based upon informed choice. This interpretation reinforces a woman-centred approach to midwifery. Sarah endeavours to understand the meanings and concerns that are at stake in a situation so that she is in a position to be able to help women choose among alternative possibilities. This approach may be said to be women-centred as it is focused on an exchange of knowledge with the aim of sharing power (knowledge) with women in her care. In this way, pregnant women may be empowered to cope with the new situation they find themselves in.

<u>The Ascendency Of The Rational Way of Knowing</u>

In the following extract, Sarah compares a women-centred approach with an alternative approach to midwifery:

> Rather than being above women, midwifery is being with women.
>
> **What is 'being above' women?**
>
> By contrast medical knowledge is often elitist and hierarchical because it is not shared with women in their care.
> Sarah, Int. 2

Sarah suggests that the authority which underwrites medical knowledge is often elitist and hierarchical because the knowledge is not shared with women. In this way, a doctor is in a more powerful position than women in their care. In the following extract, Sarah suggests that some doctors do not value midwifery knowledge and skills:

> Some doctors expect you to drop what you're doing and carry out their instructions because they don't consider that what you're doing is as valuable as what they want you to do. They do not see midwifery knowledge as valuable. They often see us as just carrying out their orders...But I've learned to value my knowledge and skills...which are complementary to theirs.
> Sarah, Int. 2

Sarah views midwifery knowledge and skills as complementary to medical practice. This is in contrast to medical knowledge which she believes some doctors view as superior to midwifery knowledge. Some authors (Ryle, 1949; Pring, 1976) have pointed out that it is theoretical propositions (know-that) that have been the dominant way of knowing in Western society. This has been to the detriment of practical (know-how) ways of knowing. In the following extract, Sarah implies the 'expert' help is medical:

> I have a responsibility to give the best care for women...if we...undertake the care of someone who is high risk then in my opinion I need to intervene or get more expert help quickly...in some situations. So I ring the registrar rather than going through the house surgeon because this wastes valuable time. You undertake to look after women and you have a responsibility to make sure that they get the appropriate care.
> Sarah, Int. 1

Sarah indicates that she works collaboratively with the medical profession and she is conscious of the limitations of her own

knowledge as well as that of the house surgeon. Sarah is critical of some house surgeons practice:

> Some house surgeons don't see a vaginal examination as an invasive procedure. They see it as a clinical procedure, to collect their data about the state and dilatation of the cervix. But they don't seem to take into consideration how the woman might feel about it.
> Sarah, Int. 2

By engaging in critical dialogue, Sarah is able to see the limitations in the forms of consciousness that may give rise to invasive procedures that are incongruent with her own beliefs. Sarah describes how some doctors take a narrow clinical view of medical practice:

> Some medical staff...look at practice purely from a physical or medical point of view. Take hyperemesis. If a woman's showing ketones in her urine and is low in potassium, they will rehydrate her by putting up a drip...because there is clear evidence for them to act...But if I tell them something about the woman's social problems, they do not seem to take that into consideration...So I write my observations into the clinical notes so the doctors are aware of...the whole person, that is, not just medical or obstetrical problems to be solved.
> Sarah, Int. 1

Sarah's contribution to everyday midwifery practice may go unrecognised by doctors who are preoccupied with women's medical or obstetrical problems. Yet Benner (1984) has shown that practical knowledge, or "knowing-how" in practice, may elucidate scientific propositions or "knowing-that". That is, experiential knowledge, as part of practical knowledge, may challenge or extend knowledge ahead of scientific or medical propositions. Sarah explains how doctors do not see women's personal knowledge as legitimate knowledge:

> Doctors only believe objective tests. This is similar to their disbelief of a woman's dates (of delivery). A woman can be sure of her dates but the doctor will believe the scan before her opinion...
> Sarah, Int. 3

A woman's personal knowledge of her last normal menstrual period is a form of practical knowledge which is not trusted by doctors who resort to an ultrasound scan as 'necessary' evidence to estimate the expected date of birth. However, while increasingly 'necessary' routine tests

and technological monitoring schemes have permeated the maternity services, they have increased medical control over women in pregnancy and childbirth. Sarah alludes to this point:

> If the doctors want to do a caesarean section, a CTG (cardiotochograph) trace is taken to back up the reasons for doing it.
> Sarah, Int. 3

A cardiotochograph may be obtained by the medical profession as concrete evidence for performing a caesarean section. The dominance of a medicalised approach to maternity care has lead some pregnant women to question the need for medical intervention. As Sarah explains:

> Sandy wanted a homebirth but she had a bleed at 29 weeks. She came into hospital after she bled. The scan showed that she had a placenta praevia. The doctors wanted to do a few more scans during her pregnancy but she wouldn't let them. She had two scans in her whole pregnancy. That is really unusual in the management of placenta praevia, very unusual. She refused CTGs too because she does not trust medical opinion.
> Sarah, Int. 1

Sarah goes on to suggest that a woman's refusal to give permission for a series of ultrasound scans for a placenta praevia may be well founded:

> Sandy's interesting because she's got a grade four placenta praevia and she's got to 35 weeks gestation. Most women with placenta praevia don't reach that far on. This might have something to do with the fact that Sandy refused most scans. Midwives have noticed that when women with placenta praevia go for a scan they have a moderate to severe bleed two days later. One midwife, who has been working there for a long time, says that you can predict it by the clock. If the placenta is attached to the uterine wall, and they're busy sticking that ultrasound probe against it, then they may be dislodging it.
> Sarah, Int. 1

Sarah suggests that midwives' empirical observations and knowledge have been undervalued as they predict adverse patterns with some technological intervention.

The General View Of A Midwife

Medicalisation of the maternity services is reinforced through women's

general lack of knowledge with regard to the practice and responsibilities of a midwife. As Sarah explains:

> I have had to educate women about what a midwife is...A lot of women are not familiar with what your skills actually are...They have never been socialised to think that birth is a normal process. Whereas in Holland, the Dutch accept that when you are pregnant or giving birth you have midwifery care. They don't see a doctor unless they're referred by a midwife. In New Zealand that's not part of the socialisation process. Women here just don't see it like that. A midwife is sort of like a helper-nurse who helps the doctor by carrying out his or her orders. That's the general view.
>
> **How do women perceive birth to be in New Zealand?**
>
> Women...actually perceive birth to be a dangerous business and that something is going to go wrong and they want the best for their baby...And therefore they feel safe in hospital. They don't feel they can manage on their own to have the baby and they need to be told what to do. I think that there is a lot of fear instilled into them or they actually have a lot of fear.
> Sarah, Int. 1

Sarah suggests that the issue of safety may be used to reinforce the dominant medical ideology that women need to give birth in hospital and with a doctor present. Sarah goes on to explain how some midwives also accept this ideology without question:

> The midwives from different cultures, such as Malaysia and China...never question doctors orders. They follow doctors orders to the red letter because they accept that the doctor knows what is best for a woman. Their practice is based on a different philosophy. I find these attitudes frightening. They won't question the system because they're more concerned with getting it right or fitting in.
> Sarah, Int. 2

Sarah criticises midwifery practice which is based on a philosophy that is accountable to another professional body (medical) rather than to themselves or to mothers and babies.

Midwives Who Put-down Midwives

In the previous discussion, it is evident that Sarah believes that women have generally been socialised into believing that having a baby means that they need to go into hospital and that a doctor needs to be present. Some New Zealand midwives have also been socialised into

accepting a dominant medical ideology. Sarah gives anecdotal evidence for this:

> Some midwives put-down other midwives.
>
> **What do these midwives do when they put-down other midwives?**
>
> They make sure that midwives go along with their ideas which is a usually medicalised approach to midwifery.
>
> **So the midwife has to conform?**
>
> Yes. You have to. And they do things to make sure of it. Like they'll withhold knowledge. Or they'll give you too many patients to look after. Or they'll allocate the heaviest workload to the person who is being put-down...that type of thing, so you won't step out of line if you're clinically not up to it. I believe that it is oppressed people who put-down members of their own group.
>
> **Midwives do this in the hospital where you work?**
>
> Yes. It happens with some of the older charge midwives...particularly to the new midwives. They either just leave you when you are new or they make you do things through...control in getting people into line. That's the reason why there was a high turnover of staff.
> Sarah, Int. 3

Sarah identifies lateral violence in midwifery which is not conducive to establishing rapport between midwives as colleagues. Sarah explains the way this has affected her practice:

> We are responsible for our actions...but look at how the midwifery profession operates as a group in that organisation...It's army oriented...If you speak out and say what you think you may be penalised for it.
> Sarah, Int. 2

Sarah experiences a conflict between practising by the principles of her midwifery programme and those imposed upon her by a regimented bureaucratically organised system. She believes that if she was to "speak out" when working in an "army oriented" system she would be penalised for it. She therefore finds it easier to conform than 'rock the boat'.

Midwifery Education

Sarah reflects upon midwifery education:

> Our midwifery curriculum was good because it wasn't an objectives based curriculum. It wasn't concerned with doing so many tasks to pass as in midwifery courses of the past. We had tasks in our programme but they were minimal in their requirements.
>
> **Why do you see an objectives curriculum in an unfavourable light?**
>
> When the student has a concern with getting a number of tasks completed this becomes the main thing to achieve. Energy is not devoted to reflective and critical thinking because you're too busy just coping with the demands of the tasks or assignments. Our midwifery curriculum taught us to think about what was happening in the clinical area and why we were doing things. That is what the diary was for. The written work in the diary was shared with the tutors or sometimes with the class. I now see why they did that...
> Sarah, Int. 3

Sarah notes that the orientation of her midwifery course was generally different to previous midwifery programmes. She notes that past midwifery courses were procedurally oriented and therefore structured according to predetermined learning outcomes that students were required to meet. But as Sarah has said, the set objectives that the student had to accomplish "becomes the main thing to achieve" regardless of what is appropriate for an individual's learning needs. Sarah contrasts past midwifery courses to her midwifery programme:

> The emphasis in our midwifery curriculum was on attitudinal change rather than technical tasks.
>
> **What attitudes needed changing?**
>
> They were trying to empower us, so it was those attitudes that perpetuate non-assertiveness.
>
> **So the emphasis was on trying to empower you.**
>
> Yeah, I think so, before we could go out and empower women ourselves. There was a module on reflecting upon the midwife as a person. They really got you to look at yourself...And you looked at what your strengths were, and what you found hard, and how you coped with stress, and how you coped with confrontation, and ways of dealing with people. We had sessions on assertiveness. So you were forced to think about what your attitudes and values are and develop an awareness of where you are coming from...If you don't examine this you just operate out of what you've always done, or been conditioned to do, and you don't know the rationale for doing it.

Sarah, Int. 3

Rather than accepting the dominant ideology as given, Sarah's midwifery curriculum allowed for formal self-reflection through an examination of each midwife's self-image and professional image. As Sarah further explains:

> our class...was the first official midwifery class and a lot of the attitudes that we came into the clinical area with were new and challenging, particularly to some of the older practitioners who had been in the system a long time. Things like empowering women and informing them of the choices available is a simple thing but it was actually quite new.
> Sarah, Int. 1

Sarah states that the concept of 'empowerment' and offering women 'choices' was part of her midwifery programme and that the idea of partnership, which these concepts imply, challenged midwives who had been socialised into accepting the dominant ideology and forms of domination. Despite new knowledge, Sarah found difficulty practising within a hierarchically organised system:

> It's hard to be a change agent within the hierarchy. There are things that you have to do and can't do as you have to go through a set procedure. The bureaucracy is a way of keeping people in line...I don't see myself as an effective change agent as much as just coping with the system.
> Sarah, Int. 4

Sarah's awareness of forms of social domination was not always translated into praxis (refer to **Chapter Three**).

Vested Interests

As discussed earlier, some midwives use their authority to reinforce hierarchical relationships and to retain control of knowledge. That there are others who have vested interests in maintaining the status quo is suggested by Sarah:

> Society operates according to the economic laws of supply and demand. If there is a scarcity of resources then everybody has to compete with everyone else, including clients in the maternity services. I think that this is why the GPs are threatened by midwifery autonomy because they think their livelihood is at stake and midwives will take their work. The doctor stands to lose deliveries and care of the family.

Sarah, Int. 3

In the following extract, Sarah sees a marked difference between the maternity services available to women in the city where this study was undertaken:

> In one district the population is predominantly white and middle class and inclined to consider that to have optimal maternity care it is necessary to have a doctor. Whereas in the district which is predominantly working class and poor, the majority of births are attended by midwives...and the doctors actually support that...But in the more affluent area the GPs are very reluctant to let midwives have any part in an autonomous midwifery practice. It's interesting that there are those differences.
> Sarah, Int. 2

Sarah notes that there is a relationship between the socio-economic status of an urban population and the autonomy acceded to midwives. Sarah reflects upon the implications of the changed socio-political situation for midwives:

> There might be plenty of women to go around for everybody. But midwives might end up looking after the poorer end of the scale, the ones who can't afford obstetricians...as has historically been the case.
> Sarah, Int. 1

Sarah goes on to suggest that collective interests of any group in society may be generally threatened by competitive self-interests:

> It's...market forces that generally propels society. So people in private practice are likely to be driven by competitive self-interests that devalue collective interests.
> Sarah, Int. 3

Sarah alludes to the philosophy of extreme individualism that pervade Western societies and which affects professional attitudes to caregiving. This philosophy may be contrasted to a philosophy rooted in the centrality of interdependence and essential reliance on others. Reliance on others is evident in the following extract:

> Today the public attitude toward AIDS is such that we are probably one of the few groups of people that would ever consider looking after these people. I mean other people just would not do it. They would say that they are not going to handle anyone elses blood...We have ways of protecting ourselves but part of the ethic of caring is to be a bit

> selfless. **Is that altruistic?** Yes it is...
> Sarah, Int. 3

Sarah suggests that a concern for others may not be competitive with self-interest if it is grounded in an ethic of care and responsibility.

Work Constraints

Sarah had several experiences which demonstrated to her that there are externally imposed constraints on her midwifery practice:

> The postnatal wards are not fully staffed by midwives. There are a lot of enrolled nurses and staff nurses working there as it's not considered to be an area where you actually need to be a midwife which is wrong...This is reflected in medical attitudes as well. A lot more interest is paid to antenatal and intrapartum women. And postnatally, the problems of breast feeding or mothering skills are not considered to be as important. And...yet how women are treated postnatally is related directly to their mental health. Phillips (1983, Mothers Matter Too) has written a book about this. Mental health statistics show that as women feel positive and confident about their mothering skills they're going to bring up children that feel like that too. This area needs to be staffed by midwives.
> Sarah, Int. 3

According to Sarah, inadequacies arise in the postnatal area because of an assumption that knowledge and skills appropriate for nursing may be interchanged with those of midwifery. This assumption is reinforced through rigid protocols which in Sarah's view impose further constraints on midwifery practice:

> In a hierarchical organisation you are constrained by protocols that make you fit into the system. There are so many protocols to follow...I tend to ignore them.
> Sarah, Int. 2

Hospital protocols constrain flexible practice for Sarah as there is a tendency to make her "fit into the system" rather than to question the underlying rationale of protocols. Sarah goes on to identify the budget constraints which she sees are at the heart of staff and equipment shortages resulting in a heavy workload for midwives:

> Because of the budget constraints we are short of equipment and staff. A lot of the equipment gets stolen too I think...But it is sometimes expected that midwives should preceptor while at the same time take quite a heavy workload with the shortage of staff the way it is. The staff are just getting exhausted.
> Sarah, Int. 3

Sarah finds that her practice is constrained by a lack of resources within the public health care system as a result of budgetary constraints. In the following extract it is the allocation of resources in private practice which is brought into question. As Sarah explains:

> General practitioners would not employ practice nurses if the practice nurse subsidy wasn't there. They get 75% of the practice nurse's wages which means they pay one hundred dollars per week or 25% out of their profit for the practice nurse.
> Sarah, Int. 3

Part of the way the system operates is for the government to pay a practice nurse subsidy to general medical practitioners. Sarah explains how the medical profession has retained a position of advantage:

> Midwives have only just started to have a journal, which is good, but that's a monetary thing too. It costs money as does research. Other professions, such as the medical profession, have a lot more money for research and journal publications.
> Sarah, Int. 3

Sarah has identified limited resources for midwifery research and journal publications as a potential constraint on the development of midwifery knowledge.

Reflection And Action

The collaborative involvement of this study provided the conditions for critical reflection. When asked to reflect on her experience of participating in this study Sarah had this to say after the final interview when she had read the transcripts:

> I think that it's been a valuable experience to participate in this study...Often in your everyday life you are too busy to think about why you are doing something. You don't have the chance to do that. The research gives you the opportunity to sit back and reflect on practice and the conditions surrounding it...Other professions have research and have it above us because whether they are right or wrong, they can say that their research shows this or that. We've got no research. So it's really valuable to be part of it.
> Sarah, Int. 4

Interpretive Summary

Sarah's approach to women who are admitted into the antenatal area is women-centred. She believes midwifery to be "about sharing knowledge so that women are empowered because to withhold knowledge is to be in a more powerful position." Through critical dialogue Sarah gives evidence that there is an approach to women in midwifery which is contrary to what she considers is acceptable practice. She states that this approach is "elitist and hierarchical" and therefore not conducive to establishing rapport with women as it is accompanied by an objective, impersonal and "superior" view of knowledge. Thus, midwifery knowledge and skills are not viewed by some practitioners to be complementary with medical knowledge but as inferior and less "valuable". Sarah suggests the social philosophy of individualism may motivate practitioners toward self-interest and dominant forms of knowledge in preference to practice which is derived through an ethic of care and responsibility. She explains how hierarchical social relationships are perpetuated by midwives who adopt a colonised mentality and in so doing perpetuate individual and professional subordination. This situation is translated into lateral violence against their colleagues - practising midwives - as a result of a power imbalance.

Throughout the interviews, Sarah indicates that it was difficult for her to practice autonomously in a hospital setting. She attributes this difficulty to a hierarchically organised system with rigid protocols requiring her to "fit in" with the established order. For Sarah, this raises a contradiction between the liberatory principles which she gained from her midwifery course and those she found to be

operative in the everyday practice world. Sarah believes this situation to be compounded by several structural constraints imposed by those with vested interests to maintain the status quo. These contraints include: bureaucratic procedures, as a "way of keeping people in line"; equipment and staffing shortages, as a result of diminishing resources in the health care system; and structured inequalities in relation to the allocation of state funding to one group (doctors) over another (midwives).

Sarah believes that women perpetuate the status quo because they generally lack perception of the authority, status and skills of midwives. Sarah says the general view held by women is that a doctor is necessary at birth and birth should be in a hospital situation. Here the midwife is viewed as carrying out doctors' orders rather than as an autonomous practitioner in her own right. This in turn reinforces a medicalised system. Such a system is further reinforced through staffing of people in the postnatal area who are not midwives and therefore do not have the necessary knowledge and skills.

To conclude, Sarah is unable to openly question a system which she nevertheless recognises as oppressive.

APPENDIX 1

CONSENT TO PARTICIPATE IN RESEARCH

I.....
have had the nature and purpose of this study fully explained to me by the researcher. I have had the opportunity to discuss its implications to my satisfaction. I understand that the research process may result in changes to my midwifery practice. My permission to participate in this study is given voluntarily, and I understand that I may withdraw this permission at any time.

Signed.....Date.....

Witness.....Date.....

I agree to the use of a tape recorder to record interviews. I understand that I may stop the recording at any time, and the tapes will be for the exclusive use of the researcher and her supervisor. I understand that documents/tapes will be destroyed on the publication of this study.

Signed.....Date.....

Witness.....Date.....

APPENDIX 2

CONSENT OF WOMEN INVOLVED IN THE RESEARCH PROCESS

I.....
have had the purpose of this study fully explained to me by the researcher. Assurances have been given to me that if personal or identifying information is collected it will be treated as confidential and with anonymity. I also understand that I may choose to withdraw this permission at any time.

Signed.....Date.....

Witness.....Date.....

I am interested in receiving a copy of the research results on completion of this study.

Signed.....Date.....

Witness.....Date.....

APPENDIX 3

A NOTICE TO MIDWIVES

My name is Jocelyn Moloney. I am a Registered Nurse and Midwife at present working towards a Master of Arts degree, with a major in Nursing Studies, at Massey University.

I am currently undertaking research which focuses on midwifery practice. In particular, I wish to explore the relationship between knowledge and understanding based on everyday midwifery practice. I will be observing midwives' practice in a number of areas within the maternity services. In this process I am seeking to understand individual midwive's experience and reflections on their practice and will be engaging them in reflective interviews.

The study proposed will therefore consist of two parts:

Part A: observing practising midwives.
Part B: a series of interviews.

I wish to emphasise that I shall not be collecting any personal or identifying information about any woman, staff, or study participant, that no personal evaluation of performance is involved and that I am completely independent of hospital management. Any midwife who would like more information and/or may be prepared to participate in this project can contact me by telephoning:

(09) 861517

Thankyou in anticipation of your interest and cooperation.

Jocelyn Moloney

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