MIDWIVES' USE OF UNORTHODOX THERAPIES:

A FEMINIST PERSPECTIVE

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ABSTRACT

In New Zealand independent midwives are increasingly incorporating unorthodox therapies into their practice. This research studied the experience of metropolitan midwives using unorthodox therapies within the existing medically dominated maternity care system. It also explored the forces that facilitated and constrained midwives in their use of unorthodox therapies.

Feminist case study method was used to research the experience of five independent midwives who had integrated unorthodox therapies and practices into their midwifery practice. Their individual stories are related in separate chapters. Semi-structured interviews were used to gather the data which was analysed using the feminist concepts of power and gender.

Three key points emerged from the analysis. The midwives strongly believed that the way in which they used unorthodox therapies in their practice benefited and empowered women. Secondly, they had some concerns regarding knowledge of unorthodox therapies. Thirdly, the midwives who used unorthodox therapies felt professionally vulnerable within the bio-medical orthodoxy.

Feminist theory was used to analyse the data and enabled the researcher to place midwives' use of unorthodox therapies within a broader socio-political context. It is hoped that this may stimulate midwives to examine their own use of unorthodox therapies as well as provide the impetus to initiate change within both the bio-medical orthodox maternity system and alternative heath movement.

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CHAPTER ONE

INTRODUCTION AND OVERVIEW

This study was initially conceived when I began independent midwifery practice in 1994. As a new independent midwife, attending home as well as hospital births, I felt immediate pressure to expand my repertoire of unorthodox therapies. I realised I was not sufficiently resourced in this area. I had been a hospital based midwife, both overseas and in New Zealand, for 16 years before I entered independent practice. It was evident to me that there was valuable knowledge and skills amongst independent midwives - skills and knowledge that were not valued or used within hospital settings. I wanted to know what these midwives knew. I was also curious about what midwives' experiences were of using unorthodox therapies within the larger bio-medical system. What influenced their decisions to offer unorthodox therapies to women? These thoughts led me to think about the use of unorthodox therapies by midwives from a feminist perspective. It was difficult to find any feminist critique of unorthodox therapies. This made me wonder whether midwives were in danger of uncritically replacing one form of oppressive orthodoxy for another. A study was born.

STUDY CONTEXT

New Zealand midwives are at the forefront of innovative midwifery practice world wide (Page, 1995b). Independent midwifery is established within our health system. Midwives can take responsibility for the care of women throughout pregnancy, labour, birth, and the post natal period. We can choose to give women midwifery only care[1], or work in a shared care[2] arrangement with medical practitioners. Independent midwives have admitting privileges to maternity hospitals and limited prescribing rights. Midwives have pay equity with medical practitioners. Many midwives work

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1. Midwifery only care means that all the antenatal, labour and birth, and postpartum care is given by midwives.

2. Shared care is care for women that is shared between two practitioners, most commonly midwife and gp or midwife and consultant.

within the New Zealand College of Midwives (NZCOM) midwifery model of care that has as its cornerstone the concept of partnership between midwives and consumers. A sophisticated system of professional review for all independent midwives is in place[3]. Midwifery education programmes, which are creative and contemporary, recognise midwifery as being distinct from nursing. To obtain midwifery registration, women have the choice of either direct entry programmes or post registered nurse programmes. Post registration university studies are also offered in midwifery at the undergraduate, graduate and doctoral levels. Page (1995b) believes we are in a position of leadership in the worldwide community of midwives. Midwifery in New Zealand, however, has not always been this strong.

The 1904 Midwives Registration Act provided for the training and registration of autonomous midwives. However, as the 20th century progressed this autonomy was gradually eroded by the increasing political strength of obstetricians and their accompanying technology. By 1971 most midwives practised under the control of doctors in medically dominated hospitals. Consequently, when the 1971 Amendment to the Nurses Act legally ended autonomous midwifery practice and required that all births be supervised by a doctor, there was little reaction from midwives to this limitation of their practice. In most cases it made very little difference to how they had already been practising. From 1971 midwifery practice in New Zealand continued to be overwhelmingly controlled by the medical orthodoxy (Donley, 1986).

Despite this medical domination, in the 1970s, there were a handful of domiciliary midwives (midwives who attend homebirths) nationwide who were practising outside the obstetrically controlled hospitals. In Auckland, in 1974, there were two domiciliary midwives, Joan Donley and Carolyn Young, who each attended 50 homebirths each a year, although they also were required by law to have a doctor attend the birth. Domilicary midwives were paid by the Government but received a pittance for their work (a maximum of $76 per woman in 1975). They were seen as radicals by the medical establishment and received very little professional support. Nevertheless the demand from women wanting homebirths outstripped their ability to provide the services.

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3. The Auckland region of the College of Midwives annually reviews independent midwives' practice. This is done face to face. The review panel consists of 2 consumers and 2 midwives.

Consumers became their greatest supporters. By 1979 there were four domiciliary midwives involved in attending Auckland homebirths. They were now officially supported by the Homebirth Association that had been formed by consumers and domiciliary midwives in 1978 to combat the increasing medicalization of birth.

Domiciliary midwives used unorthodox therapies[4] in their practice and many of the women they attended wanted these alternatives to orthodox medicine. Donley (1992) mentions the practice of domiciliary midwives, in 1979, of putting breast milk in a baby's sticky eye and giving a brew of kikuyu grass[5] for a urinary tract infection instead of a course of antibiotics. The women planning homebirths during this period wanted and expected midwives to use unorthodox therapies.

Back in the hospitals the medical domination of midwives continued. During the 1980's, as the obstetrical control of childbirth in New Zealand grew, consumers joined together in other organisations throughout the country to fight the domination of midwifery by the medical and nursing professions. Groups such as the Save the Midwives Association and Parent Centre became politically active to raise the profile of midwives. Midwives also joined together and became politically active. In 1989 the New Zealand College of Midwives (NZCOM) was officially launched[6] . The NZCOM offered membership to both consumers and midwives thereby formalising the partnership between consumers and midwives that had developed over the previous 20 years. The NZCOM's major task was to continue the drive towards the independence of midwifery practice through amendments to legislation. The hard work of both the consumer groups and the NZCOM culminated in August 1990 when amendments to the 1977 Nurses Act gave midwives back their autonomy. At the same time midwives won pay equity with medical practitioners for comparable work. Suddenly it became

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4. See p. 7 for an explanation of the terminology used.

5. Couch grass

6. Previous to the NZCOM there had been a Midwives' Special Interest Section of the New Zealand Nurses' Association. The NZCOM was established separately from the New Zealand Nurses Association.

financially possible for more midwives to leave the institutions and work independently with their own case loads.

Not many midwives were ready for this challenge. Years of medical domination had effectively undermined midwives' skills, knowledge and confidence. Midwives needed to learn new and innovative ways to practice. They needed to learn to work within the midwifery partnership model. Very few hospital based midwives had had the opportunity to use unorthodox therapies within their institutions. Nonetheless, many midwives who left hospitals for independent practice had years of experience, supported women's choice for non interventional childbirth, and were very woman - focused in their practice. They came into independent practice eager to learn.

New Zealand Home Birth Association statistics show that 1146 women in 1994 planned a homebirth. Of these births 1013 occurred at home. All the 1146 planned homebirths are included in the following statistics whether they birthed at home or in hospital. Forty eight percent of women had no procedures[7] in labour. Although not an unorthodox therapy, it is still unusual (and therefore unorthodox) for women to have a non interventional labour and birth. Of those women who did have some procedure thirty two percent of women received homeopathics and 3.9 percent received acupuncture (New Zealand Home Birth Association Statistics, Spring 1995).

Although statistics on unorthodox therapies, other than acupuncture and homeopathics, used are not presently available, the 1994 revised New Zealand College of Midwives review form (Auckland region) asks independent midwives to include all the therapies they use. Under the heading 'complementary practices' midwives will be able to document their use of homeopathy, acupuncture, water, massage, herbal remedies, aromatherapy or any other therapy. Once this data is collated it will indicate what therapies independent midwives are using and how often.

However, I wanted to know more than the what and when. How were

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7. Procedures collated were acupuncture, homeopathics, TENS machine, pain relief drugs, epidural, artificial rupture of membranes (ARM), oxytocin augmentation, episiotomy, and sutured laceration.

midwives learning about unorthodox therapies? What was their experience? How did midwives feel about their practice? Did other midwives also feel pressure to know more about unorthodox therapies? Were women asking for unorthodox therapies? How easy was it to incorporate unorthodox therapies into a midwifery practice within the orthodox system?

I also had some concerns. From a feminist perspective the history of the bio-medical orthodoxy is a story of the increasing control of women's bodies by the male dominated medical profession and the systematic undermining of both the knowledge and practice of traditional women healers (Donley, 1986; Morgall,1993; Savage, 1986). I needed to know whether midwives, as they integrated unorthodox therapies into their practice, were looking critically at their practice. Were unorthodox therapies being substituted for orthodox therapies without any change to the underlying medical model? Were unorthodox therapies being used indiscriminately? Were they being used instead of good midwifery practice? In other words, I was interested in the process surrounding the use of unorthodox therapies, rather than what midwives used.

AIMS OF THE RESEARCH

1. To make visible midwives' experience of using unorthodox therapies in the existing biomedical orthodoxy.
2. To describe some of the common unorthodox therapies midwives find effective and use regularly.
3. To explore the facilitating and constraining forces on midwives' use of unorthodox therapies.
4. To analyse midwives' use of unorthodox therapies from a feminist perspective.

THEORETICAL FRAMEWORK

This research is concerned with the experiences of midwives using unorthodox therapies as they care for women, often within the constraints of biomedical orthodoxy. Although some authors (Cooter, 1988; Sakala, 1988) believe that the increase in interest in unorthodox therapies is partly due to the

resurgence of feminism, a feminist perspective on the use of these therapies is lacking in either the feminist, nursing, or midwifery literature.

The health system is a social structure which reflects the gender based organisation of our society with all its related inequities. Despite the fact that midwives work from a woman centred basis the reality is that they also work within the confines of the larger health system, which is medically controlled and patriarchal. Moreover, midwives' practice, formally and informally, is evaluated in at least two different ways - through the eyes of the medical model by institutional personnel, and by colleagues and consumers through the Midwifery Review Process. These two 'judges' often disagree about what is safe and informed midwifery practice. Such conflict leaves midwives carefully balancing their practice within the powerful biomedical orthodoxy.

While midwives practice from a different model than those in the medical hegemony, they are still largely dominated by the biomedical orthodoxy. Some midwives also offer unorthodox therapies to women who want them. Many of the unorthodox therapies offered are not condoned by the biomedical orthodoxy. Using unorthodox therapies in midwifery practice under these conditions provides an ideal opportunity for feminist research. Jaggar (1994, p.11) states

> Our commitment to ending women's subordination inevitably leads us to confront complex, multidimensional problems that require us to balance a variety of values and to evaluate the claims and interests of a variety of groups or even species, including a variety of groups of women.... This in turn requires us to commit ourselves to seeking as many different perspectives as possible... We must find ways of hearing the voices of woman muted in the dominant culture, and we must respond to these voices by giving special attention and weight to the concerns they express.

Midwives are women whose lives are worthy of examining as individuals and as people whose work is interwoven with other women.

I am a white, middle class, middle aged, feminist midwife. This research stems from, and is part of, my own life as a woman, a mother, and a midwife. My

personal experience has been the starting point of this study and I have drawn from it to develop the questions, find my participants, and make choices and decisions about the direction of the research and the conclusions. As my personal experience is relevant to the research, I have written this thesis in the first person. As much as possible I have also allowed the participants to speak for themselves with the use of direct quotes. Presenting research in one's own voice counteracts the study's pseudo-objectivity and is a distinguishing feature of feminist research (Reinharz, 1992b; Webb, 1992). I was an 'insider' of the experience I was researching. Reinharz (1992a, p.260) describes this as a new "epistemology of insiderness" that sees life and work as intertwined.

Childbirth is a feminist issue. The increasing use of unorthodox therapies in midwives' practice needs to be examined from a feminist perspective. All factors considered, a feminist approach seemed to be the most appropriate theoretical framework to use in investigating midwives' use of unorthodox therapies.

TERMINOLOGY

There are two labels used frequently throughout this research that require some clarification - unorthodox therapies, and woman/women. Unorthodox therapies, was considered, out of all the options, the most descriptive term to use in this research. This section gives background to that choice. The term woman /women can be problematic and so is discussed.

Unorthodox therapies

There is a wide variety of terms in the literature for therapies that stem from beliefs about the nature and causation of disease which are at variance with orthodox knowledge and practice (Aakster, 1989; Fairfoot, 1987; Gates, 1994; Jingfeng, 1987; McGinnis, 1990; Wolpe,1990). Prevalent terms used are alternative, complementary, marginal, traditional, indigenous, holistic, and quackery. Among these the two most common are alternative and complementary. Sometimes these are clearly defined as being different, often they are not, and are used interchangeably. Generally the term 'alternative therapy' is used when remedies replace conventional medical treatment and 'complementary therapy' is used when they work alongside conventional

medicine. Both these terms however, place the established medical system as the norm and define themselves in relation to it.

Terms used in the literature for our established medical system include conventional, patriarchal, regular, official, cosmopolitan, modern, biomedicine, scientific, westernized, and orthodox. Wolpe (1990, p. 914) uses the term 'orthodoxy' which he describes as any institutionalized ideology. Bio-medical orthodoxy controls the health care of the western world. This ideology believes that western, scientific conceptualizations of the body and bodily processes are the only legitimate means to understand physiological functioning and disease. It also tries to prevent competing ideologies from obtaining an institutional foothold. This institutional foothold that has been achieved by the medical profession, has been greatly assisted by legislation[8]. This legislation secured a monopoly by registered medical practitioners on certain practices, for example, full prescribing rights, hospital admitting privileges, and health insurance cover. Fairfoot (1987, p.384) contends

> Orthodox medicine and unorthodox therapies can be identified in society where there exists an occupational group whose job it is to apply therapeutic procedures to the sick and whose members display not only a high level of consensus concerning the causes of illness and appropriate treatments, but have also achieved legitimacy within that society as the approved healers.

This study looks at midwives' use of both alternative and complementary therapies. I shall use the term 'unorthodox therapies' to include both unless I am specifically differentiating between them. Although tempted to use the term 'patriarchal medicine' for biomedical orthodoxy I have decided not to as I suspect that some unorthodox therapies are also patriarchal.

Woman/women

'Second wave' feminism was based on the premise that the differences between women were less important than what united them - women are oppressed by men. Generalisations were made about women that ignored or

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8. Medical Practitioners Act 1968.

denied their different experiences of sexism and oppression. While this has led to division in the feminist movement, it has highlighted differences between women involving class, race, mobility and sexuality. These differences are now being recognized as important and seeing women as united by certain characteristics is treated as essentialist (Coppock, Haydon & Richter, 1995; Stanley & Wise, 1993). However, Stanley and Wise argue that at this period in time in Western culture, women *do* share certain kinds of socially constructed attributes and are subjugated to and by men. This, they argue, continues to make 'women' a legitimate 'object' of enquiry. In this research I use the word 'women'. However, I recognise the differences amongst us and acknowledge that 'women' does not mean all women.

OVERVIEW OF THE STUDY

This study researches midwives' use of unorthodox therapies. My interest in researching the use of unorthodox therapies by midwives' arose when I entered independent practice. The following chapters describe the process of this research. This chapter has placed the study in a historical and current midwifery context. Aims of the research and the theoretical framework have been described. Two frequently used terms - unorthodox therapies, and women were explained. Chapter two introduces, discusses, and critiques the literature relevant to this study. Chapter three reviews the method and methodology used. The five chapters from four to eight are the case studies of five individual midwives. The case studies are made up largely of the midwives' own words but have been organized by me into theme headings . These themes were validated by the participants. Chapter nine integrates the data from the five midwives' case studies. This data is examined using feminist theory including the concepts of gender and power. Chapter nine concludes by discussing the implications of the research for midwifery practice, education and research.

CHAPTER TWO

LITERATURE REVIEW

This chapter provides a literature context to add further background to the research. The increase in the popularity of unorthodox therapies generally is discussed. Midwifery and nursing literature pertaining to the use of unorthodox therapies is examined. Critiques of alternative health practices and particularly unorthodox therapies are sought within the feminist literature. The relation of unorthodox therapies to the bio-medical orthodoxy is explored as it provides an understanding of how the dominant medical culture views unorthodox therapies and the practitioners who use them.

THE INCREASING INTEREST

Unorthodox medicine has grown in popularity over the last 20 years (Himmel, Schulte, and Kochen, 1993; Murray & Sheperd,1993; Patel,1987). There are many reasons put forward for this increased interest. They include, the public's increasing tendency to question the practices and decisions of doctors and care givers, more people attempting to live more 'natural' lifestyles, the belief in the benefits of self-help in all matters concerning health, and consumers growing dissatisfaction with the technological and scientific dominance of modern medicine (Himmel et al., 1993; Murray and Sheperd, 1993; Tiran, 1988). Wolpe (1990) and Sakala (1988) believe this increase in popularity has come about in part as an outgrowth of feminism and other social movements of the 1960's, such as the peace and environmental groups. During the 1960's people were encouraged to explore such phenomena as Asian culture, altered states of consciousness, and herbs, and to question authority.

Orthodox medicine is fiercely resisting this trend to unorthodox therapies. Midwives and nurses, on the other hand, have welcomed this interest and are enthusiastically incorporating new therapies into their practice.

MIDWIFERY LITERATURE

Midwives are showing a huge interest in the use of unorthodox therapies. However, while there are plenty of articles about unorthodox therapies related to midwifery, there is very little published research. Unorthodox therapies are just beginning to emerge in articles that discuss supportive strategies in labour. My study looks at the use of unorthodox therapies by midwives. No similar study has been found in the literature, although there is literature that includes some of the aspects.

Three American studies are particularly relevant because they have looked at the unorthodox practices of independent (lay) midwives (Campanella, Korbin & Acheson, 1993; Sakala, 1988 &1993). Lay midwives practice outside of the bio-medical orthodoxy and often serve distinct religious or ethnic communities. Campanella et al studied pregnancy and childbirth among the Amish. While they did not focus solely on midwifery care, they described some of the herbal remedies that the midwives relied heavily on. However the taking of vitamins, herbs and teas are also a part of non-pregnant life for Amish women so this midwifery care is not viewed as unorthodox.

Sakala (1988) used grounded theory to study the content of the care that independent midwives gave to assist with pain in labour and birth in a fundamentalist Latter Day Saint community. The group of midwives studied were, because of historico-cultural traditions, exceptionally independent of bio-medical traditions. Sakala describes their practice as innovative. Their practice involved minimal intervention, a strong commitment to prevention and negligible costs for supplies, equipment, and facilities. Specific remedies and therapies that the midwives used are described throughout the paper. The article is exciting and inspiring to read. The midwives' content of care is contrasted to the bio-medical obstetrical model of care. Sakala concludes by recommending that these midwives' practices be formally evaluated for safety, efficacy, consumer acceptability, cost-effectiveness and their potential for favourable impact on the practice of medical obstetrics. The midwives in this study challenge our view of care in labour. Most of them described themselves as conservative and not politically involved, yet their practice is very unorthodox.

The second piece of research by Sakala (1993) was ethnographic and focused on midwifery knowledge and practice relating to circumstances that frequently result in the diagnosis of dystocia[1] in routine obstetrical practice. Independent midwives who worked in home settings, also in a community Latter Day Saints, were interviewed. As in her other study the midwives' practice was innovative, flexible, and women centred. The midwives' sources of knowledge were derived from, and oriented toward, women's childbearing experiences. They felt obstetrical sources of knowledge relating to dystocia had virtually no meaning to their understanding of childbearing and midwifery practice. Sakala suggests that obstetrical sources of knowledge, that are derived from extrinsic and extraneous sources, legitimates professional control and management and invalidates women's bodies and experiences and the process of birth. The stresses of working in such an unorthodox way within the larger bio-medical orthodoxy is not explored in any of these three studies.

Information sharing articles, usually on one particular modality are popular throughout the midwifery literature (Beal, 1992a, 1992b; Burns & Blamey, 1994; Dale & Cornwell, 1994; Fursland, 1992; Leigh, 1991; Schultze, 1994.; Smith,1991; Stapleton, 1993; Swinnerton,1990a, 1990b, 1991a, 1991b; Whitty,1993). These articles tend to be focussed on aromatherapy and acupuncture, and are usually written by a midwife who uses the therapy in her practice. Articles that provide a general overview of unorthodox therapies in midwifery practice often include guidelines for practice, reasons for their use, a summary of the available therapies, cautions, and a call for more research (Budd, 1993; Spiby,1993; Tiran, 1988). These articles are a useful starting point for midwives who are interested in incorporating unorthodox therapies into their practice. However they stop short of placing, and examining, the use of unorthodox therapies in the larger socio-political context.

The only two research articles I found on unorthodox therapies in the midwifery literature were on aromatherapy. Burns & Blamey (1994) describe the results of their six month pilot study using aromatherapy in a delivery suite, although they do not draw conclusions about the effectiveness of the aromatherapy. Interestingly, they note that both the women and the midwives

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1. Unacceptably slow or absent progress in labour as defined within the bio-medical model.

experienced a high level of satisfaction in using essential oils. Dale & Cornwell (1994) researched the effects of lavender oil on relieving perineal discomfort on women postpartum. They found no reduction of postnatal perineal discomfort. More midwifery research on particular applications of unorthodox therapies is urgently needed to add to our midwifery knowledge and enhance our use of unorthodox therapies.

Recent midwifery literature has dealt specifically with coping strategies and supportive care in labour (Dancy, 1995; Gagnon & Waghorn, 1996; Hodnett, 1996; Simkin, 1995 & 1996). Despite the growing interest, unorthodox therapies are not automatically included with the strategies used by midwives caring for labouring women. Two North American authors (Gagnon & Waghorn,1996; Hodnett,1996) looked at the supportive care maternity nurses gave women in labour. Neither of these articles include unorthodox therapies. While both articles stress the benefits to women of continuous labour support, the support discussed is very mainstream. On the other hand, Simkin (1995) describes a wide range of non pharmacologic, simple, effective, low-cost methods to relieve labour pain. Some of the methods suggested are not in orthodox use but she believes they are effective and should be taught to caregivers. Dancy (1995) discusses a broad list of coping strategies for women having homebirths. She includes homeopathic and herbal remedies. These articles provide a useful source of supportive care, both orthodox and unorthodox, to midwives.

The only piece of literature I found that investigated midwives' experience of unorthodox therapies was in a British book by Tiran and Mack (1995). It includes a section on midwives' attitudes to complementary therapies. Tiran and Mack interviewed 65 individuals, including midwives, on their attitudes to complementary therapy. The number of midwives interviewed is not specified, and the authors clearly state that these interviews do not constitute a researched study. They discuss some of the common themes the midwives spoke of. The midwives felt confused about the role of midwives and complementary therapies, especially what were they 'allowed' to do. It is not explicit whether these midwives were hospital or community based. Some of the midwives were concerned about their lack of competence to give advice, and lack of time to incorporate complementary practices into their routine

practice was identified as a major problem. The majority of midwives interviewed would have liked more training and knowledge in complementary therapies. They were also concerned about the qualifications of practitioners, and midwives' accountability, when they made referrals to other practitioners. Overall, most of the midwives were open and interested in the use of complementary therapies. They felt complementary therapies belonged in midwifery practice, and were not concerned how these therapies would be received by the doctors. However, we do not know enough about the midwives areas of practice to make a direct comparison with the midwives in this study.

In New Zealand very little has been published on midwives' use of unorthodox therapies. Yet courses run especially for midwives, by homeopaths and acupuncturists are advertised in midwifery journals. Herbal remedies, homeopathics and essential oils are sold through the same pages. Midwives are obviously using these products, attending the courses and practising what they learn. The Auckland Home Birth Association has published a useful guide to healthy pregnancy and childbirth. This publication suggests a wide variety of unorthodox remedies and treatments for women to try should they need. This book which is used by both midwives and consumers is user friendly and well referenced (Auckland Home Birth Association, 1993).

There has been no research to date related to midwives' use of unorthodox therapies in New Zealand. Despite this lack of New Zealand literature, recent New Zealand midwifery and childbirth conferences reflect in their programmes the growing interest of both midwives and consumers in these therapies. Workshops given by experienced practitioners have featured aromatherapy, homeopathy and acupuncture, and chiropractic care (Anthony, 1993; Donley, 1994; Funnell, 1994; Hudson,1993; Muller, 1994; Nash, 1993).

While most authors advise more qualitative research into unorthodox therapies, they stop short of suggesting a feminist approach. However, there is an urgent need to include a feminist perspective on our use of unorthodox therapies in midwifery practice. A general review of the feminist health literature provided little that dealt directly with unorthodox therapies.

FEMINIST LITERATURE

Although some authors believe that the increase in interest in unorthodox therapies is partly due to the resurgence of feminism, a feminist perspective on these therapies is sadly lacking in either the nursing, midwifery, or feminist literature. In a brief paragraph at the end of her book on feminism and women's health care, Webb (1986) comments that homeopathy, acupuncture, and other 'holistic' treatments can be as exploitative to women as orthodox medicine. This is the only feminist reference I have found that deals specifically with critiquing homeopathy and acupuncture. Unfortunately this idea is not explored further. Moreover, a thorough review of recent feminist journals found only one reference that dealt specifically with alternative therapies. However, there are some debates about other areas of women's health that offer interesting ways to look at unorthodox therapies.

Celia Kitzinger (1993) examines psychology in the light of the feminist slogan 'the personal is political'. She argues that psychology personalises the political turning social, economic, and ecological concerns into individual psychologies. Empowerment depends on a radical split between the personal and the political fostering revolution from within at the expense of political change in the outside world. Furthermore, by solely validating women's experiences it ignores the social and political factors that shape experience. Therefore, she utterly rejects psychology, claiming that feminism and psychology are not ethically or politically compatible. Some of the same arguments are useful when examining the use of unorthodox therapies by midwives.

Morgall (1993) addresses the consequences of medical technology in the context of women's lives. The issues she addresses are relevant also to the introduction and use of unorthodox therapies for women. They include the realities of dominance, control, knowledge interests, and conflicting values. Non critical approaches to medical technology assessment aim to promote quick social adjustment, whereas a feminist approach calls for an analysis of domination as a means of preventing exploitation of one group by another.

Wilkinson & Kitzinger (1993) examined alternative advice and treatment given

to women with breast cancer through self help books and tapes. They argue that because women often feel powerless in the hands of the medical profession, they turn to the alternative, self-help movement as it appears to offer them a measure of control and power over their lives. They believe the basic argument of self help is that we give ourselves cancer because of unhealthy attitudes, personality, or behaviour - and that we can get rid of it by developing positive thinking and /or a healthier lifestyle. They state that these tapes indulge in victim blaming of the highest order and they offer a spurious illusion of power over illness, indeed over all aspects of life. Kitzinger (1993) believes that alternative medicine's attempts to get people to take individual responsibility only reinforces such a victim-blaming approach, and ignores societal, economic factors.

Schilling & Fuehrer (1993) and Simonds (1992) also examined the politics of self-help books and reached similar conclusions. They believe the books offer internal explanations for social conditions and that individual change strategies are proposed that ignore social and economic arrangements. Simonds believes self-help books only offer an illusory cure. Sethna (1992) analysed self-hypnosis tapes that targeted women. She calls these tapes new age neo-feminist and believes they are dangerous and noxious to women. Once again they seemingly empower women but ignore the patriarchal structures which intersect the listener's experience.

Unfortunately these discussions did not explore the alternative health movement further than looking at self help books and tapes. While unorthodox therapies have been left largely unexplored by feminist writers, pregnancy, childbirth and motherhood have been widely critiqued.

FEMINISM AND MIDWIFERY

Feminist writers in the social sciences, and within midwifery, have explored the issues surrounding pregnancy, childbirth and motherhood. However, the most influential writings in the popular press have been written by social scientists (Kitzinger,1988a, 1988b, 1991; Rich,1976; Rothman,1982, 1996). Their writings have strongly influenced the way women have viewed childbirth and motherhood, resulting in women demanding changes within the maternity

system. These works all include perspectives on midwifery and midwifery practice looking at the issues of patriarchy, power, and control.

There is a paucity of feminist midwifery literature. That is not to say that there are no midwives writing challenging and thought provoking material. Quite the contrary, but it is not explicitly feminist. Reinharz (1992) believes that some (social policy) feminists deliberately do not mention their feminism to circumvent the prejudiced response many people have to the word. I believe the same could well be true for midwifery.

McCool & McCool (1989) present a historical overview of feminism and nurse-midwifery in the U.S.A. They suggest that while childbirth is often an exciting and joyous event, it also presents issues of power and control which have deep social and political ramifications. They urge nurse-midwives to evaluate the midwifery profession and its future within a woman-centred perspective. The reality of practising as a feminist midwife in a hospital setting has been described by Kirkham (1988). Kirkham writes from her own experience and suggests ways feminist midwives can enhance their practice and obtain support from one another. Homebirth has been studied from a feminist perspective (Bortin et al.,1994). They believe that a feminist qualitative research approach recognises the centrality of women in birth. I would add it also recognises the importance of midwives in caring for birthing women.

Two New Zealand midwives have contributed to a much needed feminist critique of midwifery in New Zealand (Donley, 1986; Fleming, 1995). Fleming's pioneering feminist-critical study analysed some of the concepts on which midwifery in New Zealand has based its practice. This analysis showed how midwives and clients develop ways of co-creating the experience of childbirth within but around the all pervasive medical structures. She recommends further studies, using similar theoretical frameworks, to further document the strengths as well as the social, political and historical barriers which may constrain midwifery practice. Joan Donley is a midwife who fights tirelessly for birthing women, childbirth choices, and midwives. She is a central figure in New Zealand maternity care and has consistently and radically challenged the status quo for many years.

NURSING LITERATURE

Nursing interest in unorthodox therapies is high. Complementary therapies appear to be the preferred term in the nursing literature. In 1993 a special edition of a large nursing magazine focused solely on complementary therapies (Nursing Times, 1993). This was in response to the growth of interest by nurses in complementary therapies which the magazine claims has "outstripped all other areas of nursing" (p.4).

The nursing literature consistently argues for a research based approach to unorthodox therapies. Although there is general information sharing, the commentary articles stress the need for, and some suggest how, nurses can initiate research on unorthodox therapies (Byrne, 1992; Gates, 1994; Osbourne, 1994). All authors recognize the lack of research on the topic. Byrne stresses it is the responsibility of all nurses to examine the research that is available and to produce the data where this does not exist. She acknowledges that quantitative methodology can be used in some cases but the majority of unorthodox therapies will also require qualitative evaluation.

Gates' (1994) review of the literature also leads him to conclude that there is a relative scarcity of controlled experiments related to alternative and complementary therapies. Despite the lack of empirical evidence, he does not believe nurses should reject complementary and alternative therapies. Rather, he suggests they should review the literature before taking careful and reasoned action.

The integration of complementary therapies is described by Rankin-Box (1992) within orthodox nursing care as an exciting and stimulating challenge. She calls for a standardisation of training courses in complementary therapies for nursing practice, a need for accreditation, and the development of a research base. In 1988 Rankin-Box edited a book about a selection of complementary therapies that she believes had the potential for complementing or enhancing nursing care. Each chapter gives an overview of the historical background and the principles behind the selected therapy. She stresses that complementary therapies fit into the holistic approach to nursing demanding a shift in our perception of current health care. However,

this book does not offer any critique of the therapies.

Pfeil (1994) suggests that many nurses see complementary therapies as improving the quality of life for patients, despite the lack of 'hard data'. While encouraging research into complementary therapies, he poses the question, that if it is possible to accept that pain is what a patient claims it to be, then it should be possible to accept that wellbeing is also what the patient claims it to be.

Overall the nursing literature has embraced the integration of unorthodox therapies into nursing practice. There is an obligatory call for more research included in every article but the general sense one has of reading the nursing literature is that the use of unorthodox therapies will grow regardless. While authors caution nurses in aspects of accountability and safety, there does not seem to be any critical debate about the use of unorthodox therapies.

The increasing demand for unorthodox therapies by consumers is challenging the bio-medical orthodoxy. Their response, while varied, is overwhelmingly self protective and disparaging. This is the orthodox bio-medical context that independent midwives often work within or alongside. From the literature it appears as if midwives and nurses have not taken the same defensive position as doctors. On the contrary, both professional groups seem to have welcomed unorthodox therapies into their practice. There is a huge amount of interest in the different modalities and although caution is advised, there is not the sense of threat one perceives on reading the bio-medical literature.

MEDICAL LITERATURE

The increase in interest in unorthodox medicine has fuelled reactionary responses from the medical fraternity worldwide. Medical articles discussing unorthodox therapies tend on the whole to be disparaging (Baker, 1992; Cole, 1992, 1993; McGinnis, 1991). McGinnis (1991, p.1788), an American doctor who addresses unorthodox therapies in relation to cancer treatment, describes them as "questionable, ineffective, fraudulent, dubious, and unproven". He states the increasing interest in unorthodox therapies is due to "an anti-establishment, anti-intellectual, anti-medical climate, with an

increasingly mobile, rootless population". Paradoxically, later in the same article he acknowledges that it is affluent, well educated persons who want to take care of their health, who use unorthodox therapies. He concludes that there is no documented information that any of the unorthodox therapies are helpful and much documented information on the harmful effects. This, of course, is because he places all his belief in the scientific method and no value on "emotional, anecdotal, or testimonial" reports (p. 1791).

Orthodox medicine demands that unorthodox practitioners prove their therapies scientifically before their treatments will be accepted (B.M.A., 1986, 1993; Cole, 1993; McGinnis, 1991). However, it is argued that the scientific method is not an appropriate method for proving unorthodox therapies. It is highly likely that unorthodox therapies do not fit into the scientific paradigm and will never be 'proved' this way (Jingfeng, 1987; Patel, 1987; Tan, 1989). Jingfeng states "an overall and impartial evaluation of AM [alternative medicine] cannot avoid the theories for that system. Since the theories of AM are based principally on ancient philosophy, it is not realistic to assess and investigate by disregarding them" (p. 665). If, however, these practitioners can prove scientifically that their therapies do work, we can be sure orthodox medicine will incorporate these practices into their medicine. Regardless of whether unorthodox therapies fit the scientific paradigm, there is public demand for them and bio-medical practitioners have had to respond.

Orthodox medical associations have reacted to the growing public demand for unorthodox therapies. It is interesting to see how the British Medical Association (BMA) has done an about turn regarding unorthodox therapies in the last decade. A 1986 BMA report claims bio-medical medicine's credibility and dominance in healing, as opposed to therapies which do not "base their rationale on any theory which is consistent with natural laws as we now understand them" (British Medical Association, 1986, p.1407). This report was criticised at the time as validating modern orthodox medicine while largely being "antagonistic towards and/or dismissive of the therapeutic claims of the unorthodox" (Fairfoot,1987, p.385). However, in 1993 the BMA published another report that represents a reversal of the original stance (British Medical Association, 1993). It recommended that priority be given to research into acupuncture, chiropractic, herbalism, homeopathy, and osteopathy. It also

suggests that familiarisation courses of non-conventional therapies be included within the medical undergraduate curriculum. This dramatic change of position from the orthodoxy in seven years shows how, although lagging behind their patient's needs, the B.M.A. are responding to consumer pressure. Wolpe (1990) however, would describe the change as a political response to a heretical attack.

Doctors who use unorthodox medicine challenge the bio-medical orthodoxy and are described by Wolpe (1990) as heretics. They threaten the orthodoxy precisely because they are of the orthodoxy. He argues that this implies a political stance and therefore cannot go unanswered by the orthodoxy. Depending on the level of threat, strategies used to suppress challenges in the past have included cooptation (acupuncturists), isolation (chiropractors), subjugation (pharmacists), absorption (osteopaths), or suppression (midwives) (p.922). It is the heretics that particularly concern Cole (1992, 1993).

Cole (1992, 1993) writes frequently on issues of New Zealand medical conduct and has a particular interest in the medical profession's use of unorthodox therapies. Cole is concerned that registered medical practitioners who are scientifically trained are using 'fringe methods'. He believes ethically that "a profession proud of its scientific heritage might therefore ask a doctor providing fringe therapies to cease practising as a registered medical practitioner" (p. 132). He warns that doctors who have moved away from convention, believing they are serving their patients well, are espousing concepts that are scientifically unsound and not supported by peer experience. However, there is growing evidence that patients of orthodox doctors also want to be offered the option of unorthodox therapies.

Several authors have studied the use of unorthodox medicine in general practice (Himmel, Schulte, and Kochen, 1993; Murray and Sheperd, 1993). Himmel et al. surveyed both patients and doctors and concluded that while both patients and doctors were interested in complementary medicine, nearly 70% of the patients requested that it be practised by their general practitioner (gp) more frequently than at present. Murray and Sheperd questioned patients only, and found a substantial number of them used alternative

therapies. They also found that these patients were frequent gp attenders with higher rates of chronic disorders. Furnham and Forey (1994) compared attitudes, behaviours and beliefs of patients of conventional and complementary medicine. They found that there were definite differences between the groups' health belief systems. Although patients of unorthodox practitioners were more critical and skeptical about the efficacy of modern medicine, they were drawn to the alternative practitioners because of their health beliefs, rather than being pushed because of their dissatisfaction with conventional medicine.

Recently two books by renowned medical authors have given their support to the use of some unorthodox therapies. Enkin, Keirse, Renfrew, & Neilson (1995) have systematically reviewed data in order to provide a guide to effective care in pregnancy and childbirth. In their evaluation of non-pharmacological methods of control of pain in labour they include acupressure, acupuncture, aromatherapy, water, massage and hypnosis. While they recommend that the effectiveness of these methods still needs to be fully evaluated, they recognise that some women find them useful and therefore they are worthy of further investigation. Wagner (1994) has published the recommendations of the World Health Organisation Perinatal Study Group, which were made by consensus, in his latest thought provoking book. "During delivery, the routine administration of analgesics or anaesthetic drugs that are not specifically required to correct or prevent a complication in delivery, should be avoided"(p.158). He recommends that consideration should be given to trying other kinds of intervention before resorting to pain relief medication in labour. Suggestions are made to use therapies such as reflexology, acupuncture and acupressure, hypnosis, massage, music and water. While supporting the role of unorthodox therapies in labour and childbirth, they have not included their use in relation to pregnancy or the postpartum period.

While there is indication that some unorthodox therapies are acceptable among the bio-medical orthodoxy, there can be little doubt that the medical establishment feels challenged by unorthodox practitioners both within and outside the orthodoxy. Fairfoot (1987) and Wolpe (1990) both agree that as long as the unorthodox practitioners are not numerous or powerful enough to

mount a serious challenge against orthodoxy, they may be allowed to continue as a boundary testing system. While unorthodox practitioners are denied the secure status of the orthodoxy, the orthodox practitioner's position is not seriously challenged.

SUMMARY

Unorthodox therapies have become more popular and are being used increasingly by midwives. Midwives are attempting within their practices to offer women choices from both unorthodox and orthodox medicine. While midwives in New Zealand have autonomy of practice, they still work largely within the confines of the medical orthodoxy. The bio-medical orthodoxy remains critical of unorthodox therapies and is demanding that they prove themselves in scientific ways or forever remain marginalized. This marginalization of unorthodox therapies perpetuates the subordination of the practitioners of these therapies.

Increasing the care options available to women by introducing unorthodox therapies during pregnancy and childbirth appears to be a positive experience for both midwives and the women they care for. However, the use of unorthodox therapies generally, let alone by midwives, has not been adequately critiqued from a feminist perspective. Our failure to examine the use of unorthodox therapies in this way could lead us to replicate some of the power and control issues in the existing bio-medical system. Feminism can provide midwives with the framework to investigate the subordination of women, midwifery and midwifery care within the context of our society and particularly within the confines of our medically controlled and patriarchal health system.

CHAPTER THREE

METHODOLOGY AND METHOD

The use of unorthodox therapies by five midwives has been researched using feminist case studies. This chapter discusses the methodology, method and data analysis used in this research. Harding (1987) defines methodology as a theory, or analysis, of how research does and should proceed, and method as a technique for (or way of proceeding in) gathering evidence. The methodological stance of this research is introduced by briefly reviewing feminist theory and discussing the epistemological basis for this research. The case study method used in gathering the data is outlined. Finally the data analysis is reviewed.

METHODOLOGY

Feminist Theory

Feminism has been defined as a world view that confronts systematic injustices based on gender (Millet, 1970). This white, western, middle-class view of feminism has come under increasing challenge in the last decade (Maynard, 1994; Stanley and Wise, 1983). Women from third world countries (Gimenez, 1994), women of colour (Crenshaw, 1994; Lutz, 1993), lesbians (Hoagland, 1988) and working-class women (Lillie-Blanton, Martinez, Taylor, & Robinson, 1993) are challenging feminist theory and practice that prioritises gender over other social divisions, and that represents all women as members of the same oppressed group, unified by their experience of male domination. Many feminist writers are now placing more emphasis on the differences between women, rather than the ideal of universal sisterhood. There is a more sophisticated understanding of the relationship between race, class, and gender (Doyal, 1995).

As the second wave of feminism[1] began, feminists developed differing theories within feminism. The four most known theories are liberal feminism, Marxist feminism, socialist feminism, and radical feminism. Today these are

1. Second wave feminism is identified as starting with the publication of The Feminine Mystique by Betty Freidan in 1963.

under challenge. New and complex theories are continuing to evolve. These include African-American feminism, lesbian separatist feminism, essentialist feminism, existential feminism, psychoanalytic feminism, and post modern feminism (Rosser, 1992). Despite their diversity, all feminist theories would agree that the main issue of feminism is to address injustices involving women. They see gender as a significant characteristic that interacts with other characteristics, such as race and class, to structure relationships between individuals, within groups, and within society as a whole. With the exception of liberal feminism, most feminist theories reject the neutral objective observer for a social construction of scientific knowledge (Rosser, 1992).

Epistemology influences the design and methodological stance of feminist research. "An epistemology is a theory of knowledge which considers what kind of things can be known, who can be a knower, and how (through what tests) beliefs are legitimated as knowledge" (Rosser, 1992, p.536). Second wave feminism developed its own epistemologies as a consequence of women's attempts to explain the world from the perspective of our own lives. Three feminist epistemologies appear regularly in the literature: feminist empiricism, feminist standpoint theory, and feminist post modernism (Allen & Baber, 1992; Harding,1987; Hawkesworth, 1989). These three epistemologies provide the current basis for the ongoing, complicated debate about the nature and status of feminist knowledge and are continually evolving. However, even these authors do not regard the three feminist epistemologies as absolutely distinct.

Feminist empiricism is based on positivism and follows the mainstream scientific practices of experimentation, observation, and recording. Feminist empiricists maintain that androcentrism and sexism are identifiable biases of researchers that can be eliminated by stricter application of existing methodological norms.

Feminist standpoint theory reflects the view that women occupy a social location that affords us a privileged access to social phenomena. It rejects the notion of an unmediated truth, instead claiming that class, race, and gender structure a person's understanding of reality. Its expression varies from the

idea that women come by nature or social experience to be better equipped to know the world than men, to the idea that a social science for women must proceed from a grasp of the forms of oppression women experience.

Feminist post modernism questions the claims of a single truth or reality. It is committed to plurality, tolerance of differences and regards class, race, age, family status, and sexual orientation to be as important as gender. It challenges and exposes existing beliefs and concepts that are accepted as natural.

The split between liberal and post modernist feminism, and the critiques of white, middle-class feminism by women of colour and lesbians, creates new problems and opportunities for feminist theory and practice. This discussion provides an ongoing and stimulating epistemological debate in the literature amongst feminist theorists. There is recognition that there are deep divisions among feminists as to which epistemology should prevail (Harding, 1987; Hawkesworth, 1989; Jaquette,1992; Olesen, 1994; Rosser, 1992). Stanley and Wise (1993) and Olesen (1994) recognise that while we do not have to agree with other people's positions, we do need mutual respect between different feminisms. In fact rather than have the hegemony of one form of feminism over another, they support the need for diversity.

This research is based on standpoint theory. Standpoint theory was chosen because it stresses the view that builds on, and from, women's experiences in everyday life. Postmodernism was rejected because it eschews generalisations and emphasises deconstruction, which leaves it only a limited role in challenging patriarchal structures and promoting social change (Maynard,1994). As feminist empiricism follows the standards of the current norms of qualitative inquiry, it was not considered (Hawkesworth, 1989).

Bunkle (1992) contends that in New Zealand many of the attempts by the women's health movement to move medicine to a more 'patient-centred' practice are made from a feminist standpoint position. However, as with the other positions, there is ongoing debate about the standpoint position amongst scholars and there are still areas of contention (Harding, 1991; Hekman,1992; Maynard, 1994; Stanley & Wise, 1993). This research

incorporates some of the ideas from the ongoing debates amongst feminist theorists into its stance, particularly those propositioned by Stanley and Wise (1993).

Standpoint theory believes that if we start off our research (our experience) from women's lives as these are understood through feminist theory, we will be more likely to arrive at less distorted and more complete knowledge claims than if we start off only from the lives of men in the dominant groups (Harding, 1990; Jaggar, 1994). However, Stanley and Wise (1993, p.228) argue that the judging of some knowledge over other knowledge as superior is ethically objectionable. They suggest some knowledge is more preferable than other knowledge in that it fits with a proponent's experience of living, being or understanding. They argue that feminist knowledge is rooted in women's concrete and diverse practical and everyday experiences of oppression. It is situated specific and local to the conditions of its production and thus to the social location and being of its producers.

Standpoint theory insists that the knower and the known are inseparable, thus challenging the Cartesian separation of self from the world and of the analytic from the personal. Stanley and Wise (1993) and Jaggar (1994) add that emotion is vital to systematic knowledge about the social world. In this research reason and emotion are not polarised. Emotion is not seen as a second class source of knowledge, and the participants are seen as feeling, experiencing 'subjects'.

Knowledge production is a crucial part of power. It becomes part of a political process where some knowledge claims are seen as superordinate to others. If we accept Stanley & Wises's idea that all social knowledge is generated as a part and a product of human social experience, we must reject ideologically derived theories of knowledge as there is no way of moving outside experientially derived understanding.

Feminism is a political movement for social change which addresses injustices against women (in all their differences and similarities). Jaggar (1994) has used a very broad definition of feminism that identifies it with the various social movements whose goals are dedicated to ending the

subordination of women, however they conceive it [subordination]. It is within this context of feminism that my research is placed. There are specific feminist research principles that inform the study.

Feminist research principles

Certain principles are unique to feminist research. These principles identified by a number of authors are: viewing women's experiences as important by using them as suitable 'problems' and sources of answers; designing research *for* women; and placing the researcher on the same plane as the subjects (Acker, Barry, & Esseveld, 1983; Allen and Baber, 1992; Duffy & Hedin, 1988; Hall & Stevens, 1991, Harding, 1987; Leach, 1993; Webb,1984).

The first principle puts women centrally, valuing and validating their experience in its own right. It recognises that the questions asked or not asked determine our picture of the world. The questions researched are often political, in the way that they look at understanding the dominant world forces and ways to neutralise those forces.

Designing research *for,* rather than only *of,* women is the second major principle. The goal of the inquiry is to provide explanations of social phenomena that woman want and need. The knowledge produced can be used by the women themselves. It benefits women. Research for women must also be emancipatory with an ultimate goal being the end of social and economic conditions that are oppressive to women.

Thirdly, feminist research places the researcher in the same critical plane as the subjects. The researcher should either study a group that is similar to herself and her own place in society or a group that is in a higher socioeconomic group. She needs to be as visible as the participants by explaining her gender, race, class, and culture in the research report. Feminist researchers must be self-reflexively gender sensitive about their own perceptions, knowledge, and biases and be willing to share these with the research participants during interaction.

Feminist research is women centred, grounded in actual experiences, and closely related to social change (Webb, 1994). It is characterized by

interaction between researcher and participant and non-hierarchical relations. The research must have the potential to help the participants as well as the researcher (Seibold, Richards, & Simon, 1994). Feminist researchers deliberately seek challenges to their own assumptions. Research which is designed for women intends to provide explanations of social and biological phenomena that women want and need. It has emancipatory potential, enabling those researched to reflect upon the social and economic conditions that are oppressive to women. It is self-reflexive, collaborative, attuned to process, orientated to social change and concerned with the empowerment of women. Rather than rely on traditional concepts, feminist researchers are using new ways to conceptualise and evaluate rigour.

Reliability and Validity

The criteria by which the quality and usefulness of research are judged must be their effectiveness or potential for improving women's lives. Maynard (1994) suggests rigorous research means being clear about one's theoretical assumptions, the nature of the research process, the criteria against which good knowledge can be judged and the strategies for interpretation and analysis.

Hall & Stevens (1991) have suggested specific criteria by which to evaluate feminist research. They state that feminist researchers have had few guidelines regarding reliability and validity issues because the standards used in traditional studies do not evaluate feminist research well. They draw on a number of texts to identify criteria that assist rigour in feminist research. An explanation of reliability and validity in feminist research follows. This thesis is evaluated using these criteria.

The two major criteria developed by Hall and Stevens (1991) are Dependability and Adequacy. Dependability increases if different investigators using similar analytic procedures perceive similar meanings. This differs from reliability in the empiricist tradition as it does not decontextualize the data. Dependability can not be assessed in this instance as there are no other similar pieces of research.

Adequacy is the term they use to replace reliability and validity and implies

that research processes and outcomes are well grounded, cogent, justifiable, relevant and meaningful. To achieve Adequacy the following criteria are identified: reflexivity, credibility, rapport, coherence, complexity, consensus, relevance, honesty and mutuality, naming and relationality.

Reflexivity fosters integrative thinking, appreciation of the truth, awareness of theory as ideology, and willingness to make values explicit. This has been attempted throughout the research process. The afterword contains my self-reflexive reporting of the whole research process. Credibility means that the research report interpretations are validated by the participants and believability is assessed by other feminist researchers. Individual case study interpretations were validated by the participants. The entire first draft of the thesis was read by two feminist scholars. Rapport is a criterion of adequacy reflecting how well participants' reality is assessed. The participants have commented on this at the end of their own case study.

Coherence indicates a unity in the research account from all observations, records, responses, and conversations involved. The research is coherent. Complexity in feminist inquiry means rejecting standardisation for exceptions and including the experiences of many differently situated women. This small study does not include the experiences of many differently situated women, but does research the experiences of midwives who are practising in a 'non standardised' way. Consensus looks for the emergence of recurring themes in the data while still noting complexities. Recurring themes did emerge from the data, although the specifics of these themes were often different. Relevance directly relates to the level of critical activism in the study. This research did not directly produce change or activism in the midwives. However, all the midwives felt it had caused them to critically reflect on their practice.

Honesty and mutuality mean the research must be open and mutual without hidden agendas. My assumptions and biases are made explicit at the beginning. Naming addresses women's lives in their own terms and generates concepts through words that are expressive of women's experience. The participants are able to speak for themselves in their case studies through the use of direct quotes. Connection with the reader was a goal therefore I used direct quotes to help the reader understand her own

behaviour and that of others. The data analysis is written in a way that is clear and accessible to clients and midwives. Finally, relationality includes collaborative working methods both with other scholars and the research participants. The themes that were generated from the data were collaborated on with the participants on two occasions. It was participatory, there was openness, reciprocity, mutual disclosure and shared risk. As this is a Master of Arts thesis I had to work alone, albeit with the support of other scholars.

Feminist researchers, therefore, incorporate a critical stance into all methods (techniques for gathering evidence or data) of traditional research. Method helps the researcher find out what she wants to know. It is not necessarily attached to one's philosophical position and does not drive assumptions. However, for this research feminist case study has been chosen as the method. The methodology described, influences the way case study method in this research is used.

METHOD

This section describes how case study method was used in this research. Details are given of participant selection, ethical considerations, data collection, and data analysis.

Case Study

Yin (1984, 1993), Wilson (1989), and Reinharz (1992) have described the purposes of case studies. Yin (1993) states that case study method is appropriate when investigators desire to define topics broadly and not narrowly, cover contextual conditions and not just the phenomenon of study, and rely on multiple and not singular sources of evidence.

According to Wilson (1989) case study design is useful in gaining insight into little known problems, providing background data for the planning of broader studies, developing explanations of social-psychological and social-structured processes, and offering rich descriptive anecdotes or examples to illustrate generalised statistical findings.

Reinharz (1992) believes the three major purposes for feminist case study are

to analyse the change in a phenomenon over time, to analyse the significance of a phenomenon for future events, and to analyse the relation among parts of a phenomenon. She continues that feminist case studies usually consist of a fully developed description of a single event, person, group, organisation, or community. It is a method which vividly documents aspects of women's lives and experiences that would be lost in other methods.

Midwives' experience of using unorthodox therapies has not previously been researched. Case study seemed an appropriate method because little was known about the area of research. The topic was broad and could not exclude the context in which the midwives worked. The research provided an opportunity to analyse the way midwives' use of unorthodox therapies is significant today, and to contribute a base for future study. This research is important not only for New Zealand midwives but globally for all midwives. Because New Zealand leads the world in innovative midwifery practice we have a responsibility, as we learn and change, to document our experience for the benefit of others. This research also provided rich descriptive data to illustrate the statistical findings, that are now being documented[2] , on what unorthodox therapies midwives use.

Descriptive multiple-case study

Case studies can be single or multiple and can be exploratory, descriptive, or explanatory (Yin, 1993). This is a descriptive multiple-case study.
Multiple case studies include two or more 'cases' within the same research. Five participants, rather than a single participant, were chosen for this research as I believed there could be replication of findings between the participants. Yin (1993) states that replication of findings over multiple cases and even multiple studies can be considered a very robust finding. However, Reinharz (1992a) believes case studies look for differences as well as similarities. According to her, case studies, both single and multiple, typically look for specificity, exceptions, and completeness rather than generalizations. This research, therefore, also looks for, and acknowledges, the differences between the midwives' use of unorthodox therapies.

Descriptive case study was chosen from the three types of case studies,

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2. The NZCOM midwifery review process is collating these figures for 1995.

exploratory, explanatory, and descriptive, as the most appropriate type for this research. An exploratory case study aims to define the questions, hypotheses, or feasibility of a research procedure in a subsequent study. An explanatory case study presents data that focuses on cause-effect relationships to explain which data causes which effects. A descriptive case study presents a complete description of a phenomenon within its context, with description as its main objective (Yin,1993).

Both Yin (1994) and Wilson (1989) agree that there is a need to define the unit of analysis. The design of the case study, as well as its potential theoretical significance, is heavily dominated by the way the unit of analysis is defined. The unit of analysis in this study is the experience of five proficient independent midwives who use unorthodox therapies. The midwives work both in home and hospital settings. They were interviewed over a three month period.

Kenny and Grotelueschen (1984, p.38) have identified the parameters by which case studies may be identified. They are: data are qualitative; data are not manipulated; studies focus on single cases; ambiguity in observation and report is tolerated; multiple perspectives are solicited; holism is advocated; humanism is encouraged; and common and /or non-technical language is used.

The major disadvantages identified with the case study method are lack of definition (Wilson, 1989; Yin,1994), problems with generalisability (Stenhouse, 1988; Wilson,1989), and researcher bias (Wilson, 1989). This study is well defined through participant selection, limited time frame and subject. It is acknowledged that generalizations are limited to like cases. However, other domiciliary midwives may find a focus in the report for their own ongoing critique and reflection of their practice. Researcher bias has already been addressed under feminist theory (refer p.29). Feminist research values the subjective experience, considering it paramount to the research process. It rejects the assumption that maintaining a strict separation between researcher and research subject produces more valid, objective research. In fact, feminist scholars point out that quantification, although linked with objectivity, has its own inherent biases and distortions (Cook & Fonow, 1986).

Case studies provide a method to vividly document aspects of women's lives and achievements that would be lost in other methods. They also provide the raw data for future secondary analysis and future action on behalf of women (Reinharz, 1992). Feminist case study seeks to understand the commonalities and the differences in the midwives' experiences and look specifically at the relationship between gender and power on and in midwives' practice.

Participant selection

Five experienced independent midwives who practised both in home and hospital settings, and who used unorthodox therapies, were asked to participate. All of the midwives were already known to me, through professional networks, although I had not worked closely with any of them. They were approached personally by me and the background to the study and the reasons for my interest were explained. They were given the opportunity to ask questions about me and the study. Questions asked were mostly about the process of the research and the end result. They were then given an information sheet to read (Appendix one) and I called them one week later to ascertain their interest in participating in the study.

The first five midwives approached were keen to participate. They all thought the topic was interesting and very relevant to their practice. The study generated interest among friends of these midwives. Several of the participants also mentioned other midwives, whom they had spoken to, who had expressed an interest in being part of the study.

While, of course, there is diversity amongst the participants, it is a small group and I deliberately chose participants who tended to be homogeneous and similar to myself. They all practice independent midwifery in a large city setting. I observed that all the participants were white, middle class, middle aged, able-bodied women. I did not deem sexual orientation of the participants to be relevant to this study, therefore it was not asked about, nor did I make assumptions.

Ethical considerations

Permission for the study was sought and obtained from the Massey University Human Ethics Committee. The following ethical concerns were considered.

1. Consent. Midwives were contacted in person. Those interested in participating were given a full explanation of the study. The time involved, the nature of the study and the possible implications were discussed as fully as possible. A follow up phone call a week later indicated their willingness to participate in the study. Written consent was obtained at the first interview and the participants were made aware that they could withdraw from the study at any time. In addition verbal consent, recorded on tape, was obtained at the beginning of each interview. Transcripts of the interviews and draft reports were returned to the participants.

2. Confidentiality. Participants were asked for permission for interviews to be taped. The participants were aware that this permission could be rescinded at any time. Tapes were accessible only to the researcher and her supervisor. Individual tapes were returned at the completion of the research to the participants. Transcribed interviews on computer ware were stored in a locked cabinet in the researcher's home. Pseudonyms, chosen by the participants, are used in written reports and in the final thesis.

3. Reciprocity. Reinharz (1992, p.264) states " to the extent that part of the ideology of feminism is to transform the competitive and exploitative relations among women into bonds of solidarity and mutuality, we expect assistance and reciprocated understanding to be part of the research/subject relation." This study involves reciprocity between myself and the participants. The interviews permitted a two way exchange of information which promoted interaction between myself and the participants. All the participants thought the research was meaningful. Participants were able to remove, add, or edit any material from the data or transcripts. My thesis is based on these edited transcripts. The case study chapters consist largely of quotes from the participants that have been organized into broad themes. Participants commented on and validated their draft chapters. Conclusions reached from the data were shared with the participants.

Data collection

Reinharz (1992) states that research methods in feminist case studies span the spectrum of literary analysis, surveys, archival research, interviewing and others. This study used semi-structured taped interviews as the method of data collection. Semi-structured refers to a research approach whereby the researcher plans to ask questions about a given topic but allows the data-gathering conversation itself to determine how the information is obtained. Open ended questions maximise discovery and description, exploring women's views of reality. It provides nonstandardised information that allows researchers to make full use of differences among people. We hear what women have to say in their own words.

I took the following list of questions with me to each interview.
What do you consider unorthodox/alternative/ complementary?
When do you use them?
Why are you using them?
What is different about them?
How do you decide what to use?
Hospital /home difference?
Where did you learn about them?
Is there pressure to use them? From whom?
Is there pressure from orthodox medicine?
Are midwives challenging the medical orthodoxy?
What support do you have, information sharing, etc. among other midwives?
What have been the repercussions you have experienced as a result of using these therapies?
Do you think midwives are overusing these therapies?
Are they individualised therapies?
Are they empowering to women?

I did not ever intend to ask each and every question. Rather they provided an overview of the topics I wished to cover. Where I did ask a question, the participants indicated, by the time they spent talking about it, whether or not that it was a relevant question to their practice. Participants often led the interview in their own direction of interest about unorthodox therapies.

Moreover, I did not define 'unorthodox therapies' for my participants preferring instead to hear their own interpretation of it. Consequently the interviews included discussion about both unorthodox therapy and unorthodox care.

I spoke to each midwife individually about the research prior to the taped interviews. Each midwife was interviewed, on tape, twice and had the opportunity to comment on the final draft of their chapter (see Appendix 2). Multiple interviews have the potential for developing trust, the opportunity to share interview transcripts with the interviewee and invite the interviewee's analysis. They are more likely to be more accurate than single interviews because of the opportunity to ask additional questions and the opportunity to get corrective feedback on previously obtained information.

Four of the midwives were interviewed in their own homes and one midwife was interviewed in her rooms. The interviews took an average of one hour each with a range between 45 to 90 minutes. The midwives were encouraged to provide examples and anecdotes.

Data was collected using feminist principles. I studied women with whom I already had a bond. I was learning from, not learning about, these midwives. They also had the opportunity to learn from me. Each woman's experience was valued and validated in its own right. I interacted with the participants during the interviews, sharing my perceptions, knowledge and biases. Individual interviews were taped. I personally transcribed all the interviews and sent copies of her own transcript to each participant.

DATA ANALYSIS

The data was analysed throughout data collection using case study analysis. An examination of the integrated data was done using feminist theory and the concepts of gender and power.

Case Study

Yin (1984, p.112) presents several important strategies for analysing case studies. He states it is important initially to have a general analytic strategy, whether that is based on theoretical propositions or a basic descriptive framework. Yin suggests the researcher has a basic descriptive framework

for descriptive case studies. The descriptive framework that I used allowed a chapter to each participant to tell her story. Within that chapter I organised the data around general common themes that occurred across the five participants.

From the basis of this general strategy, Yin suggests a choice of three effective specific strategies to be used; pattern matching, explanation-building, and time-series analysis. He warns that none of these strategies are easy to use. The specific analytic strategies that Yin suggests are all based on predicting outcomes prior to the data collection and then comparing them with the empirical data. Outcomes were not predicted in this descriptive research, therefore these specific strategies were not relevant. However, the general analytic framework organized the case studies by identifying common themes and contrasting similarities and differences as sharply as possible. Feminist theory, and in particular the concepts of gender and power, was then used to examine the integrated data.

Analysis of the data involved returning transcripts of the interviews to the participant for her input. At the second interview the participant had an opportunity to make any additions, deletions, corrections, or qualifications to the first interview that they wished. All the participants expanded on what they had originally said. We also clarified and validated data from the initial interview based on the themes I had found in the initial analysis of data. I asked women to comment on how well these themes fitted their own experiences. In this way we shared our overall analysis of the first interview and came to an agreement that reflected what the participant believed had happened. Meaning therefore was constructed in negotiation with the research participants. This avoided my taking control of the participants and provided a sense of connectedness.

Individual case studies were returned to the participants prior to the final draft for their validation and their comments have been added to each chapter. This provided participants with an opportunity to check that no material by which they could potentially be identified was included and a further opportunity to comment on the accuracy of my interpretations. I deliberately worked toward producing case studies that were as free as possible of my

analytical voice. My interpretation of the data is limited to the organisation of the midwives' direct quotes under recurring theme headings. These quotes are interwoven with my statements. I believe the unmediated voices of the midwives have the potential to dissolve differences between the reader and the speaker (Marcus,1986).

The completed thesis will also be viewed by, and discussed with, each participant as all of the midwives have expressed interest in seeing it. Their ideas of where and how the research could be most usefully used, and expanded upon, will be gathered at this point.

Gender and power were the central feminist concepts that were used to examine the integrated data. The pervasive influence of gender divisions on social life is an important defining characteristic of feminist research, in relation to patriarchal power and control. The health system is a socially structured experience that reflects the gender based organisation of our society with all its related inequities. Despite the fact that midwives work from a midwifery (woman centred) model the reality is that they also work within the confines of the larger health system, which is medically controlled and patriarchal.

Gender

Gender is learned behaviour that meets social expectations associated with being female or male. The differences between the sexes are seen to be the source of gender differences. Within these gender differences the sexuality of a female, or male, is clearly defined. Gender divisions are sustained through a process of genderisation and within this there is hierarchy of sexuality (Coppock, 1995). However, Torres (1992) argues that gender must not be treated as an individual characteristic or difference but as a matter of social relations and power. Likewise, MacKinnon (1987) believes in the idea of gender as dominance, rather than difference and that the difference defined as sex difference only becomes important as a consequence of power.

The need to continuously and reflexively attend to the significance of gender and gender asymmetry is a basic feature of feminist research. Gender is an integral part of the research process, not just something to be studied. I am a

gendered being and I recognize this influences my interpretations and analysis (Cook & Fonow,1986). Therefore it is necessary to be reflexively open and honest about the research process (Maynard,1994).

Women and their experiences are the focus of my inquiry. The researcher, the participants and their clients are all women. Obviously I have a concern with generating data that comes from the perspective of women. However, the relationship of women to men also needs to be analysed so we can understand how women's experiences in a male world are structured. Stanley and Wise (1993) are of the opinion that all feminist theories minimise the complexities of actual relationships between women and men, which may, in particular times, places and situations undermine or even reverse elements of oppression and the supposed powerlessness of women.

Power

Standpoint theory positions women subordinate to men although the specifics of that subjugation differs. This view of power has been challenged (Jones & Guy,1992; Stanley & Wise, 1993; Torres, 1992). These authors view power as shifting, uneven, and context-dependent rather than inherent within categories of people. They see it as contradictory and variable. While they do not deny that power is played out and experienced in gendered-patterned ways, they also argue that simple dualisms, for example men/women, heterosexual/lesbian, don't explain the variability of power.

Power is lived out in uneven and fragmented ways between different categories of people but it is also variable within the experience of one individual. Jones & Guy (1992) see a conception of power which is variable, resisted, and productive, as well as dominating, as a more optimistic and empowering approach than one which divides and makes power both invariably oppressive and personal. It places power in a historical and structural context rather than a personal one. Power can be understood by looking at its operation in specific contexts but its basis in local and variable patriarchal, capitalist and colonial formations must not be forgotten.

Coppock (1995, p.43) believes the concern to theorise power within the structural and institutional relations which subordinate women and the

development of knowledge which analyses power and its dynamic impact on the lives of women, have done much to deconstruct patriarchal and essentially masculinist paradigms.

This study analyses midwives' use of unorthodox therapies by identifying and comparing themes both within a midwife's practice and between the midwives. It uses a feminist analysis which includes the concepts of power and gender. As a result of this feminist examination, I found I generated more questions than I provided answers. These questions are scattered throughout the analysis.

SUMMARY

This chapter has outlined the methodology, method, and data analysis on which this study is based. Bryar (1995, p. 211) states "qualitative research ... has the potential to uncover people's real feelings about their lives, their midwifery care or, for midwives, to describe the reality of being a midwife". This study seeks to describe the reality of being a midwife using unorthodox therapies in a bio-medical orthodox system through a feminist case study method.

INTRODUCTION TO DATA

Chapters four to eight are the stories of each of the five participants who were interviewed. Each of the participant's stories is presented in a separate chapter. I have let the participants speak for themselves with a minimal amount of commentary, although I have organized their stories into theme headings.

I drew out what I interpreted as the major themes from each of the first interviews. These themes came from reading and rereading each of the participant's interviews. I then discussed these themes with the participants at the second interview. The themes were commented on, and validated by the participants at the second interview. The themes developed and subsequently changed after the second interview. At this point I compared all the participant's themes and found some similarities occurring between participants. Where similar themes occurred I gave them identical titles. The four broad themes that occurred throughout all of the interviews were: integrating unorthodox therapies into practice; the political context; reflection on practice; and resources. These four themes occur in some, but not all, of the midwives' stories. In each midwife's chapter these broad themes have been divided into sub themes. Sub themes highlighted some of the differing concerns and issues that surfaced from the midwives' interviews. This does not necessarily mean that any, or all, of the other midwives would not hold a similar view. Rather the differences reflected the trail that the interview took with that particular midwife on that particular day.

It is important to realise that these themes are broad and not distinct. I recognise that there are many areas of overlap between themes. Many of the sub themes relate to one or more of the broad themes but for ease of reading have been placed in the category that seemed most fitting. Although I have chosen a theme heading of 'reflection on practice', it is acknowledged that the interviews were in and of themselves a reflection on practice and all the themes include reflection. I have used the heading 'reflection on practice' when midwives reflected on their practice about areas that were not included in the other broad theme headings. Feminism is not reductionist and this

theme allowed me to relate the full range of experiences that the midwives reported, even though the experiences did not fit into distinct themes.

Participant's stories were written into draft chapters. I have written my commentary throughout the stories in the present tense, to complement the storyteller. Each participant read her own draft chapter and gave me feedback. The chapters were altered accordingly. Some of the participants were not concerned about being identifiable and chose not to change distinguishing facts. As much as possible I have tried to relate this process of validation in each individual's chapter summary.

Throughout the following chapters I have used the word 'women' in a specific way. The key people in this research are all women; the researcher, the participants, and their clients. However, for clarity I have differentiated between them, using the general term 'women' for the midwives' clients, as it is the term used by the midwives themselves for their clients. Therefore, in this study woman/women means client/s of the midwives. Clients are the women who receive care from midwives. Midwife/midwives means midwife/midwives including the midwives who participated in this study. Participants are the five midwives whose case studies appear in this thesis. Within these categories difference is acknowledged and generalisation is not assumed.

Chapter nine presents an integration and synthesis of the data.

Key to case studies

Participant's speech is indented in bold type

... Material edited within a sentence
. ... Material edited between sentences
[ ] Editorial comments to clarify speech

Numbers following quotes. For example, 1203-2 is number 1203 on the audio tape of interview 2.

CHAPTER FOUR

JUDITH'S STORY

BACKGROUND

Judith has been a Midwife for 17 years. Her practice was hospital based for the first seven years but she has been a Domiciliary Midwife for the last ten and a half years. Judith stepped out of the orthodox midwifery system in 1984 at a time when there were few other practising domiciliary midwives and where there was little support for domiciliary midwives either financially or physically. Although a sole practitioner providing a complete maternity service, Judith met sporadically with other domiciliary midwives to share information and as a form of peer support. She now has a formal arrangement with a group of midwives who hold similar philosophies. They share premises and resources and cover days off and sick leave for each other. While she is a member of the College of Midwives, she does not use them for support or involve herself politically. With the introduction of hospital access agreements for independent midwives, Judith once again began to include hospital births into her practice. Her current full time practice is 75% homebirth and 25% hospital birth. However, she would prefer to attend homebirths full time.

Judith and I have known each other for many years. We worked together in the early 1980's in a hospital delivery suite. I deliberately chose Judith as the first participant to interview because I already had some shared history with her and this helped ease my initial researcher anxieties. Even so, Judith's first interview was the most structured of all the interviewing I did. The interviews with Judith lasted approximately 45 minutes each. They were audio recorded in her home with minor interruptions from her children.

The common therapies Judith uses in her practice are homeopathy, herbal remedies and acupuncture. Although she does not practice cranial osteopathy herself, she occasionally refers women to cranial osteopaths. She sees these therapies as **'part and parcel'** (034-1) of her practice. Her knowledge of these therapies has accrued over the years from various

sources but has come mostly from other midwives and attendance at courses.

Judith does not consider the therapies she uses unorthodox and uses the term 'complementary' rather than alternative. However, she adds

> **I would see any therapies as unorthodox if they were used inappropriately, and that includes conventional therapies. ... I had a woman who wanted to give birth in the sea and I consider that very unorthodox** (219-2).

This chapter is organised around four major themes that ran through Judith's interviews; integrating unorthodox therapies into practice, the political context; reflection on practice, and resources.

INTEGRATING UNORTHODOX THERAPIES INTO PRACTICE

At the end of the second interview Judith made the following comment:

> **When you ask midwives these questions it is quite likely you are going to get the midwives' philosophy about why and how they practice. When you ask me these questions you are asking me about my philosophy** (942-2).

In the process of talking about her use of unorthodox therapies Judith felt she had shared her philosophy of practice. This is in large part because she could not isolate her use of these therapies from her overall practice. Unorthodox therapies are an integral part of her midwifery care. However, while Judith uses unorthodox therapies the emphasis in her practice is on understanding who each woman is and looking at her in her life context. Understanding, and ultimately empowering, women in her care are the central issues on which Judith bases her use of unorthodox therapies.

Understanding

If problems surface during a woman's care, Judith's initial approach is to find out, with the woman, what it is in the woman's lifestyle that could be

contributing to the problem and what the woman can learn from the process. Only then will she decide, with the woman, whether an unorthodox therapy would also be helpful.

> **Someone is coming to see me at the moment and they are getting bad indigestion and they have had it for each pregnancy. This is the third one. And I've suggested that she take Slippery Elm[1] , which she says has helped. But I also know that she spends an hour plus putting her other two children to bed and she has to get up at night because one of the children has recurrent UTI's [urinary tract infections]. So she has to do the night time thing, overnight. ... She could restrict how long it takes to get the two kids to bed, or get her husband's help. And then she'll have more time to herself and I don't think she would have as much indigestion. Because what she has said to me is that 'I get so angry and then I get more indigestion'. You know why you get angry, you know what happens to your stomach when you get angry. So I believe there is another component to it. I mean you can treat her from the outside but there is something happening within her that she won't or can't take responsibility and say 'I want space here, you guys have got to go'. The upshot is that with the third child she will be forced into that situation and it will be uglier than if she tried to do it gently now. I've talked to her a lot about that and I think her indigestion is a lot to do with that, and that she doesn't feel supported** (206-1).

Judith actively engages her clients in their own care by first exploring with them their lifestyle for potential solutions and then, if necessary, discussing a variety of therapies including unorthodox therapies. Hence her clients have an opportunity to become involved in and responsible for their own health.

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1. Slippery Elm is a herb that is known to be soothing to the digestive system (Weed, 1986).

Empowering women

Alongside understanding, Judith encourages women to adopt healthy lifestyles and expresses her belief about, and confidence in, women's bodies to do the job of childbearing. She believes her style of practice enables women to feel confident to rely on their bodies.

> **Ultimately it** [using unorthodox therapies] **has to be empowering. And the way I practice is designed to be like that. It is designed for people to become responsible and know that they can make a difference. It is empowering in that sense** (1200-1).

So although Judith has skills in acupuncture and believes it will **'tonify and uplift people'** (394-1) she doesn't offer it to every woman.

> **I don't use it on every woman. I could do, but I'm not trained to be an acupuncturist. The other reason I wouldn't use it is that I don't want to alienate people. I want them to learn to be confident to rely on their bodies ... I wouldn't use it unless we were already having a conversation about it and they were enthusiastic about it and believed in it** (465-1).

Judith conveys her deep respect for, and belief in, women and their ability to birth. Through her style of practice she helps women gain confidence in their own bodies before they consider outside therapies. Thus when considering introducing unorthodox therapies Judith describes a process that involves the woman and takes her individual situation into account. This also includes Judith evaluating her own skills and assessing the need for outside support.

RESOURCES

Judith is very willing to ask for advice or to refer women on to specialists in their field. Throughout the interviews she talked about looking up remedies, using books as resources, asking other midwives for ideas, and referring to specially trained therapists.

Use of resources

The process Judith goes through to decide whether or not to use a particular therapy is complex. For instance if a problem occurs in labour Judith uses every resource at her disposal to change or alleviate a problem.

> **I'll get my books out and look up remedies. ... My decisions would be dependent upon the woman. But I don't have any difficulty. A lot of it is bringing fresh energy into the situation. Like we don't seem to be making any progress here, do you want to try some acupuncture? Or if I look up the remedy for this, you have back pain, slow labour, ... Kali Carb[2] might be good or something like that. You put it out there. Occasionally you might say, you don't seem to be making any progress here, I think I should give you some acupuncture. Get things moving here because you are just going to get tired. ... It's not always the same. I might ring somebody up and say I don't know what to do here - ring around for ideas. I don't have one set thing - that's where it is tricky. Oh, you are having this sort of a labour you need that** (638-1).

Whilst Judith uses homeopathy, herbal remedies and acupuncture in her midwifery practice she believes a therapist specifically skilled is often the best person for the job. She readily admits that she is not a trained acupuncturist, homeopath, or herbalist. So while she will offer a therapy she often also suggests to women that, should the problem continue, they should see a specially trained therapist.

> **I can suggest you take slippery elm but if the problem continues and you want to see a homeopath, then you should see somebody who is going to give a remedy that is specific to you and that is their specific training. You**

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2. Kali Carbonicum is a homeopathic remedy that is useful when there is slow progress in labour (Tiran & Mack, 1995).

> **get a better deal, than I can look through a book and we can try this, that and the other thing** (587-1).

However, a referral to a private practitioner costs money and not everyone is able or prepared to pay.

> **The biggest bug bear is cost for people so if they can't afford it, I will look at ringing an acupuncturist and ask them which points they would use. But there are some things I can't do like cranial osteopathy. ... This is where you stress this isn't going to happen very often in your life.** [They] **can't spend money on themselves but you can reframe it as money spent on the family and it makes transition to parenthood smoother and get them to do it that way. It is that it is worth spending money at this time in their lives** (420-2).

While Judith encourages women who need more specialised care to seek help from other therapists, she too is encouraged and supported in her practice by other practitioners.

Support

Judith feels well supported in her use of unorthodox therapies.

> **I'd like to have more referral points. I don't think I have the skills totally. As long as I have people I can refer to and collegial support that feels OK** (1147-1).

> **I think homeopathy, herbal remedies and acupuncture can be really useful, you just need to know when and how to use them. I'm the first to admit I don't always know what to use, but I feel like I do know how to find the people that do know what to use** (1447-1).

The group practice Judith is part of works well for mutual support. They actively and supportively use each other as resource people. They also have weekly meetings where, amongst other things, specific issues related to their

midwifery care are discussed.

> **One of the midwives rang me the other night from hospital and there was stuff going on and she said "This is what I've done and I just need to run it past you to see if I'm doing the right thing". More to confirm what the other person is doing is OK and is there anything else you would do. At our group meetings we will all talk about cases that are concerning us and give feedback. Because I am meeting with midwives regularly I don't notice so much that I am doing it** [giving support] (460-2).

Judith also expresses a wish for more sharing of information among midwives generally.

> **I'd like to see a situation where midwives are more comfortable about asking each other - admitting that they don't know. ... It is when you can ring around and say I've done this, this, and this, and nothing seems to have worked for this woman. So I think that would be a happy situation if you thought you could ask around. ... I think there can be that sharing and I think it is behoving on midwives to form alliances, and a lot of the younger midwives have done that. Then you don't work in isolation and there is something about keeping your practice fresh too** (1011-1).

Judith has a willingness to consult with other sources regarding her practice and her use of unorthodox therapies. She is willing to share her knowledge and is not threatened by sharing her lack of expertise in a certain area with either her clients or other professionals she works with. In fact, she draws strength, knowledge, and fresh energy from the sharing of experiences, difficult situations and possible solutions. She also uses this support to reflect on her own practice.

REFLECTION ON PRACTICE

During the course of the interviews Judith expressed what she felt were the differing and changing expectations of midwives, women, and orthodox practitioners, of her use of unorthodox therapies. She reflected about how this impacted upon her practice.

Expectations of midwives

Although Judith obtains and relies on support from her colleagues (as documented in the previous section) sometimes she receives support which she experiences as pressure to use more unorthodox therapies.

> **Somebody rang the other day who I hadn't met and I was going to see her in a few day's time and it was coming up to the weekend and she said "I have a cold sore. What can I do?" I said "What sort of job are you in?" .... I had this conversation with her that didn't include the arginine versus lysine diet[3] , which was if you can't slow down then when you get home you need to buy takeaways and be a slob. It was about slowing down rather than anything alternative. But I felt pressured to come up with something from my colleagues** [who were in the room at the time]. **Like why didn't you recommend this, why didn't you recommend that? Which I could have done. When I saw her after the weekend I got the green book** [Auckland Home Birth Association, 1993] **out and said this is what the alternative therapies are for cold sores but the reality is people only get cold sores when they are run down** (913-1).

In this situation Judith's philosophy of practice is challenged by other midwives who would approach the same situation a little differently. While she welcomes feedback she does not believe there should be pressure from other midwives to practice in any particular way.

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3. A diet where balancing the ratio of the amino acids, lysine and arginine, is reported to help reduce the length of herpes outbreaks and prevent recurrences (Koehler, 1985).

> **It's always good to expand your practice and your horizons but I don't think that if you are made to feel that your practice is less than adequate, that that's good. It doesn't help anybody** (990-1).

She laughs when she says

> **Oh people make judgments about you all the time. You are not involved enough politically. You don't use alternative therapy. You do use alternative therapy. ... People do make judgments and so be it** (890-1).

Thus, while other midwives may pass comment on her handling of a situation, that they would manage differently, Judith remains confident with her own (different) philosophy of practice. Similarly, in the past, she has also felt pressure from women who expected her to use various unorthodox therapies.

Expectations of women

While in the past she has felt this pressure from women to know and offer unorthodox therapies, she believes that pressure has eased.

> **I think for me in terms of that pressure I haven't felt it for a wee while - it probably peaked about two years ago. You still get the odd person but maybe I have learnt how to handle that pressure and diffuse it by saying I think they should see** [for example] **an acupuncturist** (587-1).

However, she finds that the process of exploring with women about what else is going on in their lives frequently results in identifying a need for a change in lifestyle. Judith believes women often don't want to hear that. Although some women wish (and expect) unorthodox therapies to work in the same way as orthodox therapies, Judith is adamant that unorthodox therapies are not smart drugs or a **'quick fix cure'** (300-1).

> **People want smart drugs. ... Sometimes that means cutting down on work and a lot of women don't want to hear that. They want to be able to work, they want to be able to be pregnant, they want to be able to have their children and sometimes it doesn't always work out** (317-1).

She believes women who think they need a remedy given to them before they can be healthy, rather than looking at their lifestyle and their body, fall into this quick fix trap.

> **I think that is equally as bad as someone who wants to go on antibiotics every fortnight because they have a cold** (506-1).

So while some of the women who are requesting and wanting unorthodox therapies understand the holistic nature of the therapies, others are wanting to use them in the same way as orthodox medical treatment.

As a group, orthodox medical practitioners are often the least sympathetic to midwives' use of unorthodox therapies.

Reactions of orthodox medical practitioners

Although Judith has not experienced any repercussions from the orthodox system for using unorthodox therapies she has experienced criticism for stepping out of orthodox medical management.

> **A repercussion for not doing anything! A child whose parents didn't want it to have Vitamin K[4] . When it was 9 months old it developed a very rare blood disorder and the parents were questioned about the birth. And in big black bold type** [written in the hospital chart] **was 'DELIVERED BY MIDWIFE JUDITH. NO VITAMIN K GIVEN'. ... The parents were really relieved because they knew there**

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4. New Zealand paediatricians recommend that Vitamin K be given to every newborn to reduce the incidence of intra cranial haemorrhage (Darlow & Nobbs,1993).

> **was nothing that had been put into this kid. ... For them it was a relief, but for the house surgeon or whoever, it was a blame. It is alternative in that I didn't give the Vitamin K** (1440-1).

Here Judith was in a situation where the expectations and wishes of the parents and the medical staff were clearly at odds; with the medical profession taking the more orthodox line.

However, despite this disparity she believes that more and more women are going to medical model practitioners and asking for alternatives.

> **Somewhere that's got to "humblify" the medical profession to the point where they say I don't know and the woman gets to make the choice** (1169-1).

> **I think that a lot of people who use alternative therapies within the medical profession are purely using them because they are getting pushed to by the women, that is what the women want** (650-2).

Whatever the medical professions' motivation for offering more alternatives to women, Judith certainly believes that the expectations of women are influencing some change.

However, a reality that Judith lives with is that different groups with different expectations pass comment on her practice. This is especially so when her practice interfaces with orthodox medical practice and occurs within the hospital.

THE POLITICAL CONTEXT

A quarter of Judith's practice takes her into hospitals for births. She also consults with obstetricians, if the need arises, during a woman's care.

Working with orthodox practitioners

Judith expressed a wish that orthodox practitioners become more aware of the

positive outcomes of unorthodox therapies. Yet she finds it difficult in her own practice to share that information.

> **It is not worth putting it out there if they** [the medical profession and hospital midwives] **are already convinced that it is not going to work** (559-2).

Judith gave an example of a woman who took Arnica[5] through her labour and despite having had a two and a half hour second stage resulting in a very swollen vulva, was better the next day.

> **Now I'm convinced that is Arnica. A very quick recovery from a tough 2nd stage. There is no one in the hospital I can share that with because if you come into hospital you are not going to have a 2 1/2 hour second stage. So there is not much opportunity to share it. ... There are very few opportunities to share it in a positive way. If I said anything about that woman to anyone in orthodoxy they would say it was outrageous that she had had a two and a half hour second stage. They wouldn't be able to hear anything else. So a lot of the time it is wasted** (570-2).

Judith has tried to share information such as this with orthodox practitioners but found it to be frustrating experience.

When Judith is consulting obstetricians, she does not hide the fact that she may have tried some unorthodox therapies but she is not specific about what they are.

> **I would probably put it under a little umbrella. We have tried a few alternative therapies and we don't seem to have got so and so into labour. ... I don't think that** [sharing with them] **would be efficacious as far as future**

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5. Arnica is a well known homeopathic remedy that can be given during labour and after delivery to reduce bruising and swelling (Auckland Home Birth Association, 1993).

> **relationships with this obstetrician is concerned. I would say we have tried several ways of getting her into labour and it hasn't worked and then appeal to his orthodoxy. .... Give them the whole picture from an orthodox perspective ... Because the alternative therapies haven't worked at that point, there is no point in sharing them. Medical people don't very often get to see alternative therapies work** (1278-1).

Hospital practice

Despite orthodox (hospital) practitioners being less than supportive, Judith does not believe this influences her style of practice within the hospital. She agrees, however, that she is more likely to be orthodox in hospital, than at home. She thinks this has less to do with the hegemony of the hospital and more to do with the expectations of women who plan hospital births and who generally don't have the expectation of unorthodox therapies.

> **I'm more likely to be orthodox in hospital. I don't think I ever have** [used acupuncture in hospital] **but I don't think being in hospital would stop me using it. The repercussion thing doesn't seem to perturb me, it is more, I guess its got more to do with the woman who is planning a hospital birth. She doesn't have the expectation of alternative therapy, although that has pervaded a lot of people's thinking now. A lot of people will know about Arnica now where they didn't a few years ago. ... I'm racking my brains, I don't think there has ever been the opportunity to use acupuncture, you see I don't use it very much** (808-1).

The power of the orthodox medical model is apparent. Although Judith believes in the therapies she is using and offering to women she remains reluctant to share these with the orthodoxy. She sees it as a waste of energy for herself to engage orthodox practitioners in an exchange about unorthodox therapies as they are generally not receptive. Moreover, orthodox medical practitioners rarely see the unorthodox therapies work. Often women have used unorthodox therapies to avoid orthodox medical treatment and therefore do not come under orthodox care. Judith maintains that it is the women

themselves, rather than the midwives, that are exerting an influence on orthodox practitioners and forcing change. She has chosen to empower the women in her care and let them, should they so choose, go on to request similar options and care from any orthodox practitioners they may deal with.

JUDITH'S INPUT ON HER CHAPTER

Once the draft copy of this chapter was completed I sent it to Judith to read and comment on. A week later I meet with Judith in her home to discuss it. This meeting was not audio taped, rather I hand wrote notes as we talked. Judith was happy with the themes I had chosen to depict our interviews. The only changes Judith required were some refinements to her quotes. She requested a couple of sentences and several words be deleted where she felt she came across as indecisive. These changes did not alter the general body of the chapter.

Judith felt that the chapter was very personal, reflecting not just her philosophy of midwifery but her philosophy of life. She thinks the whole process has encouraged her to think about her practice. On reflection she feels satisfied with the way she uses unorthodox therapies in her midwifery practice. Judith believes that discussions such as this about midwifery helps to keep her practice alive instead of "practising in a dream". She is very curious to read the other participants' chapters.

Judith thought her use of unorthodox therapies was well represented in this chapter and was keen for it to be part of this thesis.

SUMMARY

Judith has offered an alternative to institutional maternity care to women for the last 10 years. Her use of unorthodox therapies is an integral part of her practice. She offers woman in her care the opportunity not only to learn about certain unorthodox therapies, but also to learn more about how their own lifestyles affect their health. Judith uses a diverse array of approaches and techniques and stresses the need to be responsive to a particular woman at a particular time. When Judith is not confident in her own abilities to use an

unorthodox therapy she will seek out other resources or encourage women to see an experienced practitioner. While she is aware of the differing expectations clients, midwives, and orthodox practitioners have of her use of unorthodox therapies she expresses confidence in her philosophy of practice. She believes she provides care for women in the context of their overall life circumstances.

CHAPTER FIVE

MEREDITH'S STORY

BACKGROUND

Meredith trained as a Registered Nurse in the 1960's. She left nursing as soon as she registered and worked in other areas but always felt drawn back to nursing. She decided in her 30's to be a midwife but a pregnancy put her midwifery education on hold. However, the empowerment she felt by birthing her own child at home fuelled her desire to be a midwife. Ten years later, in 1990, she completed her midwifery education at a technical institute. Meredith then worked for one year in the delivery suite of a large city hospital. She felt during this time that her practice became very conservative and that she lost touch with alternative therapies. She followed this experience with a year of postnatal work in the community with the group of midwives she currently works with. This postnatal work, and the support she received from the other midwives, greatly enhanced her postnatal knowledge. At the end of that year, she began to take her own clients for full midwifery care and has been in independent practice since. The last four years in independent practice have been with the same group of midwives. Meredith has a full time practice which is about 50% homebirth and 50% hospital birth.

I interviewed Meredith twice. The interviews were one and half to two hours duration of uninterrupted time. Meredith was introduced to homeopathy at the time of her own pregnancy. That was the beginning of her knowledge and her desire to learn more about unorthodox therapies. She believes having a child reinforced that desire and made her even more keen to avoid medical interventions and drugs where possible.

Although Meredith did hear about homeopathy and acupuncture during her midwifery education, it was not a strong part of the course. The unorthodox therapies she uses now in her practice include homeopathy, acupuncture, massage, water, the use of the Hamilton rocker, cell salts, and some aromatherapy. She will also refer women for acupuncture and sacral osteopathy as needed.

This chapter is organised around four broad themes that ran through Meredith's interviews; integrating unorthodox therapies into practice, reflection on practice, the political context, and resources.

INTEGRATING UNORTHODOX THERAPIES INTO PRACTICE

Meredith sees unorthodox therapies as an extension of the overall care women often take of themselves and their pregnancies. Therefore, unorthodox therapies are offered as part of this overall care.

> **I think of the number of women who go to antenatal classes and aqua natal, and all sorts of things, who will do quite a lot to try and make their labour better and this is part of that process** (793-1).

When women are offered an unorthodox therapy as a choice in their care that they believe will, at the least, do no harm they are often very willing to try it.

Openness of women to try

Meredith believes many women who come to her practice are open to trying alternatives or are already using them in their lives. She contends that pregnancy is often the impetus for women to try unorthodox therapies. It certainly was for her.

> [Women say] **What are the alternatives? In some ways she does trust her body but she is willing to try them** [alternatives] **knowing that in her belief system they may or may not work. That doesn't matter. She will just try them. That is quite often an attitude, suddenly driven to look for alternatives when you may not have before because there is this other life that we don't want to put drugs in that we have been quite happy with previously. Quite often women will say what can I do about it? Is there something you can do? Is there something we can try? I do find there is an openness. Women will often try to do anything to make it better, whether it is childbirth or labour, or growing a baby** (610-1).

Meredith's clients may well be different to clients choosing an orthodox practitioner for their pregnancy care. Some women come into Meredith's practice having already tried unorthodox therapies. Others have not but most come in with a willingness to try. Meredith will offer the option of unorthodox therapies to women whether or not they have had previous experience with them.

Offering options

Meredith discusses options with women who face problems during their pregnancies and childbirth that include those options that are outside the orthodox model . Meredith believes that women's choices are increased when she offers them the option of using unorthodox therapies as well as, or instead of, orthodox therapies.

> **The major ones are homeopathy and acupuncture, and those are when it seems necessary; that is the pregnancy is not going as either expected or enjoyed.** [I am] **trying to use** [unorthodox therapies] **to change her enjoyment of pregnancy or change her health. I don't use it just for the sake of using it. B.P** [blood pressure], **fetal positions, conditions that can't be helped medically. It is about comfort of pregnancy and possible outcomes of labour** (514-1).

Orthodox medicine's limited approach to some situations justifies her practice of offering other alternatives.

> **Often I find modern western medicine** [hospital practice] **doesn't have any thing to offer. It doesn't change anything. I'm thinking of someone with a breech presentation. There is no answer except external cephalic version, which I don't do. But there we are, that's it. We have a ceasarian section or a trial of labour. Whereas the**

> **alternatives that I offer are things that may turn her baby**[1] (200-2).

As well as offering an alternative to the limited orthodox options, Meredith believes that the unorthodox therapies she offers will do no harm.

No harm done

I agree that it can do no harm so I will give it a try (845-1). Meredith believes that the unorthodox therapies she uses will at best help and at the worst do no harm. This influences her decision to offer therapies to women.

But lack of research in unorthodox therapies presents Meredith with some problems. She doesn't want to deny women a therapy that might help yet often there is no research to base her decisions on.

> **I trust nature but I also think why not help it and why not offer it anyway. But I can't think of a way to test it out** (890-1).

> [The rocker] [2] **I know is not based on particular science, it is just based on a certain midwife's experience and her reasons why. ... I am also quite aware that there is no way to do a double blind trial to test this out. It is really a faith thing of the woman as well. I agree that it can do no harm so I will give it a try knowing that there are no guarantees. I see the rocker as pretty harmless and just a positional thing and a way of sitting** (809-1).

While Meredith believes that the unorthodox therapies she uses do no harm, in fact there is little research in some of the modalities she is using to indicate either their efficacy or harm. Her experience, and that of her colleagues, tells

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1. Macrobiotic diet, breech tilt exercises, acupuncture and homeopathy (Auckland Home Birth Association, 1993, p. 82).

2. The Hamilton Rocker is a kneeling chair that rocks. It is designed particularly to help turn babies who are positioned in the posterior position in late pregnancy. The suggestion is that women who use it daily for 3-4 weeks prior to labour will have an increased chance of entering labour with a baby in the anterior position.

her there is no harm in the unorthodox therapies she uses. Consequently Meredith's concern about the lack of research focuses solely on whether a therapy is beneficial or has no effect and prompts her to spend time reflecting on her practice.

REFLECTION ON PRACTICE

Throughout both interviews Meredith reflected on her practice.

> **It is interesting for me to see what I say** [in these interviews] **because I have never talked at length about some of my views. I realise I think about it a lot but not speak it. It is interesting to see what comes up (1356-2).**

She talked about her idea that homebirth as an unorthodox therapy, decision points in her practice, and safety. She wondered as she talked what her practice would look like in the years to come, what therapies she would offer, and how it would be different.

> **I am a self questioning person. I am never that sure that what I do is right. I'll question it until the day I die. I used to think this was the way but there is such a vast majority doing it another way I sometimes wonder 'have we got it wrong?' But all I go by is a deep belief that this is life, this is nature and it comes from my own philosophy and that is what guides me. Even the fact of the huge number of plastic disposables in the hospital. It doesn't stop me going into hospital but it affects everything else around it, the whole hospital approach. It is a personal philosophy that influences. Birth is a natural process and pain is a part of that** (1017-2).

> **I may throw them** [the alternatives] **all away, may not offer other things and just totally trust. There may be another way I start doing it one day. It is interesting watching older midwives and the sureness they have ... I hope I**

> **don't stop offering it because I don't think women need it anyway because I am then not offering them their options. Or if I get tired of using it then I am still not giving them what I see as alternative options. So I suppose what I need to do over the years is keep looking back over the records and maybe after 10 years I can say 'there seems to be a trend'. ... There is also the thing that maybe I gave them more of my time by giving them** [eg] **acupuncture** (1164-1).

Meredith's own philosophy guides her practice. It is an evolving process that she recognises has changed and will continue to change. She talked about her thoughts on homebirth being an unorthodox therapy during our second interview.

Homebirth as an unorthodox therapy

Although my broad research question was about unorthodox therapies, I did not define 'therapies'. On reflection after the first interview Meredith felt it was important to include homebirth and homebirth preparation as an unorthodox therapy.

> **Homebirth is an alternative therapy in the sense that the preparation and everything that goes with it psychologically and sociologically and emotionally is unorthodox therapy in itself. I think more and more about the positive thinking and self reliance of women who are about to have a homebirth** (325-2).

> **It** [homebirth] **has a huge philosophy that is unorthodox that goes with it and goes with strengthening the woman** (293-2).

Women who want to birth at home can be seen as unorthodox in their approach. Meredith believes it is often the women who demand that things be done differently. They ask Meredith's help to resource materials for them or they will resource them themselves.

> **The** [unorthodox] **part is that I allow it, rather than say 'no, no, you can't do that'. That's not within the way I work. They** [the women] **taught me a huge amount in that way anyway. ... The fact is that it is not just a quick visit to do blood pressure and weights and measures. That's it , out the door again. I think there is quite a lot that goes on that is unorthodox** (387-2).

> **Because I do homebirths and hospital** [births] **I keep seeing a vast difference. I compare myself to other midwives that do all homebirths and for them to look after someone who wants a hospital birth it is quite a vast place to cross. It is just another way of thinking** (293-2).

Meredith provides very focused support to women in labour. She believes that it is the setting of birth, as well as the midwife, that allows women to feel free enough to express themselves.

> **Allowing the woman to be free enough. If we are at home there is just that much more determination from both of us to try it. It is an unspoken determination and being at home allows it, gives her freedom to express herself. Because it is that intimate intimate side and I think of a person ... who dropped all her fears. She got stuck at 7 centimetres (cm) and we started to talk. She was inviting the talk and she quickly came up with what was blocking her, her fears of childbirth, her fears of childrearing, was her partner going to be supportive? (And she may well have wondered that - I was too!) And with that outcome and the tears she softened visibly and became very sexual and very intimate with herself and her partner. ... Labour then became a really sexual experience, it was amazing to watch and she just opened up. And that is not orthodox but it was allowed by being at home. Her partner was blown away by the difference** [with her], **and I didn't tell her** [to do it]. **It was just allowing her to be herself and allowing her that intimacy that home bought. She did**

> **what she needed to do and it was delicious to witness. So all that is the unorthodox part but I think it is the allowing that is unorthodox** (730-2).

Meredith believes it is more than just birthing at home that is unorthodox, it is the 'allowing women to be'. This is something that is difficult to foster within the constraints and environment of a hospital. Within the process of 'allowing women to be' there are major decision points for Meredith about whether or not to offer certain therapies, and if so when.

Decision points

Offering women alternatives to conventional therapies brings with it its own dilemmas. Meredith wonders when pregnancy and labour don't proceed normally whether it would have been different if an unorthodox therapy had, or had not, been used.

> [Especially] **if I haven't offered it, not so much if they refused it. Because I think women just know. But it is more that I didn't at least tell them "These are things that are offering now that are alternative" and I didn't give them that opportunity. ... I'm so unsure still that that really is the thing that made the difference, that the baby wasn't going to turn and the acupuncture did help it. But if I haven't offered it, I haven't given her the full options** (1152-1).

Meredith generally offers the Hamilton rocker and acupuncture tonification[3] to primigravidas, although she states that her **practice is not hard and fast and there are some primips who somehow miss out** (745-1). Wording the offer of routine preventative unorthodox therapies like the rocker and acupuncture presents a challenge to a midwife who believes that pregnancy is normal.

> **They** [the rocker and acupuncture tonification] **are the two things I offer and they are not problem oriented. They are a**

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3. A series of three sessions of acupuncture prior to labour to relax, tone, and promote good energy flow to the uterus and cervix (Auckland Home Birth Association, 1993). It is offered to women by some midwives who have been trained in the technique by a Registered Acupuncturist.

> **possible enhancer. I'm still trying to word it so it is not a desperate act. 'If I use the rocker I will have an easy labour'. I'm working on my wording on that so it is something women can decide to use while facing the fact the labour is painful** (200-1).

> **I am quite careful to say this doesn't mean you will have a wonderful labour** (755-1).

Sometimes offering orthodox options to women puts Meredith in a difficult situation. If, as one of the options offered through a long or difficult home labour, Meredith suggests the orthodox alternative of hospital transfer she feels she is telling the woman that she (the midwife) has lost faith in the woman's ability to birth at home. Meredith recognises in these situations she has a huge influence on women. However, she has resolved this dilemma by offering transfer if she thinks it is an appropriate option, sure that some women will say no.

> **My main thing is safety and me judging wrongly or rightly how much more this woman can take. ... I used to think putting the option to them was letting them down but I have seen women say no** (944-2).

Procedure protocols are quite clearly laid out in the hospitals and are carefully monitored by the staff. It is difficult to bend the rules without someone in charge challenging you. A homebirth is different. There is no one else laying down rules.

> **I don't mind being criticised because I didn't move** [from home to hospital] **this woman soon enough because in the orthodox view I would never move them fast enough. It is the safety outcomes. How far can this woman go, how far can this baby go safely? I can think of long second stages where the time flies anyway and the women haven't looked like giving up but they are way outside orthodox** (872-2).

> **It is to do with a faith itself about how much can this woman take. I'm trying to listen to her as well and it is usually the woman who says I want to go in** [to hospital] **now. I trust that one quite deeply that they can say it when they want to** (833-2).

Every homebirth is an individual situation that lends itself to midwives making appropriate and safe decisions for the woman she is caring for. Meredith's confidence in her use of unorthodox therapies does not mean that she forgoes orthodox therapies when they are needed.

Safety

Meredith is very clear that in emergencies she uses unorthodox therapies only in addition to orthodox therapy. She believes that she uses what she was taught conventionally and adds the unorthodox extras.

> **In an emergency I'll do it the orthodox way** (2133-1).

> **I definitely don't feel I could forego the orthodox. If I'm pushed I'll go to the orthodox stuff. It** [this interview] **sorts it out for me. What I'm doing is just extra stuff but not if it is life and death** (2161-1).

She gives an example of how her practice in an emergency situation differed from that of a student midwife she was working with .

> **A woman with 2 previous LSCS** [lower segment caesarean section] **and one vaginal delivery. At 6 cm I ruptured her membranes, because the general practitioner (gp) wanted to keep things moving to up the chances of her having it vaginally and there was just miles of meconium stained liquor, 41 weeks, huge amounts of liquor so if there had been less it would have been heavy, and the cervix hadn't dilated up any more in an hour, just a little bit thicker. I remember the student midwife saying what about**

> **trying Gelsemium[4] and at that stage the fetal heart plummeted and it was like 'Gelsemium, haven't got time, too late'. Yes we could try it but it would have been nice to try that as well and perhaps the miracle might have happened. To me they are an added thing. ... That was an example of yeah, I'll use the alternatives but when the chips are down I haven't time for homeopathy as well** (2320-1).

Meredith is quite clear in her use of unorthodox therapies that safety is a priority. As she reflected on her practice, Meredith examined herself and her practice in the larger political context.

THE POLITICAL CONTEXT

During our interviews Meredith compared her practice to that of other midwives, both past, present, and in the literature, and reflected on her level of unorthodoxy. She also touched on her practice within orthodox institutions.

Practice comparisons

In the following extract Meredith describes how a particular article she read made her reflect how she practices, and what has influenced her practice.

> **I was trying to find out some information for somebody with twins and I found an American article. She had a wonderful twin birth and then haemorrhaged and the midwife wrote that she tried Shepherd's purse[5] and various herbs and then tried to manually remove the placenta and found that she couldn't get it out and meanwhile the woman continued to bleed. And then** [finally] **she gave her an injection of pitocin and I realise I wouldn't do that. To me it is partly that the medical**

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4. Gelsemium is a homeopathic remedy that can be useful in a labour with slow progress (Tiran & Mack, 1995).

5. Shepherd's purse herb is a blood coagulant and vasoconstrictor (Weed, 1986).

> **profession would not buy it at all and it is also the type of women I have. I don't know that many that would be so totally against and say 'no, no, no' or if it is that they have taken me on as their practitioner, and I'm the one who says 'no', and I'm not prepared to try those while you are continuing to bleed. I realise I have probably shifted away, where I would have thought I would use all herbs and hardly ever use conservative or orthodox. Now I have changed my practice and I will use the orthodox ones especially for bleeding, faster. I don't know if I will change the other way unless I'm out in a place where there aren't** [any oxytocics] **(But then I would take it with me.) I'm not that fixed and I use a mixture of unorthodox and orthodox. I can see I'm shifting. I was sort of admiring that midwife but I was also thinking that is a lot of blood loss while you are trying all your herbs** (485-2).

Although Meredith admires midwives who predominantly use unorthodox therapies, she has decided to blend the use of unorthodox and orthodox therapies in her practice. Meredith gives the following example of a woman in hospital who used both orthodox and unorthodox therapies at the same time with good results.

> **Sometimes the hospital helps, the deeper baths. I have had a woman with a posterior** [baby in a posterior position] **in the bath, upright, pethidine and acupuncture points in her toes. There was the lot being used at once. It was an appropriate decision because the pethidine allowed her to stay upright and get her posterior baby out whereas an epidural may not have (1430-1).**

Practising in this way has led her to 'grade' herself on the unorthodox/ orthodox scale.

> **I see myself to the left of middle. I'm not quite middle**

but when I see what some of the old homebirthers did, I don't do those (588-2).

I might be shocked. I may find I am way to the left of centre. Some where there is always a voice about being fired from my job basically if I overstepped a mark. I think my practice is being cautious. Yes I will use those alternatives, but I have strict rules (655-2).

I realise how much my views have changed. I came into it a homebirth stalwart and then worked in a hospital for a year and went the opposite way because there was nothing extra you could offer women, other than support. So I have practised various ways and then gone down the middle (988-2).

Meredith's 'left of centre' practice brings her into contact with orthodox practitioners.

Working with orthodox practitioners

Because Meredith feels very confident about the safety of the therapies she uses, and the reason for using them, she is not intimidated by the views of orthodox practitioners in hospital. She is clear about who she is working for.

It is for the women, not the consultant (1287-1).

It is OK with me because if they [orthodox medical practitioners] **hear it** [about unorthodox therapies], **they hear it and they keep hearing it and may choose to look down that avenue. I suppose I also work mainly with supportive doctors. The stuff I do is not harmful so it is not as though anyone is going to want to stop me. I have never been in a situation where I would refuse the consultant's input and say no, acupuncture instead or homeopathy instead will do it. I still see it as an additional thing. I have never been in a position where I'm fighting my views versus theirs.**

> **Usually it is the woman who is happy to try it and she is the one who talks to the consultant about what she has tried. ... It is not an obvious secret. The more I do it the more I am happy to. I'm more sure, and I'm more sure of the relationship with the woman and that she wants it anyway. I'm not as secretive. I have all my remedies out in the delivery unit** (1316-1).

Sharing knowledge about unorthodox therapies with orthodox medical practitioners is not a priority with Meredith. However, she does share knowledge and resources with like minded practitioners.

RESOURCES

Meredith reflects on her knowledge and practice and shares her experience through discussion with other midwives, homebirth doctors, and the peer review process. She also observed the fact that our competitive health system can work against this knowledge sharing.

Support

Meredith offers support to and receives support from other midwives and homebirth doctors. This is done formally through the Midwifery Review Process and informally in group meetings.

> **We keep letting other midwives know** [about unorthodox therapies] **and the review process is good for that. The people on the review panel often have alternative experience to offer, that they have quite carefully worked at. When a midwife comes along who has no idea of any alternative whatsoever, from the review panel, they will often suggest and let them know where to find information just to start** (2050-1).

> **That is where meeting with groups of midwives more often is really interesting. You learn huge amounts about another way of doing it, because we are all so different. Things I wouldn't have thought of, and clarifying the way I**

> **do it anyway, and learning. When we get together we go on and on about this case and that case and we all have a wealth of knowledge to share. It is helpful** (1380-1).

> **Whenever we get together** [homebirth midwives and doctors] **there is a huge amount to be shared. I just think we don't get together often enough. Because it is hearing from experience what they did about it and it sticks. I think they are good at sharing it** (3580-1).

Meredith has the support of specific groups of midwives and homebirth doctors that meet her needs for support and the sharing of information. Yet while Meredith realises that sharing knowledge is beneficial to everyone's practice, she concedes midwifery services are now in the health 'market place' which places support and knowledge sharing under threat.

Midwifery practice as business

Independent midwives are paid by the Government on a fee for service basis. The current demand from women for independent midwifery care is high, generating more than enough work for midwives. However, like any other business, we need to assure this demand long term in order to remain economically viable.

> **I think there can be a tendency sometimes because we are in business** [to protect our knowledge] **. With students I work with I will happily show them what I am doing. Perhaps there is an unwillingness to rush out there and get all the other midwives in and say 'look this is what we are doing, come and listen'. And we perhaps need to do more of that, There could be some protection in that way... It is a dangerous statement but I am aware that sometimes on the big level I wish that we would all use them** [unorthodox therapies] **and do our very best, and sometimes the mean part of me hopes that people will come to me because you know - it's business. When somebody talks to me I'm very willing to share it. If we**

held something like an information sharing, I'd be happy to come and whoever comes to it let's share it out (3593-1).

Meredith's concern about the impact of competition on midwives' practice and knowledge sharing is very realistic in our increasingly competitive health 'market'.

MEREDITH'S INPUT ON HER CHAPTER

Once the draft copy of this chapter was completed I sent it to Meredith to read. Three weeks later I met with Meredith to discuss her comments. This meeting was not audio taped, rather I hand wrote notes as we talked. She was happy with the way it was arranged and the themes I had chosen to depict our interviews but very critical of her own comments. She felt she had come across as indecisive. To remedy this Meredith requested I make some clarifying comments in various quotes. Several identifying features were also changed for the sake of anonymity.

Most of Meredith's comments about the chapter concerned what she thought was the essence of the interviews. She believes allowing women to be themselves, and listening to them, rather than telling them what to do is the essence of unorthodox midwifery practice. She also wanted to make the point that she works under the shadow of a large secondary care hospital. She sees the midwifery practices in this hospital as very orthodox but it is from this standard that all other practices are measured.

Meredith confirmed her belief that homebirth can be seen as an unorthodox practice. She believes women are not bound by rules, programmes or timetables at home and in the process they discover their own resources. She suspects that sometimes unorthodox therapies are really the 'fix-it' mentality in a new disguise.

She concluded by saying that she was proud of herself and her practice from having moved so far from the 'fix-it' pethidine mentality but she thinks she still has further to go. She asked that I write down the following word for word. "Maybe all that really works for women is allowing them to discover for

themselves what they need for labour and birth".

SUMMARY

Meredith has been in independent practice for four years and her practice has evolved over that time. She includes unorthodox therapies as a part of the overall pregnancy and childbirth care she offers. Many of the women who come to her practice are open to trying alternatives or are already using them in their lives. She maintains that by offering unorthodox therapies, as well as orthodox therapies, to women it opens up the choices available to them. Meredith claims the unorthodox therapies she uses do no harm. While she has confidence in unorthodox therapies, she is clear that in emergency situations she will use orthodox therapies first.

Meredith believes that homebirth can be seen as an unorthodox therapy. She contends that it is more than just the birthing at home that is unorthodox, it is the 'allowing women to be', as opposed to telling women what to do. 'Allowing women to be' is difficult to foster within the rules and regulations of a hospital.

By sharing knowledge with other practitioners Meredith finds support for, and an opportunity to reflect on and evaluate, her practice. However, the impact of competition amongst maternity care providers on midwives' practice, and knowledge sharing, causes Meredith some concern.

CHAPTER SIX

BRIGID'S STORY

BACKGROUND

Brigid trained as a midwife in 1969. Almost immediately after she qualified she worked in a small country hospital in Asia for 2 years. Here she had to 'unlearn' some of the more interventional midwifery practices she had been taught in her training as the Asian women she cared for wanted no interventions. During the period Brigid trained, there had been a large focus on the routine use of interventions such as episiotomies and pethidine. In Asia Brigid learnt about different labouring positions and, more importantly, learnt to assess women individually for their own expectations of labour.

When she returned to New Zealand Brigid did a mixture of social work and public health nursing. In 1977 she meet up with Joan Donley and Carolyn Young[1] and became involved in domiciliary midwifery. She worked as a domiciliary midwife for six years until 1984. After this she worked in hospitals as an agency midwife until she entered independent practice in 1992.

Brigid is a sole practitioner[2] although she has several other independent midwives she liaises with who do second midwife[3] work with her, and she with them. She has a full time practice that is mostly hospital based. Her clients come from a wide geographical area and are approximately 50% midwifery only care and 50% shared care.

Brigid was interviewed twice at her home. It was uninterrupted time. The

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1. Joan Donley and Carolyn Young were the only domiciliary midwives in Auckland in 1977 (Donley, 1992).

2. A sole practitioner is one who works alone rather than in a group.

3. When midwifery only care is provided throughout pregnancy, labour, birth and postpartum, a second midwife is always available as a backup to the primary midwife. The second midwife also attends the birth.

interviews lasted one to one and half hours. Brigid's knowledge of unorthodox remedies came originally from the domiciliary midwives she worked with. She has since expanded on that knowledge by reading, learning from the women she works with, and exchanging information with other midwives and professionals. Brigid intends, when time permits, to do a structured acupuncture course. The unorthodox therapies she uses mostly are acupuncture, homeopathy, and some plants.

> **I am wary about concoctions that I don't know anything about. I don't know a lot about herbal remedies. ... I'm confident about things that are made from plants, like the couch grass** [kikuyu] **tea**[4] **or the nettle tea**[5] **or barley**[6] **or that I have a fair idea what is in it. I use it with caution because things like raspberry leaf tea**[7] **and nettle tea, you can have gallons of it at the wrong time** (1371-1).

She also puts an emphasis on diet. However, she predominantly follows the woman's lead when deciding what, if any, unorthodox therapy would be appropriate. **A lot of what I use is according to the woman's own use and knowledge of it** (559-1).

Three main themes were identified from the two interviews; integrating unorthodox therapies into practice, reflection on practice, and the political context.

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4. Couch grass tea is useful for urinary tract infection (Auckland Home Birth Association, 1993).

5. Nettle tea is useful for leg cramps, prevention of haemorrhage and stimulating the production of breast milk (Weed, 1986).

6. Barley water is also useful for urinary tract infection (Auckland Home Birth Association, 1995).

7. Raspberry leaf tea is most useful as a uterine tonic (Weed, 1986).

INTEGRATING UNORTHODOX THERAPIES INTO PRACTICE

Brigid has a wide variety of women in her midwifery practice. Most of the clients that come to her for care are not initially aware of Brigid's interest and experience in unorthodox therapies. Brigid, therefore, is very clear about how she introduces unorthodox therapies to women. She follows the women's lead about whether or not they wish to use unorthodox therapies. In doing so she respects the influence of family and friends and supports the woman's decision whatever that may be.

Follow women's lead

Brigid's approach to introducing unorthodox therapies depends on the direction that women themselves want to take.

> **In a way I do follow the woman's lead for that. What do they know? What do they want? What do they need for themselves? And then I let them know what different things can help depending on where they are** (582-1).

She also relies heavily on the homebirth book (Auckland Home Birth Association, 1993) for information for herself and her clients. In fact she gives each of her clients their own copy.

> **And I use that homebirth book as the basis for just about everything. Early on I get a copy for women and tell them to use it themselves. In terms of researching and studying, I am disorganised in that area. I'm happier to give women a basic text and say find out in there what you would like to use. I use it now again and say this, this and this is recommended. Different things work for different people. The choices! I encourage it with them because it is so much safer holistically** (617-1).

> **In the practice that I am in, although there is not a high**

> **demand for alternative therapy, there is still a lot of appreciation when alternatives are offered. I tell people when I give them the homebirth book that some of the therapies would be considered strange. I reassure them just to try the ones that they feel comfortable with** (192-2).

When women are considering using unorthodox therapies, Brigid believes that family and friends have a huge influence, whether this is spoken or not.

Encompass family support

Brigid has a great respect for the influence family and friends have on women as to whether they are prepared to use unorthodox therapies. She is well aware of the power of the written word in legitimising these therapies and refreshing age old memories.

> **I am sure that all things have a basic effectiveness but definitely the person's metabolic and psychic systems are all different. If you slavishly follow a routine for everyone it doesn't necessarily work. I do rely on a women's intuition about what she wants to try, and not try, from her own wisdom, from what her family have said and her friends have said, what she believes will work for her** (204-2).

> **... I like them to read it** [Home Birth Association book] **and say 'ooh auntie so and so used to blah blah about that'. It rejuvenates people's memories. 'Grandma always used to say eat that and that'. It helps go back into our knowledge, reconnect, and come up with something new. Or talk about it with say a visitor who looks at the book and says 'I remember blah blah'. To me to have a text like that available is really useful for all the other members of the family. They can read through it and think it is a lot of cods wallop or whatever.** [They may] **think I put my broomstick outside**

before I come in [laughs] (274-2).

In this way, Brigid works actively to include and validate the views of the woman's family and friends. And Brigid will support them in their decision, whether or not they decide to use unorthodox therapies or remedies.

Supporting women's decisions

Brigid is very clear about the importance of supporting women with the choices they make themselves even if it is not how she would choose to practice. She understands that the decision making process is much more complex than it appears and not a simple matter. The decisions women make about their pregnancy and childbirth care are influenced by every other aspect of their lives. Brigid has a realistic view of this so, while she will present women with different options for their care, she is committed to supporting their decision whatever that is.

> **I still believe in the end that I need to go along with the decision that that woman makes. I try and be clear about what the options are but I believe we all make our decisions for a positive reason. But you can't necessarily tell the midwife about all the pressures you're under so I believe women choose ways that are compromises of other pressures. So it is no good saying this is the right way because it is only the best way in a narrow sense.** [It is] **not the best way given the relationships** [with family and friends] **they wish to maintain and negotiate. I don't expect the women always to know, but there are other reasons. I believe it is important to support the decisions that are made by the women** (2230-2).

However, she goes on to illustrate how even with the best intentions things may not go according to women's plans.

> **I really find it quite important to listen to what women want for their labour and if it is the medical model, not**

> **to totally oppose it if that is really what they want. As long as they know about the other things that they don't want. There is a whole lot of complex reasons why you can't go with anything else but your epidural. I make the point in our discussions on labour and pain relief** [about alternatives] **but then I will support them in anything else they want if that is what they want. That is difficult. I am in the process of caring for a woman who is totally distressed by her delivery because she did not get the pain relief that she wanted. I'm distressed too because the situation when we went to hospital was such that there was no time to get what she wanted. She had a very rapid multip** [multiparous] **dilation and delivery once she started opening. ... Yet at the point she delivered the baby she was ecstatic "I did it all by myself with nothing else' and yet that lasted all of five to ten minutes. Then all the other stuff came back. By the end of the day** [the baby was born at 5 am] **she was completely dissatisfied. To the point where we agreed mutually that I would hand over her care to someone else** (1071-1).

This example left Brigid to conclude that sometimes the way we care for particular women, even when we have tried to understand their needs, will not always be what they want.

> **It gets back to me that we care for somebody whether or not that is what they want. She really needed a doctor to get things going with synto** [syntocinon] **and epidural. This, I think, is the method that she would have been happy with** (1100-1).

Natural childbirth was not this woman's preference and left her dissatisfied with her midwifery care. Nevertheless, the empowerment of women is important to Brigid whether or not women are choosing orthodox or unorthodox therapies. Brigid believes that unorthodox therapies particularly

are more useful and empowering to women if they resource them for themselves.

Empowering women

> **I think these therapies are empowering for women if they learn about them themselves. That is why I give them all that book** [homebirth book] **at the beginning. And for women who haven't thought about it, it legitimises it for them. Here it is written in black and white and they can check it out with someone else. I think it is much more powerful if women actually try them themselves. My purpose in giving them that homebirth book would be in giving them an ordered collection of information. Some women read all areas, some read about what is in what foods and are really thrilled, and some just use it as an ailment thing. Others use the areas on stages of labour. That is where I feel it puts the power back into their hands** (1255-1).

Despite giving the book to all her women, Brigid does not have an expectation that women will read all, or even any, of the book. If the women find anything useful for themselves in the book they take the credit themselves for resourcing the material. Brigid is happy to support them but is very clear that it is important women take responsibility for their own care decisions.

> **Ultimately women have to make their own decisions. Even when they don't want to make the decision and they want you to make the decision** (2173-2).

By keeping women responsible for their own decisions, Brigid gives them the chance to be empowered by their birthing experience. Brigid believes this is important as many of her clients have not had the opportunity to be exposed to anything other than orthodox health care, nor have they had the chance previously to make their own care decisions.

REFLECTION ON PRACTICE

Brigid's style of practice is focused toward the women she cares for. These women are often fairly orthodox in their expectations of health care and many of them have unhealthy lifestyles.

Orthodox clients

Unorthodox therapies are new to most of Brigid's clientele.

> **I would say three quarters of the women I see are not looking for alternatives. ... Some of the woman are interested in it (although it is a totally new idea). Some of them will still go to the doctor for antibiotics and are not even aware that there is another way. They are completely closed even if I were to talk about it, almost like denial. Completely and utterly doctor, antibiotics whatever. That is what you do. ... There are some woman who would never think of an alternative. There are others that hadn't thought of an alternative but are really pleased to try something different. They might have had antibiotics but the bug keeps coming back and they are really pleased to try something different. And there are a smaller number who have already rubbished the medical model and they are interested. They have a lot of knowledge and I encourage them to follow what they know. I ask them about it and I let them know what I know** (915-1).

Brigid explains different options to women, but realises that the time period she is caring for them is short and not long enough often for women to encompass a new world view, even if they wanted to.

> **I would nearly always have to explain my views on ultrasound and antibiotics; things that I would have them avoid if I possibly could. For most it is a new idea to use something other than the orthodox. And I**

> **do have women that want a lot of ultrasound. ... I don't think you can change the whole information thing in 12 weeks. I can be very clear that this is unhealthy but it is still an option** (870-1).

The use of unorthodox therapies is frequently new to women, and often aspects of their lifestyles are not the most conducive to good health.

Unorthodox therapies and lifestyle

Brigid emphasises the importance of good nutrition in her care of women. However she is careful not to alienate women. For women who find it difficult to change their lifestyle Brigid's focus is more on balancing a woman's existing lifestyle, rather than insisting women give up unhealthy habits.

> **I don't spend a lot of time on nutrition but that is where my emphasis is. More than on other things. What they are eating and drinking and what their activities are. If they are smoking or eating a lot of chocolate, I try and tip the balance. Not so much stop this, stop that, but pile this in** (740-1).

Brigid's empathetic and non judgmental approach comes from a very clear understanding of herself and others.

> **There is a high proportion who just live very unhealthy lifestyles (like myself) and I feel total sympathy with them. Reluctance to move themselves, to take the effort to buy this and this and this. Happy with KFC** [Kentucky Fried Chicken]. **I do feel a lot of sympathy with them because I think, yes, that's me** [laughs] (827-1).

> **There is the human reality too. We are none of us what we would like to be. You can't beat yourself all the time because you are not the perfect person. And I really am optimistic about nature. I've looked after women who are not in good health and don't look after**

> **themselves and nature, nevertheless, stands them in good stead. I don't like being totally negative if what they are doing is not reasonable.** [I say] **'If you can't do any of that then go back into your history and see how many kids granny had and how easily she did it. If she didn't, then I'd think twice about your lifestyle maybe'** (412-2).

Nonetheless there are situations when Brigid recognises the need for more direct action. When a woman is fighting an infection, attempts to balance out factors in her lifestyle may not be enough. Brigid believes that unorthodox therapies are unlikely to work effectively if women are generally not taking good care of themselves. For severe infections Brigid will recommend antibiotics if she feels the woman cannot make the necessary lifestyle changes that are required to augment the unorthodox therapies.

> **I do talk to the women about the options, the choice is still theirs. It is from the women who want to try the natural** [remedies] **that I have learnt that antibiotics are a reasonable option. They have tried the natural and they have really tried because they believe in it. And for some it works, and sometimes it doesn't. I can honestly say these methods work if you do this, this, and this, and rest and if your body's immune system has got the oomph there, which it should have, then it will deal to it in two or three days. If however it doesn't, this is your other option. Then it is the woman's choice to say** (802-2).

> **Antibiotics are for those major illnesses that don't respond to natural remedies. In all my years of midwifery I haven't seen a breast infection that hasn't responded to antibiotics. None of these** [unorthodox] **remedies work if somebody runs around the house with a raging breast or bladder infection. I will say 'these are your alternatives'. In the case of a breast**

> **infection I say 'if you can rest, take extra vitamin C and eat well then do it, but if you can't, then take antibiotics'** (121-2).

Brigid believes that unorthodox therapies must be combined with a healthy lifestyle to be most effective. This can be a challenge to some women. However, the advantage of some of Brigid's most used therapies are that they can be obtained at little or no cost (for example, kikuyu grass or barley). Women who use an effective, inexpensive, or no cost self administered remedy are not as likely in the future to believe a costly prescribed medicine is the only choice.

THE POLITICAL CONTEXT

Unorthodox therapies are usually cheaper than orthodox medicine, although treatment from a specialised unorthodox practitioner can be expensive. While Brigid encourages the use of the cheaper unorthodox therapies she is well aware that there are business interests behind the marketed unorthodox therapies. She believes midwives need to be mindful of this.

Cost to women

Brigid appreciates the huge economic motives behind the orthodox drug companies and their prescribers to dominate the market. Often unorthodox remedies and approaches are substantially cheaper, and many of her clients are poor.

> **... quite a few of them can't afford the antibiotics and things. Then homeopathy is cheaper and a better diet is cheaper. It is available to them and in some ways they are quite excited to be offered a natural remedy. Especially something easy like in urinary tract infections like a tea, that they can make themselves** (920-1).

> **A lot of my women don't have a lot of money and I just encourage them to have a really good diet. If they get it from their food they don't have to spend money on**

> **supplements** (789-1).

Brigid is very aware of how little her clients can afford to pay for remedies (orthodox or unorthodox) and tries to minimise the expense to them.

> **Sometimes it is frustrating for me because I don't see the** [orthodox or unorthodox] **creams, and lotions and potions they are paying good money for in anyway helping** (970-1).

Her concern about the promotion of marketed products goes beyond the concern of cost to her clients. The current enthusiasm for unorthodox therapies among midwives, and the promotion of unorthodox therapies by business interests, leads her to worry that simple, low cost, effective treatments will be lost in favour of costly marketed products.

Political agenda

Brigid has a view of the impact of unorthodox therapies that is larger than her own practice. She is very cognizant of the larger political, social, and economic forces that surround unorthodox therapies. She is fearful that midwives, by overpromoting some unorthodox therapies, could unwittingly undermine the belief women have in themselves and restrict their choices.

> **I think anything where you suggest to people that they can know about their own bodies, remedies other than the accepted medical ones presents a challenge. ... Anybody that has credibility in the general society that is suggesting to people that it is valid to look at other options than antibiotics is definitely challenging. That is quite a political act really. Generally as a body** [midwives] **we are changing consumers' views. But we don't have direct contact with the people that are running the drug companies or those people that have a vested interest in maintaining the status quo at all cost. They will want to limit the power of any other legitimate body. (That is in the pressure to change the**

> **payment system and change the funding and all that. To counteract the shift from the medical model.) I think we have to be careful we don't become a vehicle for another interest like homeopathy and natural remedies. You really have to encourage women to be well in themselves and then choose from a variety of options** (1450-1).

Brigid feels that when we suggest unorthodox therapies to women we need to offer a wide range and ensure we include the simple remedies as well as the marketed products. In this way we can avoid becoming the selling agents for any particular interest.

> **I do think we have to careful that we don't end up promoting homeopathic companies. The politics of it. They** [the Government] **are trying to restrict the use of natural remedies and I totally disagree with that. On the other hand I think we have to be careful as a group so we don't end up promoting particular types of natural remedies regardless of whether they work or not or whether there is a cheaper alternative growing in your back garden. I can't think of anything cheaper for a urinary infection than a bag of barley** (926-2).

> **There are economic imperatives and we have to be sure we don't get on someone else's agenda** [re homeopathic companies]. **In the end that is the thing. Making our decisions and then constantly seeing where they get us and changing the ones that aren't working** (2173-2).

Although unorthodox therapies are not a large part of Brigid's practice her reflection on the use of unorthodox therapies extends beyond her practice to the potential impact on the midwifery profession.

BRIGID'S INPUT ON HER CHAPTER

I did not audio tape the meeting Brigid and I had to discuss her draft chapter, but I hand wrote notes as we talked and I have incorporated some of the phrases she used into this commentary. Brigid was surprised and delighted that I had "put order into" what she had said. She was happy with the way it was arranged and the themes I had chosen to depict our interviews. Brigid wished to remove, in the introduction, the name of the specific Asian country she had worked in. We replaced it with Asia. She debated whether she wished to be identified as one of the early domiciliary midwives in Auckland as that reduced her anonymity. She decided she was proud of the connection and wished it to remain in the text. Brigid flipped through the chapter while we talked. As she browsed the political context section she reiterated once again that midwives needed to be aware of the danger of "selling ourselves to the homeopaths".

Brigid commented that reading the chapter had made her reflect once again that there is "no right way of doing things". She felt the benefit of being involved in the research had been similar to the peer review process. It had helped her "to think through and clarify her thinking". It "strengthened the pillars" of her practice and revealed "woolly thinking that needed cleaning up". She concluded that this accountability to self and peers was important.

SUMMARY

Brigid has worked in a variety of fields since she qualified as a midwife. She has also had the unique experience of being one of only a few domiciliary midwives practising in Auckland in the late 1970s.

Brigid believes it is important for women to be responsible for their own decisions and her style of practice is focused toward the women she cares for. These women are often fairly orthodox in their expectations of health care. They have not had the opportunity to be exposed to anything other than orthodox health care, nor have they had the chance previously to make their own care decisions. As she introduces unorthodox therapies, Brigid respects

the influence family and friends have on the decision to use them or not and supports the woman whatever they decide.

Brigid is aware of the business interests behind marketed unorthodox therapies and is fearful that midwives may unknowingly become saleswomen for them. In her practice she encourages the use of unorthodox therapies that can be obtained at little or no cost. Nevertheless, she is fearful that midwives may overpromote some unorthodox therapies. This, she believes, has the potential to undermine the belief women have in themselves and restrict their choices.

CHAPTER SEVEN

ADRIENNE'S STORY

BACKGROUND

Adrienne is an England trained midwife. She completed her general nursing in 1974 and then specialised in radiotherapy. In 1975 she undertook her midwifery training at a Bristol hospital where both her aunt and grandmother had been midwives. After Adrienne qualified she worked in two hospitals in London. She then went to Thailand and worked for three years before coming to live in New Zealand in 1980.

Upon arrival in New Zealand she worked in a city maternity hospital for six months, and then again in 1983 for 18 months. However, since 1980 her focus has been on homebirths. It was at this time she became interested in unorthodox therapies.

> **When I came to New Zealand and began to attend homebirths I realised that what I was trained to do was insufficient for the job** [as a homebirth midwife]**. When there were problems you need more tricks up your sleeve than synto** [syntocinon] **and epidural. We need more than transfer to hospital. You need other interventions, for example, acupuncture. I realised I wasn't sufficiently resourced, and had to be more skilful in things other than just conventional medical interventions** (Phone conversation two hours after the first interview).

She has gained information over the years from the women she cared for, information sharing with colleagues, educating herself through reading and workshops, her own family health, and her experience. Adrienne works full time with a case load consisting of 96% homebirths. She is in a group practice with three other midwives who work out of shared rooms. They cover

each other for holidays and days off and provide backup and support for each other.

I interviewed Adrienne twice at her home. Adrienne had just begun a month's holiday when the first interview took place. At the second interview Adrienne felt that her burnt out feeling and need for a break had negatively influenced the first interview. The second interview took place when she was back at work. Both interviews were uninterrupted and lasted one and a half to two hours each.

The unorthodox therapies Adrienne uses in her practice are acupuncture, homeopathy, and referral for cranial sacral osteopathy. She also believes her approach to communicating, where she is willing to have more confrontational or more complicated conversations with women and their partners, would be seen as unorthodox in the hospital setting. However, she sees the use of unorthodox therapies in midwifery practice as broader than even that.

> **It is really hard to isolate alternative remedies as something out of the whole political nature of being a midwife. It is part and parcel of it. It doesn't happen in isolation in the same way that most orthodox treatments do** (3416-2).

Three broad themes that ran through both interviews with Adrienne provide the outline to this chapter. They were integrating unorthodox therapies into practice, reflection on practice, and the political context.

INTEGRATING UNORTHODOX THERAPIES INTO PRACTICE

Adrienne is strongly committed to working in partnership with women. Clear communication is vital to this. Her practice aims to empower women as she supports them to make their own decisions. Adrienne is not afraid of exploring women's emotional issues with them as she believes emotional health has a direct impact on the childbearing process.

Partnership

Because Adrienne's practice is so intertwined with her use of unorthodox therapies she ensures women understand her type of practice and want that for themselves.

> **I spend quite a lot of time talking to women initially when they book with me about the sort of midwife I am to get a sense that we can work in partnership. ... I'm aware fundamentalist Christians, for example, have a problem with therapies that originate in the east, so I get those things clear first because they are part of my practice** (340-1).

The strength of the partnership is critical should a stressful incident occur. Should women require orthodox medical care in addition to midwifery care, a midwife who has used unorthodox therapies can be placed in a vulnerable position. The orthodox medical system is likely to criticise not only the therapies, but also the midwife.

> **And it is not only a criticism of you, it also the work that is done to damage the partnership relationship you've got. The couple you are involved with as a midwife were perfectly happy before someone said. 'This is dangerous. Do you realise your baby could have died?'** (695-2).

> **That partnership relationship is fragile up to a certain point. Until it gets tested you don't know how strong the partnership is. And when it is tested it might not be as strong. So we base an awful lot of what we do, on the basis of the partnership** [especially] **when a woman says she didn't want this** [some orthodox treatments] (741-2).

Adrienne has had situations where women have requested not to follow orthodox treatment but then questioned it later when that decision has been challenged by the medical orthodoxy. These circumstances place midwives in

a very vulnerable position and have motivated Adrienne into ensuring women have all the information they need. She places importance on communicating in a very clear way with women and believes her style of communication is essential to the partnership she has with women. Adrienne considers it vital that she knows what women want and that they know their options.

> **A trap you could fall in is expecting women want a particular package and they don't at all. Communicating with the women and getting really clear what it is that they want and if this is a path they are interested in going on. I think even more now I would present alternatives as one of a whole range of options, including use of drugs etc. For example if someone is progressing slowly in labour I probably would introduce the idea of being managed, have an epidural, some syntocinon as well as the other things that I am more familiar with doing, which is looking at maybe a remedy that might be appropriate, acupuncture, and also dealing with the emotional side of why the labour isn't progressing** (488-1).

As well as offering orthodox and unorthodox treatments and remedies, Adrienne attends to women's emotional well being. She believes the way she does this could be seen as unorthodox.

Using communication as an unorthodox therapy

Adrienne pays a great deal of attention to the emotional processes of the women she is caring for. She believes that naming what a woman is experiencing emotionally and providing the opportunity for a woman and her partner to talk about it, can often facilitate progress in an otherwise blocked labour. She is not afraid of what this might surface and regards herself as skilful in this process.

> **A lot of midwives don't see that the emotional health of the couple's relationship has anything to do with the birth outcome. Maybe it does and maybe it doesn't. But I have noticed in addressing those sort of issues which only**

> **come out of, maybe having that experience yourself or, having a certain amount of courage to stick with the concept that what is going to happen when all the other emotions get expressed, like upset and fear, can be extremely powerful. I had the experience earlier this year of caring for a woman who was anxious and fussing and wanting everything to be right. She was having a very very long labour. It was hard to say, to get them both to sit down and I said to her 'What else is going on?' Just allowing it, giving faith to that process. And then she said** [to her partner] **'You are fucking pissing me off'. All of a sudden things started to shift. He got upset and he got that he was being wrong, but** [I was] **just staying with that process and managing it. I don't know if it is a skill other than the noticing and giving space to what is happening** (3166-2).

Adrienne knows other midwives who also believe confronting emotional processes is beneficial and ultimately empowering for women.

> **The skill of being willing to have more confrontational or more complicated conversations with women and their partners, that would be seen in the hospital as being totally outrageous. A woman yelling and stamping her feet and you ask her what is going on for her rather than sedating her. And I have watched other midwives do that in a way that can be incredibly empowering as well. I've seen a midwife say to someone 'Now is the time that you actually have to grow up'. The woman was furious and yelled and screamed and ranted but somewhere got it. What occurred was magic and she started talking in a way that was grounded, there was something real happening. As a couple they started interacting rather than playing a game. I suspect their lives and relationship will be richer for it and if you had stepped in and just sedated her at that moment in time, she never**

> **would have had that opportunity** (2315-1).

Adrienne enters into, and supports other midwives to use, this confrontational type of interaction because she believes it can have dramatic results. She trusts the process to empower women.

Empowering women

Adrienne sees herself as a facilitator of the pregnancy and childbirth process. She is very careful to leave women with a feeling of empowerment.

> **You want to see yourself as being a facilitator of the process.... You want women to be left with the sense that they were the ones that carried the baby, that gave birth to the baby, they did it themselves. Yes, they needed someone to give them some assistance but that is all it was, some assistance. They don't need to hand over their power, their gratitude, or anything of themselves to that person** (1219-1).

Likewise, when offering women the option of using unorthodox therapies, she is careful with her wording and leaves the decision in the woman's hands.

> **For some women it is really important to feel you gave birth with nothing. You did it by your own power. You didn't need not one homeopathic remedy, not one acupuncture needle, you did it totally from your own energy source, whatever. That was very true for me. So I don't offer it** [unorthodox therapies] **like a 'have to'** (1190-1).

The empowerment also has an educational focus to it. She admits she promotes the use of unorthodox therapies and believes the women she attends leave her care with new information about the possibilities of using unorthodox therapies in their own and their family's lives.

> **In terms of mothers claiming back a sense of being able to fully care for their child even when they are sick, that**

can be really useful (2257-1).

> **...if the baby has a snuffly nose, there is the possibility of** [the mother] **using homeopathy. I would say it would be unusual for any woman who has been in my care to not at least think of that. So they have a choice and for some women they might never ever use it but** [I incorporate] **that sort of educational focus** (126-2).

One important reason for Adrienne exposing women in her care to health care options, other than orthodox ones, is because she believes they are often effective and safe.

Usefulness of unorthodox therapies

For women who need help, unorthodox therapies provide a larger range of options than those offered by orthodox medicine, without the side effects. Adrienne sees them working in different ways to orthodox medicine. With the large scope of therapies available, knowing what and when to use them is a skill.

> **Something has to change inside of her for her labour to go up to the next level. It isn't about a cure it is about an enabling. ... Offer a range of things. You are never really aware whether it was the Gelsemium that you gave because you felt her cervix was really rigid and maybe her mind seems a bit fixed and rigid about where she was going, or whether it was turning off all the lights and making it dark or whether it was when you examined her and she had a really good cry or whether it was because you put the acupuncture needles in and she stayed still and she believed that was going to work so she let go. I don't think you know. For me it becomes a style of practice and you do a whole range of things. But they aren't the sort of things you would tend to do in hospital which would be rupture membranes, put the epidural in, get the synto** [syntocinon] **up, and let's get cracking here. It**

> **is about being really gentle, the whole aim is to really support her in her focus of giving birth. Usually for me it is about so she stays at home and you honour her commitment to give birth at home** (1315-1).

Adrienne's use of unorthodox therapies also assists women to remain in their chosen birthplace - their own homes.

> **When you try something and it works it seems like such a good alternative to going to hospital and having the works. Why not do it? It does feel like a bit of a gift to be able to do that. ... It is very satisfying being able to offer something small, that is relatively innocuous, that can have really pleasing results. Whereas what orthodox medicine offers has the potential for quite harmful side effects. ... To be able to offer something that doesn't have the same rate of side effects. There is also something homely about it. It is something they** [the women] **can do. It gives it back to them** (2790-1).

Adrienne has great faith in the unorthodox therapies she uses. She expressed this as she discussed the techniques she uses to help women with post term pregnancies get into labour and avoid a hospital induction.

> **I've never known them not work, that is the other thing. They all go into labour when you do that** [use alternatives prior to induction; acupuncture, castor oil, homeopathy, cervical stretch]. **Maybe it has been a fluke for the last 15 years. Sometimes you repeat it the next day, occasionally you repeat it the third day, but they will be in labour within 48 hours** (1004-1).

However, she also appreciates that relevant research would help her in the day to day decisions of her practice.

> **I probably discourage women taking homeopathy as a**

> **routine. A lot of women want to take Caulophyllum[1] . I probably go in ups and downs in offering acupuncture. Last year I looked after eight primigravidas in a row who had straightforward, normal labours, all midwife only, intact perineums, no one was in labour more than eight hours, and the one thing they all had in common was this acupuncture tuneup. Then for some reason I didn't do it for a while and all the primips had problems. Oh yes, a study, I should have done it !** (1150-1).

Even without pertinent research Adrienne has reflected on her practice and she described how it has changed over time.

REFLECTION ON PRACTICE

Adrienne reflected on her practice throughout both the interviews. Because she has been involved in attending homebirths for 16 years she has seen changes in the attitudes of women who want homebirths, changes in the health system, and changes in her own practice. All of these factors have impacted on her use of unorthodox therapies.

Impact of the changing health system

Prior to 1991, a midwife caring for a woman birthing at home who needed to transfer to hospital, could not continue her care in hospital. The reality of transfer to the hospital staff intensified the determination of women to home birth. The majority of women who wanted homebirths 10 years ago came to Adrienne requesting information on unorthodox therapies, but now Adrienne finds she is the often the one introducing unorthodox therapies.

> **It used to be very clear cut. The women would want that information** [about unorthodox therapies] **from you. Everyone else was giving them the orthodox party line and you were seen as being their ally. You were their midwife who was caring for them at home and it was almost like a**

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1. Caulophyllum is a homeopathic remedy useful in enhancing efficient uterine contractions (Tiran & Mack, 1995).

> **wee conspiracy against the establishment. It was very easy, it was very safe to be unorthodox, very very safe. Now it doesn't feel nearly so safe. Because there are so many more midwives out there. ... homebirth has become, 'have your baby at home, have your baby in hospital', like a really easy choice** (775-1).

The changes in the health system mean that women now have more choices than they did 10 years ago. These health system changes have subsequently altered the way Adrienne practices.

> **I would be far quicker now to transfer women. We don't look after women who are as strident in their wish for homebirth. They are still going to have continuity of care. There isn't this big wrench between having your baby at home and hospital. It is much easier to transfer** (488-1).

Transfer is easier because (since 1991) it is possible for homebirth midwives to continue the midwifery care of a woman who transfers into hospital from a planned homebirth situation. Although the place of birth changes, the women continue to be cared for by their own midwife. Adrienne has also changed the way she uses unorthodox therapies.

Change in practice over time

In the early 1980's unorthodox therapies were used more in a routine prescription approach. Today Adrienne, rather than use them routinely, uses them in a more flexible and individual manner.

> **There was a prescription list that we did, from about 1980-1983. Amanda Zaren** [homeopathic midwife] **visited and said 'You don't interfere unless there is a particular symptom picture that you want to remedy'. She had an influence far greater than just on the use of homeopathics. So** [we asked ourselves] **why are we encouraging women to take things just as a routine?** (1095-1).

In reflecting on and changing her practice over time, Adrienne has become more flexible, but along with that she has lost some of the security that comes with practising one way.

> **I used to stand very still in one place which was supported by the environment that I was attached to. This is how I do it. This is how I practice, and there is a real sureness. And what has changed for me is I have lost a lot of that, and in being moderate I can really see benefits in something else. It doesn't have to be this way. It is a bit like being on shifting sand too and it is not nearly as comfortable** (1296-2).

Adrienne's practice has changed along with the context in which she works. There are many aspects to midwifery practice within this new political environment to consider.

THE POLITICAL CONTEXT

Adrienne has a broad view of midwives' use of unorthodox therapies. She is involved in the Midwifery Review Process and thus has an insight into many different midwives practices. Unorthodox therapies, she believes, are part of a larger midwifery issue. As we reclaim unorthodox therapies into midwifery practice, we must be aware of how we do it and the broader implications.

Reclaiming midwifery

Not only does Adrienne see unorthodox therapies as useful she sees **the use of alternatives as part of a much wider changing practice** [of midwives] (2120-1). After reading and reflecting on our first interview Adrienne felt very strongly that the use of unorthodox therapies was tied up in the larger issue of reclaiming midwifery.

> **Reclaiming midwifery and reclaiming birthing power and childbirth encompasses reclaiming those therapies and attitudes that promote the reclamation. That there is a certain style of midwifery that exists within a medical**

> **model, which is fine, but I don't know that that enhances us reclaiming midwifery and midwifery skills so midwifery stands stronger.** [I was] **Analysing why it** [unorthodox therapies] **is important and I think that is why. When we talk to a midwife in a review process about developing her midwifery skills like not routinely using ecbolics[2], it is about her reclaiming midwifery and it is talking in that wider context.** (250-2).

> **I'm aware because the review process is something I have been involved in for a long time, often in the interaction with the midwife about developing her midwifery skills, what she gets is that she is doing something wrong. And what this interview has given me a bit more access to is, this isn't about doing something wrong, it is fine for you to do it the way you are doing it but this is about midwifery reclaiming itself and actually having a strong sense of what is normal. Where do we need to assist this process? Where do we not need to assist this process? Where do we clearly need to intervene? Where can we use something in labour that has no side effects and will not diminish her somewhere? Somewhere, when we use drugs, like for pain relief, we are saying you** [the woman] **can't do it and there is the possibility for diminishing women. Whereas if you give something like acupuncture it is not like giving her a drug. It assists and enables her to use her resources to bear the pain. Not only is midwifery doing it's part, so are the women** (322-2).

In the process of empowering women, we reclaim midwifery practice. However, Adrienne is clear that unorthodox therapies should not just be exchanged for orthodox practices.

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2. Ecbolic drugs are synthetic oxytocics used to accelerate the third stage of labour.

Model of practice

While she believes that unorthodox therapies are a vital part of midwifery practice, she is concerned that they should not get slotted into the existing medical model.

> **We are being challenged to look outside what we currently do** [in orthodox practice] (3080-1).

> **I'm really aware that I do not want complementary, alternative, whatever, therapies to end up being used in the same model as we use orthodox. I have watched midwives, say instead of giving the injection of syntometrine, giving homeopathic Secale**[3] **. I've seen doctors do it too, and it is just like replacing one thing with another. And sure maybe it doesn't have the side effects but I think that having some consciousness about the way that you are offering and using alternatives is really important** (1250-1).

However, if we expect midwives to be skilled in unorthodox therapies, we have to more fully prepare student midwives in this area.

> **What I hear from the student midwives is a real thirst for more than they are getting from the technical institutes. ... So they are not acquiring it after the event.** [They are saying] **'We want this formalised, we want to get this properly, not just by good luck or good fortune'** (2970-1).

If our Midwifery Review Process is encouraging midwives to use unorthodox therapies then we need to ensure that student midwives have the knowledge they need.

> **If we say it is important, if we say it is midwifery, more tricks in our bag, we actually do need more than we come out** [of our educational programme] **with** (1220-2).

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3. Secale Cornutum is a homeopathic remedy useful in haemorrhage (Tiran & Mack, 1995).

Adrienne promotes the use of unorthodox therapies and finds them essential in her practice. Nonetheless she is very aware of the risks midwives take in incorporating them into their practice.

Minimal training

The lack of in depth knowledge in particular therapies leaves midwives very vulnerable to criticism from orthodox practitioners and institutions.

> **We have often acquired the information in a very haphazard sort of way. It's very experiential, you try something it works, you try it again and it still works. It is not like all of us have a great depth of knowledge. We are not the same as a qualified homeopath. We do not have a five year training in that particular specialty** (634-1).

> **I'm always slightly ambivalent about how much midwives are encouraged** [at the peer review] **not to have 100% of their women have ecbolics. Maybe the consumers do realise** [the constraints] **but they don't know just how terrifying it is to try and defend your actions when you have done something that is not orthodox. It's really scary. We are not trained homeopaths, we are not trained acupuncturists, we don't have a long formal training** (599-1).

While midwives who use unorthodox therapies or who decide not to use a recognized orthodox procedure or treatment are supported by the Midwifery Review Process, they leave themselves open to reprimand from orthodoxy.

> **Most of the time I feel quite confident. When I feel scared it is a fear of confrontation, a fear of being diminished, and it is a fear of 'My God, have I done the right thing here?** (911-2)

Adrienne has a wealth of experience in using unorthodox therapies in her

practice. Yet she is still vulnerable to criticism from orthodoxy.

Criticism from orthodoxy

Using unorthodox therapies puts midwives outside the realm of orthodox practice and vulnerable to criticism should their practice come to the attention of an orthodox practitioner.

> **The other thing that I suppose concerns me is sitting on the review committee that there's a tendency to try and encourage midwives to extend their boundaries, to become more interested in say, not giving routine ecbolics if the woman has had a physiological labour, having a physiological third stage as well. Looking for alternatives to antibiotics say for the treatment of mastitis. Both from the midwives and the consumers on the review committee, there is a lot of encouragement to do that and yet I know that those midwives know that if push comes to shove and that woman had a haemorrhage, that they would be severely criticised by the 'hospital' for not managing someone in an orthodox way** (560-1).

Adrienne feels practitioners are more vulnerable in today's climate than ten years ago, therefore the decision to use unorthodox therapies needs to be very clearly understood and agreed upon by the woman using it. Otherwise midwives are in an insecure position in relation to the orthodox medical profession.

> **A woman at nine weeks** [postpartum] **rang me because she thought she had mastitis and I gave her a whole range of information. She listened and then took herself to A&E** [Accident And Emergency]. **... The doctor said 'Your midwife told you to what? Take Belladonna**[4] **and Vitamin C? Why didn't she tell you to go to the doctor and get antibiotics straight away?' That happens. That then means that it is**

4. Belladonna is a homeopathic remedy that can be useful for the treatment of mastitis (Tiran & Mack, 1995).

> **quite scary for midwives to step out** (678-1).

> **I feel it is a bit of a siege mentality out there. I think that it** [unorthodox therapies] **is less acceptable now in lots of ways** (2590-1).

Adrienne also thinks that doctors are threatened by the increase in the amount of independent midwives, and therefore more likely to find fault.

> **Because there are a lot more midwives, I think the other issues are that there are a lot more threatened doctors who are much more willing to find fault with midwifery practice generally** (820-1).

Understandably, midwives who are being encouraged to incorporate unorthodox therapies into their practice are sometimes concerned about the potential impact this could have on their business.

Protecting your livelihood

Adrienne discussed a situation where a midwife who was being reviewed was being encouraged to take some courses on homeopathy and acupuncture.

> **She said she was reluctant to because it felt like experimenting. She wasn't prepared to do that. But I also think that it would jeopardise her alliances as well. As long as she behaves in a way that the particular obstetricians that she works with likes, then she is seen as being a good midwife and she will get lots of referrals. Her income is solid, she has got no problems. If she steps outside that, doing the odd homebirth, starts doing things that slightly might be controversial and if they get to hear about it if there is a problem it could be seen by them that somehow she has gone into another camp. I think there is a real self protection there as well** (860-1).

When midwives practice unorthodox therapies they step out of orthodox

practice. They open themselves up to potential criticism from orthodoxy and potentially risk their income. However Adrienne believes that all midwives' practices, whether or not they use unorthodox therapies, are vulnerable to scrutiny.

> **We do not practice in a litigious environment in this country so when we see someone who the worst thing** [going before the Nursing Council and/or the Medical Council] **has happened to there is a lot of reflecting on your own practice. 'I'd never do that, Thank God that is never going to happen to me'. And yet if everyone looks at their own practice there will be a time. There is that thing of trying to put distance between yourself and the possibility that that could happen to you** (1160-2).

Adrienne believes that we are all vulnerable to accusations, particularly from the medical orthodoxy, because midwifery practice is currently a highly emotionally charged and political issue.

ADRIENNE'S INPUT ON HER CHAPTER

Adrienne and I meet after I had completed her draft chapter to discuss it. I wrote notes as we talked. Adrienne asked me some specific questions about the nature of feminist research. She was impressed that she had the opportunity to read, comment on, and modify the chapter I had written from her interviews. Adrienne told me that she had previously had an experience of being misrepresented in a public domain, after an interview. She felt that the interviewer had used trickery and manipulation during the interview and in its subsequent presentation. She wanted me to know that the process of doing this research had been a healing experience for her. She felt I was interested in what she had to say. It was the antithesis to the previous interview, and she was very impressed with feminist research.

Adrienne reasserted that the first twelve weeks of last year had been really tough and that she had reflected that in her first interview. However, she was happy that the chapter did express what she had to say. She did insert several clarifications into her quotes but thought the rest of it was fine. Now

she feels she would speak even more strongly in favour of unorthodox therapies. She feels she has had a good run where her use of unorthodox therapies has been effective. It is exciting for Adrienne when she trusts the process, pushes the conservative obstetric boundaries, and the outcomes are good. Adrienne feels her practice is creative and alive.

Adrienne inquired about the other participants' experience of unorthodox therapies. She concluded by saying that by documenting experienced midwives' use of unorthodox therapies, this research gives weight and substance to the use of unorthodox therapies.

SUMMARY

Adrienne has attended women at home for 16 years and used unorthodox therapies to varying degrees during that time. This experience has allowed her to reflect on how the health system and the women she cares for have impacted on and changed her practice. Adrienne is strongly committed to working in partnership with women. She believes that at times the way she communicates with women could be seen as an unorthodox therapy, as it helps move women on in the process of labour.

Women in her care are introduced to health care options, other than orthodox ones, because Adrienne believes they are often effective and safe. She sees them working in different ways to orthodox medicine and with the large scope of therapies available, knowing what and when to use them is a skill.

Adrienne believes that unorthodox therapies are a vital part of reclaiming midwifery practice. However, as we reclaim unorthodox therapies into midwifery practice, we must be aware of the political implications.

CHAPTER EIGHT

HILIARY'S STORY

BACKGROUND

Hiliary works as an independent midwife in a large city. She trained as a Registered Nurse in the early 1970's in the United Kingdom, and followed this with her Part One in midwifery. Family circumstances prevented her completing Part Two and instead she undertook her Health Visitors training. She then worked in the community until she immigrated to New Zealand. Here she became involved in La Leche League which provided support and education to Hiliary who was caring for her three preschool children. Once her youngest child began kindergarten Hiliary returned part-time to the paid work force, and worked in a Neonatal Unit for four years. During this time she attended homebirth conferences, enjoying the family atmosphere and the sharing of information with women. She was also introduced to the politics surrounding birth. In the late 1980's she completed a technical institute course to become a midwife. Hiliary worked part time as a midwife in a hospital until 1990 when it became financially viable to enter independent practice.

She now has a full time, midwifery only practice attending 48-55 women a year. Seventy five percent of these women birth in hospital, the rest at home. Hiliary would like to increase the percentage of homebirths but says that the local population in her geographical area do not demand it. Hiliary works independently and has a liaison with two other midwives in her area who provide holiday and sickness relief, and second midwife services .

I interviewed Hiliary twice in her home. The interviews lasted one, to one and a half hours and were not interrupted.

In her practice Hiliary uses homeopathy, acupuncture, water, and massage. She uses these unorthodox therapies in non emergency situations where

orthodox medicine has limited options, and where there is potential for changing the situation.

> **Having that knowledge on board means you wouldn't have to use any kind of traditional** [medicine], **avoid that kind of interference, with benefit and without side effects. The most common thing I see is the long drawn out labour requiring pain relief. That is what I am thinking of. Rather than waving a magic wand and avoiding prolapsed cords and emergency situations** (2110-1).

She has attended formal courses in both homeopathy and acupuncture. Much of her learning has come from information sharing with other midwives and student midwives.

This chapter develops around three themes that ran through the two interviews; integrating unorthodox therapies into practice, resources, and the political context.

INTEGRATING UNORTHODOX THERAPIES INTO PRACTICE

Hiliary introduces unorthodox therapies to her clients by taking them through a very gentle and logical process that includes good communication, respecting women's beliefs, and empowering women.

> **When I go** [to visit women] **as an introduction I do tell them about different things. I introduce them to it and find out where they are coming from. And especially if I feel they are open to that or they might have used it themselves. Certainly getting back to nutrition is a big thing. Then I talk about herbs and homeopathy, arnica and acupuncture and massage. It really depends on the person and where they are coming from. If a person is really open to the idea they get hooked. It is usually a growing thing and as the pregnancy progresses we talk about it and maybe leave it with them for a while to think**

about it (1126-1).

Gentle and clear communication provides a way for Hiliary to introduce unorthodox therapies as well as '**get alongside people**' (900-1).

Communication

Unorthodox therapies are introduced as she establishes rapport. Hiliary appreciates how long it takes to establish a rapport with women, even in a midwifery only practice where she sees women for every visit.

> **Communication. I'm very much aware of relaxing people and philosophical/psychological approaches. Just getting alongside people rather than this is a remedy for that. Just find out where they are coming from because it is amazing even with continuity of care how long it takes for some people to really open up. ... I think it is just such a big area to get alongside people** (900-1).

She recognises that women have numerous issues to deal with in pregnancy. Considering the use of unorthodox therapies is just one of these.

> **A lot of first time mums don't have any idea where they are with birth, babies or even where they are with their own values. And when it comes to second time mums it is a different ball game** (990-1).

She is also aware that the notion of using unorthodox therapies is new to some of her clients and unacceptable to others.

> **For some people you need to take them down a path. Otherwise it is just too far and they see it as out on the lunatic fringe. For some people it clashes with their Christian values and it is like magic. They are not comfortable with it. So I introduce it very gently and accept that if someone is not comfortable with it, then respect the fact** (950-1).

Unorthodox therapies may not be acceptable to women for a variety of reasons. Hiliary respects this and supports women to maintain their belief system.

Respect women's beliefs

Hiliary has great respect for the differing beliefs of women. Although she is enthusiastic about unorthodox therapies she does not assume women will want to use them.

> **I have a cousin who is a Jehovah Witness and although I don't agree with them I have come a long way down the track. For them it is right, for them it is really important. So also now with women, if something is really important to them I have to respect it. I can't force my philosophy on them just because it is right for me** (1205-1).

Women decline the use of unorthodox therapies for both religious and ethnic reasons.

> **A lot of the Asian immigrants are more affluent and are used to having more of the medical model practice and they are not used to a midwife practice. They find it very foreign to even think along those lines** (830-2).

This respect for women's values can extend to supporting women who use therapies that Hiliary herself does not use.

> **One of the women I looked after, who was very much into homeopathy herself, would always use a pendulum to check it was the right remedy. I am very comfortable with that. I'm open to any ideas** (1060-1).

It can be frustrating, however, when she believes an unorthodox therapy, that is being refused by a woman, would be useful.

> **I feel a bit frustrated sometimes because I know the benefits. At the same time I have to respect where they**

> **are coming from. I had one woman who was very anti homeopathy because of her Christian beliefs. She got a breast infection. It was the weekend and it was very difficult for her to see a medical practitioner so I suggested we could try a one off, that the Lord wouldn't mind one time on the weekend. And it had such a dramatic effect on it and she came right within 24 hours that she did start to become a little more open but she has to come to it in her own time. I personally can't see any connection between homeopathy and religion** (1167-1).

Hiliary respects women's decisions to not use or not continue to use unorthodox therapies. She is also very aware that the overuse of unorthodox therapies holds the potential danger of showing no respect for women.

> **I can see overuse** [of unorthodox therapies] **could be a bit of a problem if midwives are not open to women's choice. I did hear of a woman who was most upset when she was a couple of days overdue and the midwife was trying to persuade her to take a homeopathy remedy. She didn't feel she was ready for it. I think midwives have to remember that women are a power source in themselves, we are there to help, not take away their choice** (2640-1).

It is important to Hiliary that women have the potential to find unorthodox therapies empowering.

Empowering women

Introducing the concept of unorthodox therapies during pregnancy has an effect that can extend into the woman's life well beyond pregnancy and birth. A wider variety of care options gives women a sense of control that they carry with them.

> **It means you can avoid anyone else taking over control, because that is what most traditional methods do. They take away the control of the situation. If you can do it on**

> **your own ... they feel quite special that they have found something that works. I can think of one woman particularly, who has had two homebirths and with the first one she got through pregnancy and labour without any hiccups but with the baby she was thinking about immunisation and she took it from there. She had come this far on her own, she went and talked to a Naturopath about different things, maturity, nutrition and now there is no way she will accept a traditional focus without some real contact with every avenue. Initially when I met her she was supportive but she has come a long way herself. She just blossomed** (2375-1).

While unorthodox therapies are not always successful, Hiliary believes that they offer another opportunity to women who would otherwise only have the option of orthodox medicine.

> **It is a case of well we could try this and if it doesn't work then we could go to base hospital or whatever. It is really in those situations that I will try it** (824-1).

> **If it doesn't work or it is not effective, OK, you learn more about it but if you don't try you can't make a difference** (626-2).

The use of unorthodox therapies gives women options other than those offered by orthodox medicine. Furthermore it gives women the opportunity to learn more about and incorporate unorthodox therapies into their lives. Unorthodox therapies also challenge Hiliary to learn more.

RESOURCES

Hiliary is keen to increase her knowledge of unorthodox therapies but finds resources difficult to access. She also talked about the difficulties of using unorthodox therapies in her practice without adequate midwifery support. To gain the support she needs she goes into the city. There she involves herself

politically in midwifery affairs where she can surround herself with like minded practitioners.

Need for more information

Hiliary is excited about the amount of knowledge available and its applicability to her midwifery practice. She expands her knowledge through courses, and talking with both experienced and student midwives.

> **I didn't grow up appreciating that** [unorthodox] **knowledge base and I've come back to that though my own exposure from other people. I'll have to say on the tech** [technical institute] **course we were introduced to a lot of opportunities to learn about alternatives. It was a little bit like the tip of the iceberg. Sufficient to give you a taste and realise this is a whole new ball game. Midwifery in that sense just blew me away because there wasn't anything you couldn't include. I have taken myself along to courses and talked to other midwives to pick up any tit bits along the way. I've only got to look at Joan** [Donley] **and realise it takes years to learn about things** (710-1).

> **We have new midwives coming in who are expecting midwives to have this** [unorthodox therapy] **knowledge and we haven't. Most of the direct entry midwives have gone into it because they have a long history anyway. They often have this information anyway. The ones I've dealt with have been really great in teaching me. Often their knowledge is based on personal experiences. It has really opened my eyes** (2316-1).

Although Hiliary actively seeks out courses and new information she often finds it difficult to fit in with her practice.

> **I find that most midwives are willing to share when we get together, it is just that we haven't been able to get together that much. It is a time factor. The idea of study**

> **days is great. When I was on holiday it was great I could go to anything that was available and enjoy the whole time and not worry about being called away. We have a bit of a problem with being on call, it can be disruptive especially if you have to travel far and get called back** (2230-1).

> **Unfortunately there isn't time to take yourself off and do these things in depth. It can be frustrating in that there is so much knowledge out there that you would like (...), you can't suddenly be the guru of everything** (2015-1).

While midwives are reclaiming and relearning about unorthodox therapies, Hiliary believes we also need to relearn some of the more practical skills that older midwives, who have worked in diverse situations, have.

> **What I am aware of is that some of those** [first aid] **skills have been lost. When I'm checking things out with her** [a longtime midwife] **there is often a practical way of doing things as opposed to an alternative way. Because of her range of experience, she has dealt with things that we just don't see anymore** (700-2).

As well as wanting to learn more about lost midwifery skills and unorthodox therapies, Hiliary feels in need of more midwifery support for her use of unorthodox therapies.

<u>Need for support</u>

Hiliary has only a couple of midwives in her geographical area that use, or support the use of, unorthodox therapies. Therefore, she frequently feels unsupported in her practice of unorthodox therapies.

> **If you are not working with people that do it** [use unorthodox therapies] **, because there is no one else in this area that actually offers that, you feel a bit out on a limb** (824-1).

Many of the independent midwives in her area have years of experience in

hospitals. Hiliary believes this makes it difficult to build a support network for midwives practising a midwifery model. She speculates that other areas have not had this problem.

> **There are some groups working together** [in my area] **and** [they] **are very supportive of one another but some of them are very hospital orientated. Maybe the midwives out west** [of the city] **didn't have that problem. They were out** [of the hospital] **and that was it. Maybe these** [my area] **midwives don't need the same loyalty to each other** (392-2).

Hiliary identifies that feeling unsupported emanates from collegial lack of experience in unorthodox therapies combined with inadequate time to meet together.

> **Part of the problem is we don't see enough of each other to develop those close relationships. ... It is a difficult scenario and the midwives that are out are experienced in years but I wouldn't say they were experienced in alternatives. It is a difficult time but some are coming more and more round to the idea of alternatives** (265-2).

Although in her area there is not the volume of midwives using unorthodox therapies, she does acknowledge support from two of her local colleagues.

> **An interesting thing I mentioned last time was that one of the midwives was old school, wasn't really into alternatives but she recently had a homebirth and I couldn't get there because I was with someone else. The woman was overdue and the baby was OP** [occiputo posterior] **position, high head and supposedly going for an induction a few days later. But I talked to** [the second midwife] **about it and I said you have nothing to lose, why don't you use acupuncture. And because** [the midwife] **wasn't that comfortable she sent her to** [an acupuncturist]. **So she had the acupuncture about 11am on the Friday**

> **morning,** [and] **she came home. It is about an hour's trip. She had backache on the way. She SRM'd** [spontaneously ruptured her membranes] **at two in the afternoon and the baby was born at six o'clock. So the midwife, who as I say is a little resistant to these ideas, is now very much blown away** (584-2).

Hiliary feels optimistic that interest in unorthodox therapies is growing among local midwives. However, she still feels her practice is quite different from that of many of her colleagues. She actively seeks out midwives in the city, who reflect her practice, for more ongoing support.

> **I feel a bit conscious because I am a bit proactive and I probably have a bit of a reputation of someone who has a bit of a mouth. I'm a bit of a stirrer in that sense. But when I have contact with the other side** [of the city] **they are all saying the same thing as me. Huuuh, what a relief! I'm not out for attention here. I'm not trying to outrun them. Someone is saying the same thing that I am** (445-2).

She has maintained contact with like minded midwives, who live out of her area, by involving herself politically in midwifery affairs.

> **It was one of the reasons I was quite happy to go back on the college** [regional New Zealand College of Midwives] **committee, as well as I like to know what is going on, and politically it affects my future. I always like to know ahead what is going to happen. ... The plus thing about being back on the college is the involvement with other people out of area. You do need that kind of support** (473-2).

> **I've gone looking for support. I'm also on the midwives review committee. And they focus on the midwifery model. And that works well for me as some of the colleagues I work with are more hospital oriented. So I see that as support. It is not the midwifery model that is**

> **in question** [at the review], **it is the medical model but for some of my colleagues it is the other way round. You could say I went looking for support in an indirect way. If you can't find it in one area you go looking for it in another** (528-1).

Hiliary's involvement with the College of Midwives has given her support for her practice, and also given her a broader view of the context in which midwives practice.

THE POLITICAL CONTEXT

Politically, Hiliary believes midwives are very vulnerable to the outspoken opinions and power of the orthodox medical profession. This power influences both the amount of information midwives are comfortable sharing with orthodox practitioners, and midwives' willingness to use unorthodox therapies. Nevertheless, Hiliary firmly believes that general practitioners are being challenged by independent midwives. She also believes that midwives have a responsibility to be careful how they use unorthodox therapies.

Vulnerability

Hiliary's use of unorthodox therapies in her practice causes her to feel vulnerable in the present political climate as she feels orthodox medicine is just waiting for a chance to criticise midwifery. She is aware that the whole midwifery profession is vulnerable to these accusations and understands how this affects her practice.

> **It is a political thing but you are still aware that people are waiting to pounce and there is probably a little bit of reserve about using some of the therapies with open slander because no one wants to put themselves in the position of being accused because they used alternatives instead of traditional. It is a fine line. You have to be aware that somebody could be looking for something** [to go wrong] (2017-2).

Prior to our interview an adverse article about midwifery written by a gp obstetrician had been published in the national newspaper[1]. His views were supported by the president of the Royal New Zealand College of Obstetrics and Gynaecology, Dr Tony Baird, in a different article within the same issue[2]. Hiliary had this in mind when she made the following comments.

> **Sometimes you get a little paranoid. Maybe we should never read the newspapers** (2116-2).

> **... now the atmosphere is** [that midwives are] **covering their backs a bit. We are all a bit more politically aware and need to be seen as doing what is expected of us** (1340-1).

Midwifery practice is political. The politics of practice influence many midwives to practice only in an orthodox medical way.

Working with orthodox practitioners

Independent midwives can also be orthodox practitioners. Hiliary sees a potential conflict of interest between midwives who have been hospital based for many years and are now in independent practice, and those who have been mostly independent practitioners.

> **Some of them still have a sense of loyalty to the hospital and the hospital administration even though the administration is changing. A lot of them have been there so long it is their second base. It is part of them, and to anything that is totally midwifery that will conflict with that has a pull. I find one midwife in particular that when I talk about the MPO** [Midwifery Practitioner Organisation] **she always comes back to me about what the hospital is doing, what the administration is doing, and I feel that she is in two camps. Because our hospital has a reputation of always working well with the midwives there is a feeling that we**

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1. Sutherland, A. (1995). Birthing: danger in 'active inactivity'. New Zealand Herald 3/1/1995.

2. Ferguson, A. (1995). Babies dying for need of proper care says doctor. New Zealand Herald 3/1/1995.

> **don't want to upset that and have the problem that some other places have had. But you pay the price** (275-2).

Hence to ensure a trouble free hospital working environment, some midwives are unwilling to step out of the orthodox line. However, Hiliary believes the hospital midwifery staff are becoming more interested in, and supportive of, unorthodox therapies.

> **There isn't the same kind of resistance at all. And I know one of the charge nurses for a while there was encouraging the use of bach flowers**[3] **, so if she uses it herself she can then extend it on. So a lot of the hospital midwives are changing and those that are not changing in their own practice are more accepting of mine** (1340-1).

Nonetheless, when interfacing with the hospital staff Hiliary decides on an individual basis how much information she shares. She is hesitant to alienate staff that she needs to work with.

> **I'm aware that some of the hospital midwives do independent as well, and have been exposed to women who actually want it** [unorthodox therapies]. **Probably at the moment I would be a little cautious in hospital. It gets down to personalities and it depends whose on. I'm a lot more down the track now and I feel more assertive as regards medical practitioners. If I'm in hospital and I'm the primary care giver, then no doctor is going to come near me anyway. I've probably got a reputation of leave well alone. I'm a bit more cautious with the consultant. I don't think he would be critical but I don't think he would be supportive. It just depends on the circumstances really. Because he is the only one of a few we can use, then it is a case of keeping everyone happy. That's the reality. It is different in a big hospital where you can call**

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3. Bach Flowers are non toxic remedies made from plants to help balance specific mental and emotional conditions (Tiran & Mack, 1995).

> **on different specialists. We only have one and I don't want to alienate him** (1225-1).

Consultants are limited in numbers in small hospitals. Having no choice but to deal with an orthodox consultant can prevent midwives from sharing information even when the outcomes have been positive.

> **A woman recently had acupuncture** [to initiate labour prior to a planned medical induction] **and the specialist wasn't told that she had it.** [It was successful.] **The midwife involved might tell him in the long term but not in the short term. On one hand I understand why, yet on the other hand I think it is bad because there could be benefits. I think his main reaction would be indifference really** (927-2).

However, in these highly charged times Hiliary finds it reassuring to see how time, consumer pressure, and research have all changed childbirth practices.

Change

Hiliary has found it helpful, when she is discouraged about lack of progress and change, to reflect on the past and see how practices and attitudes do change over time.

> **I have been reading this book about the history of Parents Centres and how in the 30's and 40's it was the women who made the difference. We have come a long way down the track. An example** [was given] **of a woman whose legs were tied together because the doctor wasn't there. Totally barbaric! But what are we doing today that will be unheard of in 20 to 30 years? It made me aware that we go with the flow of the day** (927-2).

Despite going with the flow of the day, Hiliary sees research as having an essential role in challenging and changing midwifery practice.

> **When Marsden Wagner[4] looked at New Zealand hospitals he identified that ...** [one hospital] **only had a 10% Caesar rate but they also had 55% plus midwifery input. So sometimes it takes epidemiology to look at it and make changes. Certainly after that a lot of hospitals in New Zealand were asking** [that hospital] **what they did differently** (988-1).

Hiliary takes pride in the fact that a critical factor influencing the (relatively low) ceasarian section rate at the local hospital was the midwifery input. She believes independent midwives are responsible for initiating positive change within the orthodox system. However, there are some general practitioners, who vie for the same clients as independent midwives, who are feeling challenged by independent midwives.

Challenging general practitioners

Hiliary does almost all midwifery only care and she thinks that independent midwives are posing a real challenge to general practitioners (gps). They now have competition for the same clients.

> [We are] **definitely challenging gps as concerns their budget. They up to now have had the control and the advantages of traditional medical techniques and** [now] **they have to justify their availability. If we have something equal to epidurals why do we need them** [the doctors] (2476-1).

> **I've had several gps that are really worried that they are losing patients to midwives. I personally think they are losing their business. ... They are already feeling threatened in that way because they are used to a certain amount of control. The one thing that a client does need them for is a prescription for traditional medicine and if she doesn't need that, she doesn't need them** (2550-1).

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4. Marsden Wagner is a Perinatal epidemiologist who acts as a consultant to WHO.

Often women who have experiences with unorthodox therapies in pregnancy realise gp's are not the only providers of family health care.

> **Even when the midwife is no longer involved** [with the woman] **then she** [the woman] **has been exposed to these things and they might go somewhere else** (2618-1).

By introducing women to unorthodox therapies during pregnancy and childbirth, there is the possibility that women will look for other health practitioners as well as, or instead of, their gp. They become more selective about the type of health care they need.

Midwifery practice

Midwives need to be very careful of how they use unorthodox therapies in their practice. Hiliary is fearful that we may indiscriminately swap orthodox medicine for unorthodox therapies.

> **The idea really is to get women to use their own experience, not just impose a quick fix on them. I think that** [the quick fix] **will happen if midwives are exposed to the idea that this** [unorthodox therapies] **is the be all and end all. There is an alternative use for everything and they just have to find out what it is. I'm not saying homeopathy and acupuncture don't have a use in every situation, I'm saying without finding where the woman is coming from you can't always jump in feet first and make that the only option and condemn everything else. You just go round in circles and then someone comes along and threatens our power because they offer something else. You have to get alongside women and find out where they are coming from (2640-2).**

Hiliary is very clear that midwives need to work in partnership with women. She believes we need to use unorthodox therapies appropriately within the context of women's lives, and not present them as the only option.

HILIARY'S INPUT ON HER CHAPTER

Once the draft copy of this chapter was completed I sent it to Hiliary to read and comment on. Two weeks and one cancelled appointment (for me to attend a birth) later, I met with Hiliary in her home to discuss it. I wrote notes as we talked. Overall, Hiliary was happy with the chapter. There were some geographically identifying names in the draft that she requested I change to maintain anonymity. She also refined the grammatical structure of two sentences, but this did not alter the meaning. She was happy with the themes I had chosen to organise the interviews into this chapter. We discussed the question about why some religions oppose unorthodox therapies.

Hiliary said she did not feel as optimistic now about midwifery practice as she did during the last interview. She feels that many midwives are just coping with getting through each day and do not have energy left over for learning about unorthodox therapies. The current political changes[5] leave midwives unsure of their future direction. These proposed changes have forced midwives to become more commercially aware to protect their income. This in turn has created divisions among some midwives. Overall Hiliary believes morale among midwives is low.

Reflecting on the chapter and her use of unorthodox therapies, Hiliary once again lamented her lack of knowledge. She wished she had more time to learn and greater knowledge so she could use unorthodox therapies more. She concluded however by saying that she believed midwives needed to see the whole picture. Caring physically, emotionally, and spiritually for a women was the most important thing and unorthodox therapies were just the '"icing on the cake".

SUMMARY

Hiliary has been interested in midwifery, and involved in childbirth issues, for 20 years. She has been an independent midwife for six years. Unorthodox

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5. At the time of this last interview, the way independent midwives are to be paid by the government is on the brink of changing. The new fee schedule appears to reduce care options for both midwives and women.

therapies are introduced to her clients in the process of building good rapport and finding out about the women's life and beliefs. Hiliary believes unorthodox therapies have the potential to empower women but respects the choice of women who choose not to use them.

She would like to increase her knowledge of unorthodox therapies through further courses but finds it is difficult to find the time from her practice. She also feels isolated geographically from midwives who use and support unorthodox therapies. By involving herself politically in midwifery affairs she can have regular contact with, and obtain support from, like minded midwives from all areas.

Hiliary is very aware of the political climate midwives work in. She believes midwives and hence the midwifery profession is vulnerable to the outspoken opinions and power of the orthodox medical profession. This vulnerability has been exacerbated by the uncertainty of the future as the Government changes its policies regarding payment of midwives.

Hiliary believes that the process of building a good rapport with women and finding out about the reality of their lives is an essential element in her practice. Unorthodox therapies are a part of this process and not separate from it.

CHAPTER NINE

INTEGRATION AND ANALYSIS OF DATA

INTRODUCTION

"Defect brings warning over herbs. Midwives doubt claims". Thus read the headlines of a recent national newspaper article which highlighted the topicality of midwives' use of unorthodox therapies (Barber, 1996). In the article two paediatricians suggested that the herbs, blue and black cohosh, were a possible cause of cerebral palsy in a newborn. The herbs were given by a midwife to a woman labouring at home. The doctors, with no experience in using herbs, proposed this causation without scientific basis. They state that these herbal treatments contain potentially toxic constituents and their efficacy is unknown thereby inferring that they should not be used by midwives. Other causes for cerebral palsy, that have been well researched such as post maturity and prenatal insult, were not discussed by the doctors (The Australian and New Zealand Perinatal Societies, 1995). Two spokeswomen for midwives believed that there was no information to indicate any problems with the herbs. Nonetheless the underlying message from the paediatricians was that this would not have happened had the labouring woman been cared for by doctors in a hospital.

It is this kind of adverse publicity that makes research of midwives' use of unorthodox therapies particularly relevant. However, it is not enough to concern ourselves solely with the safety issues of unorthodox therapies, although this is unarguably important. Beyond being safe, do unorthodox therapies empower women and midwives? The answer to this question lies in the critical examination of the impact that unorthodox therapies have on the everyday lives of women and midwives. This research explores aspects of the impact of unorthodox therapies and examines it within a broad socio-political context.

Feminist case study was used as the research method to provide an in-depth analysis of the experience of five independent midwives' use of unorthodox therapies. I did not define 'unorthodox therapies', preferring instead to let the

midwives discuss what therapies they regarded as being unorthodox. Consequently the interviews included discussions about unorthodox therapies and practices. The therapies and practices used by the midwives included homeopathy, acupuncture, herbal remedies, cranial osteopathy, massage, cell salts, aromatherapy, plants, hydrotherapy, and the Hamilton rocker. Homebirth and confrontation were seen by the midwives as practises that derived from unorthodox philosophies.

The midwives were each interviewed three times. The interviews were open ended and involved reciprocity. Themes generated from the interviews, using case study analysis, were validated by each midwife. Four major themes which were identified from the midwives' interviews served as a framework to organise the case study chapters. These themes were: integrating unorthodox therapies into practice, the political context, resources, and reflection on practice. Priority was given to the voices of the midwives. Hence the case study chapters consist of the midwives' direct quotes interwoven with my statements.

Maynard (1994) believes feminist researchers have an obligation to go beyond citing experience in order to make connections which may not be visible from the purely experiential level alone. To go beyond the midwives' individual experience, I asked the following questions. What were the midwives' main concerns? How did using unorthodox therapies impact upon their practice? What were the points common to all the midwives' experience?

In this chapter I present three key points that arose from the case studies. I discuss these in relation to relevant literature using the feminist concepts of power and gender in the analysis. This process of utilising feminist theory to make sense of experience, connects experience to understanding.

<u>The three key points evident from the research are</u>:

1. The centrality of the empowerment of women

2. Concerns regarding knowledge of unorthodox therapies

3. Professional vulnerability within the bio-medical orthodoxy.

THE CENTRALITY OF THE EMPOWERMENT OF WOMEN

The empowerment of women was a central concern of all the midwives in this study. They strongly believed that the way in which they used unorthodox therapies in their practice benefited and empowered women. The benefits of offering and using unorthodox therapies that they discussed included; giving women more choices in their care, helping them avoid medical intervention, assisting them to labour and birth at home, reducing the need for drugs and their subsequent side effects, avoiding others taking control, offering options where bio-medical medicine has none, offering remedies and options that are safe, effective and cheaper than orthodox methods, and personalising care to each woman.

Rodwell (1996) has analysed empowerment as; a helping process; a partnership valuing self and others; mutual decision making; and freedom to make choices and accept responsibility. The midwives in this study described all these features in their interaction with women. Decisions regarding the appropriateness of using an unorthodox therapy were made with the woman that the midwives were caring for. They were based on understanding, as much as possible, her life and beliefs. LoCicero (1993) calls this gender appropriate care. This care entails valuing non invasive interventions such as social support, placing less value on active medical intervention and attending to psychological and relational factors.

Attending to psychological factors means that sometimes the midwives in this study used their communication skills in ways that were confrontational and could be seen as unorthodox. However, they believe women who are given the opportunity to express and resolve their emotional conflicts during the childbirth process, can only benefit. Adrienne pays a lot of attention to, and is willing to, explore a woman's emotional health and is not afraid of dealing with what might surface. The examples she gives (p.95) demonstrate her belief that women can and do work through their own emotional blocks even during labour. Meredith also gives a wonderful example of this in her description of a

woman labouring in the intimacy of her own home (p.65). Adrienne believes that we do not need to be afraid of assisting this process and that ultimately the women are likely to be empowered much more than if they are 'treated' in an orthodox manner and anaesthetised with drugs.

She is not alone in this belief, for Sakala (1988) found that the midwives she interviewed believed that pregnancy and birth were potent catalysts for the expression of conflicts. LoCicero (1993) comments that midwives have noted the effectiveness of verbal intervention in allowing labour to progress, or to resume progress once it has slowed. They, like Adrienne, urged and assisted women with self awareness and resolution of such conflicts. This, they believed, considerably enhanced the comfort, speed and safety of birth.

This care is in contrast to the care given by obstetricians who often actively intervene. By robbing women of a potentially enriching experience and keeping them dependent upon the medical system, they disempower women. LoCicero (1993) states that gender differences in cognitive style, moral perspective, the development of empathy, in helping behaviour, and in the development of a sense of self contribute in a significant way to the establishment and maintenance of high levels of unnecessary interventions in labour. This includes women obstetricians, practising within the masculinist medical model of care, who are highly likely to function in ways that we see as masculine. Specifically LoCicero argues that the scientific/masculine model of assessment and intervention continues to adversely affect childbearing women because it fails to provide an adequate framework for dealing with psychological factors that unfavourably impact on labour. The midwives in this study do attend to the emotional lives of the women they care for. They believe that the ways in which they assist and support women to deal with the physical and emotional process of childbearing is to provide individually appropriate care and give the women a sense of control - hence empowerment.

It was important to the midwives that they gave the women they care for full information on their choices of care, both orthodox and unorthodox. Providing women with these options gives women freedom of choice and allows them to take responsibility for their own health. The process of women informing

themselves about options outside of what orthodox medicine offers, opens up a new way of looking at health care, regardless of what therapies they choose. Adrienne (p. 99) and Hiliary (p. 114) stressed how experience with unorthodox therapies in childbirth flowed into other areas of the women's lives. Many women, who use unorthodox therapies during childbirth, continue to question orthodox health care for themselves and their families by looking at a variety of health care options. When women learn that they have a broad range of options, they begin to question the monopoly that the bio-medical orthodoxy has held. This diminishes some of the controlling power that has been held by the bio-medical orthodoxy, as women are no longer reliant on the dominant method of health care.

Unorthodox therapies in labour were used mostly at homebirths by the midwives in this study. Homebirth itself is an unorthodox birth choice that has political ramifications through its potential to empower both women and midwives. The Auckland Home Birth Association (1993, p.1) states that a homebirth is a birth where an attitude of being responsible for your own health and in charge of your own body is paramount. It is not a negative or anti-hospital decision, rather it is an affirmation of women's ability to give birth. Women who birth at home have a strong sense of their own power and abilities and are not prepared to hand over the control of their labour and birth. They wish to labour and birth in ways that are appropriate for them rather than fitting themselves into hospital protocols and social mores.

Homebirth provides a woman with the familiar, private and comfortable surroundings of her own home. In her own environment she can feel more free in expressing her responses to labour and is less limited in choosing her methods of coping than she would be in a hospital. Meredith talks of a woman who in the process of labour expressed her fears about childbirth, childrearing, and lack of support. She then became "very sexual and very intimate with herself and her partner" (p.65). Meredith believes this only happened because the woman was at home. Jackson & Bailes (1995, p. 494) agree that coping techniques often used at home such as "lack of modesty, nudity, sexual intimacy, nipple stimulation, loud music, vocalisation, drums, or dancing" may be unavailable or inappropriate in a hospital.

Midwifery care at home, therefore, has the opportunity to be more focused and intimate than care in a hospital. Meredith talks of how the home setting brings intimacy to childbirth and 'allows women to be themselves'. Allowing women to be themselves is what Meredith sees as unorthodox. It requires that the focus stays on the needs of the labouring woman. Sakala (1988) states the midwives in her study described the importance during labour of, amongst other things, eye to eye contact, attentiveness of the midwife and support people, emotional and physical support. She contrasts this to the mundane chatting of hospital personnel during the birth process.

Midwives have responded to women's wishes for care outside the bio-medical system by providing innovative, safe, unorthodox care and attending them at home. Homebirth midwives have faith in women's ability to give birth. This differs from the orthodox view of childbirth which has convinced women that their bodies cannot birth without medical help and technology (Armstrong & Feldman, 1990). The power of birth remains with women when they birth outside the structures of the bio-medical orthodoxy.

The midwives in this study are confident that the way that they use unorthodox therapies in their practice empower women. However, Morgall (1993) suggests that what is best for individual women may be in conflict with what is best for women in general. While there is a general assumption that unorthodox therapies are more 'holistic'' in approach than orthodox medicine, the philosophies behind many unorthodox therapies treat an individual's problem as her own. This produces a very individualistic approach, similar to orthodox medicine, where women can be blamed for their problem without recognising society's contribution to their 'problem'.

Take, for example, a woman who is slow to progress in labour. From an orthodox point of view the woman's body is seen to have failed and to require medical intervention (artificial rupture of membranes, syntocinon augmentation of labour, instrumental delivery or caesarean section) to birth adequately. Little heed is paid to the fact that we have a society that promotes fear and powerlessness in childbearing women and it is this culturation that affects how they cope and progress in labour. Alternatively a midwife using unorthodox therapies in her practice may attend to the woman's emotional

needs and use acupuncture or homeopathy to stimulate labour. This unorthodox approach may solve that particular woman's problem, by stimulating her body to progress in labour, and thus avoid medical interference. Although the midwife may have recognised and confronted the larger issues of fear and powerlessness with this woman, her care remains individually focused. It does nothing to challenge the orthodoxy's assumptions that all women should labour within universally defined time limits regardless of individual circumstances.

Thus solving one particular woman's problem may weaken women's position in general by failing to challenge both the bio-medical and societal beliefs. Moreover, not all women have access to alternative treatment. Unorthodox therapies offer only a short term response for the privileged. Meanwhile, medical domination and interference continues for the less privileged women.

As feminists our focus must remain firmly on the larger political issues. This is not to say that individual women must not do what they can to redress the inequalities they face. As well as working on an individual level, all midwives need to challenge prevailing orthodox norms which oppress women. Celia Kitzinger (1993, p.489) states "It is possible to patch women up and enable them to make changes in their lives without ever addressing the underlying political issues that cause these personal problems in the first place". She is talking about women in psychotherapy, but the principle relates well to midwifery. We need to exercise caution lest we reduce political concerns and major socioeconomic issues to personal, individual and psychological matters. As feminist midwives we must perceive and reframe people's health concerns, not as individual pathologies, but as shared outcomes of the kind of society we live in (Webb, 1986).

Like orthodox treatments, unorthodox therapies also have the potential to undermine women's ability to believe in themselves. While the midwives in this study believed that unorthodox therapies empower women to rely on their own resources, some of the women they cared for still saw unorthodox therapies as a cure for a problem that came from outside of themselves (Judith, p. 53; Brigid, p. 85). Does offering unorthodox therapies reinforce the same message that women receive from orthodoxy, that their bodies cannot

do this without help from us? Are we implying that their strength and resources are not enough? Is it yet another way of maintaining control over the powerful processes of pregnancy and birth?
It is essential that midwives view women as strong and able to experience their own power. Page (1995a) believes it is the task of midwives to support the personal power of women in becoming mothers. She believes this personal power is essential in enabling women to mother their babies and that it will help them throughout the years that follow. It is important for us as midwives to believe that women are capable of birthing with their own resources. Thus we must use unorthodox therapies wisely to enhance these resources rather than supplanting them. We need to examine how the way we practice benefits individual women and women in general.

The midwives all described how they provided individual midwifery care to women based upon an understanding of that woman's life situation. They told of how their orthodox and unorthodox care was inextricably linked to this understanding. The midwives believed the way that they offered both therapies within the context of women's lives empowered women by giving them the opportunity to retain control over their childbirth experience.

CONCERNS REGARDING KNOWLEDGE OF UNORTHODOX THERAPIES

The midwives believe that the knowledge and skills that they have of unorthodox therapies enhance their practice. They had gathered the information about unorthodox therapies from many different sources, mainly informally. The sources of information included information sharing with other midwives, books, specialists in their field, courses and workshops, student midwives, the women they work with. There was also a genuine desire for more information and skills about a variety of unorthodox therapies among the midwives whom I interviewed. All of them expressed a desire for more knowledge and a frustration at the limitations of their time. They had all recently participated in further formal education about the use of unorthodox therapies and regularly discussed with other midwives, situations where they used unorthodox therapies. This finding is similar to that of Sakala (1988) who found that the independent midwives whom she studied were interested in

many healing modalities and were involved in continuing education. However, even though the midwives in this study actively sought out information on unorthodox therapies, they raised a number of concerns regarding knowledge of unorthodox therapies. These concerns included how this knowledge is shared, obtained, controlled, commercialised, and misused.

The knowledge sharing that has been traditional between women over the centuries, and that is reflected in how the midwives in this study gained much of their information on unorthodox therapies, is potentially at risk in our new competitive health care market. Meredith sees a tendency for midwives using unorthodox therapies to protect their knowledge as a vital and often unique part of their practice and business. She believes her use of unorthodox therapies is one of the factors in her practice that attracts clients to her (p.60). As midwives in independent practice compete for sufficient client load to guarantee their income, those offering unorthodox therapies will tend to maintain their competitive edge in the marketplace. Currently there is an abundance of work for independent midwives so there is little real competition. However, the threat is present. Ultimately the lack of information sharing is a reality that will have to addressed because it will disadvantage women.

The unorthodox therapy industry, on the other hand, willingly provides information and products for midwives. Brigid and Hiliary both expressed concern that as midwives are fed more and more information (often via advertising) from the businesses who market 'natural' remedies, these midwives will be used for promoting the business of unorthodox therapies in the same way that drug companies have used the medical profession. Murray (1994) believes that the drug companies control medical education by providing the majority of drug information to physicians, regularly offering gifts as a promotional ploy, advertising heavily in medical journals, and sponsoring continuing education courses for doctors. He reports that since 1950, the drug industry has been the most profitable industry in the United States, and it continues to increase its profit margin yearly. Osbourne (1994) has stated that complementary medicine is about to become big business in the United Kingdom, and has been given support by both the British government and other politicians. Although unorthodox therapies are, at the moment, far removed from the multinational scene of the drug market, the potential for

influence, control and excessive profit needs to be watched.

Furthermore, corporate business is dominated by men (Kanter, 1977; McGregor, Thompson & Dewe,1994). We can safely assume therefore that the marketing of unorthodox therapies is predominantly a patriarchal business. However, their target group in pregnancy and childbirth are women. Ironically some of the remedies such as red raspberry leaf, blue cohosh, and tea tree which are marketed for pregnant women have come from the wisdom of generations of women across different cultures (Goldsmith, 1990; Weed,1986). Where are the businesses obtaining this knowledge which they then pass off as their own? Are their sources of knowledge recognized? Do any of the profits return to the cultures who have held this knowledge over the years? Women's knowledge, that in the past has often been dismissed, is now usurped by men in the commercial market. Capitalism and the corporate image have given simple herbal remedies credibility - but at what price?

Will women no longer trust their simple folklore remedies because they believe the bought, packaged items to be superior? This is an issue of concern to Brigid. As midwives promote the use of unorthodox therapies in their practice, we do become unwittingly involved as agents for the commercially packaged version of unorthodox remedies. In this process we may overlook the more simple affordable remedies and options that are available to women. Brigid (p.88) believes we must continue to encourage women to be well in themselves and then offer only the simplest, low cost or non commercial remedies first. Pfeil (1994) is also concerned about the effect of this commercialisation upon women. She emphasises the need for midwives to protect women from false promises and financial exploitation precisely because many alternative treatments are in fact commercial enterprises with profit, not health, as their primary objective. Ironically in our desire to increase choices for women, and to avoid interventions and drug therapies, we are in danger of over promoting commercialised unorthodox remedies. Rather than increasing women's choices, commercialisation that is controlled by a male dominated system will ultimately reduce choices and limit midwifery practice. We must be careful not to exchange one oppressive orthodoxy for another.

Although the midwives all believed, from their own experience, that the unorthodox therapies they used were safe, they expressed concern about the lack of research basis for many unorthodox therapies. They recognised that they are using some therapies without any researched evidence of their safety, effectiveness, or benefit for women. Why this lack of research? One obvious reason is that unorthodox therapies often do not fit well into the scientific model of research (Jingfeng, 1987; Tan, 1989). Also there is little money for research because most medical research is funded by pharmaceutical companies and orthodox university institutions (Rankin-Box, 1988). More concerning is that while the commercialisation of unorthodox therapies booms, there is no real incentive to do research. Pfeil (1994) asks why the alternative health industry, which already has a lucrative market, would risk initiating, promoting or funding research that might prove its products to be worthless or even dangerous.

The commercialisation of unorthodox therapies is perceived to place profit above health. Midwives need to be aware that we are in danger of being targeted by these companies to promote their products. As we use their products we must continue to address issues of safety, research, education, and non commercial alternatives. The power and control that the large orthodox drug companies have over the education and practice of orthodox medical practitioners must not be repeated with the unorthodox therapy industry controlling midwives' education and practice.

Adrienne (p. 101) and Hiliary (p. 124) believed that the introduction of unorthodox therapies into midwifery practice gives midwives an opportunity to reclaim our midwifery knowledge and skills, and re-evaluate our model of practice. Adrienne maintains that the reclaiming of midwifery and midwifery skills includes the reclaiming of unorthodox therapies. Moreover, she sees the use of unorthodox therapies as part of a much wider changing midwifery practice. Prior to the professionalisation of midwifery it was women with the expertise in techniques to ease difficult births and a knowledge of herbal medicines who became the sought after birth assistants. Much of this knowledge, an important part of women's history, has been lost or destroyed (Goldsmith, 1990). Today it is the male dominated bio-medical orthodox system that is seen to have the knowledge and power necessary to ease

difficult births. Moving from a medical to a midwifery model of care provides a way to disempower this bio-medical orthodoxy.

There is a danger that midwives could substitute one orthodoxy for another, without changing the underlying medical model of care (Spiby,1993). Does how we practice challenge the existing system? Does it question the orthodox protocols? Are we simply trying to fit unorthodox therapies into the protocols? Both Adrienne (p.103) and Hiliary (p.124) raised these queries including how unorthodox therapies fit into midwifery models of practice. Hiliary is particularly concerned that midwives may be tempted to just replace orthodox therapies with unorthodox therapies. Although this replacement may appear to be an improvement, it does not address the fundamental problems of the system.

There were some areas of concern about knowledge, while not specifically raised by the midwives, that surfaced in finally analysing the data. In our enthusiasm to enhance our knowledge of unorthodox therapies, are we critically examining whether the people we take courses from, and refer our clients to, work in a way that is congruent with the philosophy of the therapy and congruent with our midwifery practice? Formal education courses about unorthodox therapies are not originating from midwifery schools. Courses are run either by midwives with experience in the area, or by unorthodox therapy specialists in their own areas of expertise. These courses, particularly homeopathy and aromatherapy, are frequently advertised, in our professional literature, specifically targeting midwives. The Nursing Times' (1993) introduction to its special feature on complementary therapies warns that there is a danger that the enthusiasm for complementary therapies will lead to uncritical acceptance of some practitioners' claims. This is already a real problem in the promotion of orthodox bio-medical drugs. Murray (1994) states that misleading drug advertising abounds in medical journals. An expert panel found 34% of all advertisements in a leading medical journal contained misleading, or erroneous information. The potential for such uncritical acceptance of advertisers' claims is worrying.

In our midwifery practices we use a variety of unorthodox therapies. How much knowledge do we have about the principles behind the therapies

midwives use? It is not within the scope of this study to individually identify the origins, purpose and philosophy of the various unorthodox therapies used by midwives. However, if we are using these therapies or refer women for these therapies, this information is critical. Do the underlying philosophies of the unorthodox therapies that we adopt treat a woman as an individual separated from her environment and thus responsible for the problem we are trying to change? Or do they encompass a broader view, seeing health and disease within the environmental, social and political context?

Some of the therapies, for example, homeopathy, have been developed by men. Historically, and presently, most of the homeopathic texts are written by men. However, it is interesting to note that the majority of registered homeopaths in New Zealand are women[1]. The homeopaths who are offering courses to midwives are women. The homeopaths who are writing the books for pregnancy, childbirth and childhood are women. How does this impact on the way homeopathy is practised in New Zealand? Are these women, who are offering an alternative to orthodox medicine, still agents for a patriarchal therapy?

Webb (1986) contends that homeopathy, acupuncture, and other 'holistic' treatments frequently share the same mystification and exploitative relationships found in orthodox medicine. She believes that although unorthodox practitioners spend more time with their clients than orthodox practitioners, they may be unwilling or unable to explain how the therapy works, they treat clients as solely responsible for their own illness, and often charge high fees. Wilson Schaff (1992) is also skeptical. She is of the opinion that many New Age and /or 'holistic' approaches talk about holism, spirituality, the environment, and many concerns that seem to encompass a postmodern paradigm. Yet, when they actually work with people, she believes that their behaviour and their techniques continue to come out of a mechanistic cause- and -effect paradigm that is subtly based upon the illusion of control.

Understanding the principles behind the therapies we use ensures that the way we use them in our practice is congruent with their philosophy and our

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1. The 1995 Register of the New Zealand Institute of Classical Homeopathy lists 19 women and 9 men.

philosophy of practice. Moreover, when we refer to unorthodox practitioners or undertake educational courses, we must check the credibility and experience of the practitioner. At the same time we must continue to ask ourselves if there are alternatives that are as good as, or better than, unorthodox therapies at solving the problem?

PROFESSIONAL VULNERABILITY WITHIN THE BIO-MEDICAL ORTHODOXY.

The midwives in this study attend births at home and in hospital. Their midwifery practice is their livelihood. Although much of their caseload is midwifery only care, they still depend on and interact with consultant obstetricians, hospital staff, and general practitioners on a regular basis. Some of the practice of the midwives in this study would fall outside the practice norms of the mainstream doctors. The midwives were all aware of this difference in practice and of how it impacted on them. They talked about their feeling of professional vulnerability in an environment where their practice challenged the bio-medical orthodoxy and where at the same time they needed to ensure good relationships with selected medical practitioners.

All of the midwives were cautious in sharing information about their use of unorthodox therapies with orthodox medical practitioners. They feared this information would alienate consultants that they needed to work with (Judith, p.55 and Hiliary, p.122) and open their practice to criticism from the bio-medical orthodoxy. (Adrienne (p.106) and Judith (p.55) had both been directly criticised for their unorthodox practices by orthodox practitioners.) Adrienne (p.106) and Meredith (p. 73) raised the issue that midwives are financially dependent upon the viability of their midwifery practice and when a midwife steps out of orthodoxy, she risks alienating the orthodox practitioners she works with. If, as in Adrienne's example (p.106), she is reliant on those practitioners for her clients and hence her livelihood, she may be reluctant to be unorthodox. There was a general sense of vulnerability whether a midwife had been directly criticised or not. Adrienne and Hiliary both expressed their professional vulnerability in the political climate where they believe the medical orthodoxy is waiting for a chance to criticise midwives and midwifery generally. Adrienne spoke of a "siege mentality" (p.106) and Hiliary talked of

people "waiting to pounce" (p.121). Meredith talked of the fear of "overstepping a mark" and losing her job (p.71). This feeling of vulnerability and caution is validated by Wagner (1995).

Wagner (1995) talks about a global witch-hunt of health professionals. He believes the medical profession is threatened by midwives and is fighting to regain the control they have lost in maternity services. He discusses 20 cases worldwide where health professionals (70% of them female midwives) have been accused of dangerous maternity practice. He says that all of the accused have one thing in common - at least some of their practice is not mainstream. That is, they do not do what the local doctors in authority most commonly do. The evaluation of the midwives' professional behaviour is based on deviations from peer-controlled opinions of what constitutes good practice rather than deviations from practice based on scientific evidence. However, Wagner believes the central underlying issues motivating the witch-hunt are power and gender. He believes that the real function of accusing and investigating midwives is to punish deviant behaviour that could threaten the income, practice style, prestige, and power of mainstream doctors.

Prior to the 1990 Amendment to the Nurses Act, midwives' labour in the paid work force was exploited to bolster and preserve bio-medical orthodoxies, power, and dominance in the essentially patriarchal institutions which are our hospitals. However, since 1990 midwives have had a choice to be other than handmaidens to doctors; and since 1990, independent midwives have been in competition with each other and with general practitioners for the same clients. Wagner (1995) claims that the current global witch-hunt that doctors are staging against midwives is an attempt to undermine public confidence in midwives and drive them out of business. This, he says, is motivated by the competition for pregnant 'patients' (sic) as the birth rate falls. Hiliary is sure that general practitioners in her area are losing business to midwives. Midwives, therefore, are at increased risk of being criticised because the increase in demand from women for independent midwives challenges the orthodox medical system, the general practitioner's monopoly on primary maternity care, and the medical practitioner's financial security. This pressure from the bio-medical orthodoxy is its latest attempt to maintain its control and supremacy in childbirth. It continues a long history of doctors struggling to

control midwifery and women (Parkes, 1991; Smith, 1986; Tew, 1990). All the midwives spoke of medical practitioners apparent disregard for the usefulness of unorthodox therapies. This is verified by a recent study. Cole (1992) reports an Auckland study of general practitioners of which a third each held positive, negative, and equivocal views on alternative therapy. The midwives in this study related that medical practitioners mostly did not get to see unorthodox therapies work, because when they did work, women did not need contact with medical orthodoxy. Doctors and midwives, who do not use unorthodox therapies, are challenged by women who wish to use unorthodox therapies. Swinnerton (1990a) suggests that just as doctors and midwives feel threatened by couples arriving with birth plans, they can also feel threatened by women who appear to have no faith in the treatments which they have been trained to use. The use of unorthodox therapies by women and midwives represents a challenge to the bio-medical hegemony. In attempts to secure their control during childbirth, the orthodoxy maintains the 'scientific' high ground. By dismissing any therapy that falls outside the scientific model the dominant medical culture does not have to challenge or re-evaluate their own model of practice.

However, despite this apparent disregard for unorthodox therapies from the orthodox practitioners, midwives must be aware that as we work alongside them and use unorthodox therapies we play a role within the bio-medical orthodoxy as boundary testers. Wolpe (1990) explains how a number of procedures, that have been pioneered on the margins of medicine, (acupuncture, biofeedback, meditation, for example), were adopted into bio-medical orthodoxy after a period of experimentation in more marginal medical areas. In this way the use of unorthodox therapies in midwifery practice could be seen by the bio-medical orthodoxy as an experiment that they would not risk undertaking. It is the midwives who use unorthodox therapies and who are stepping out of mainstream orthodox maternity practice that are in danger of being discredited, intimidated with legal action and threatened with the loss of their livelihood by the bio-medical orthodoxy (Wagner, 1995). Nevertheless, the bio-medical orthodoxy is highly likely to adopt those therapies that prove useful. We need to be aware that while midwifery is taking the risk in this area it is also serving a function for bio-medical orthodoxy.

It is clear that any midwife who uses unorthodox therapies in her practice is placing herself in a vulnerable position within the bio-medical orthodoxy. The bio-medical orthodoxy's political strength pressures midwives to practice in orthodox ways. However, the midwives in this study believe that many of the women who they care for want to be offered the choice of unorthodox therapies as well as orthodox options. Meredith (p. 60) speculates that she attracts to her practice a certain type of woman who is looking for alternatives to conventional medicine or who is, at the very least, open to new ideas. Midwives known to use unorthodox therapies in their practice may well be sought after by a distinct group of women. Furnham & Forey (1994) compared people who visited general practitioners (gp's) with those who visited alternative practitioners. They found, among other things, that the alternative practitioner group were more critical and skeptical about the efficacy of modern medicine than the group who visited gp's. The alternative practitioner group differed from the gp group because they believed their health could be improved, they had more self and ecologically aware lifestyles, and they believed treatment should concentrate on the whole person.

Moreover, in addition to experiencing pressure from their clients to include unorthodox practices and experiencing pressure from the bio-medical orthodoxy to practice in an orthodox way, a midwife's practice is formally and informally evaluated in at least two different ways. It is evaluated through the eyes of the medical model by institutional, orthodox personnel, and by colleagues and consumers through the Midwifery Review Process. These two 'judges' often disagree about what is safe and informed midwifery practice. Such conflict leaves midwives carefully balancing their practice, and their livelihood, between consumer expectations and the rules of the bio-medical orthodoxy.

IMPLICATIONS FOR MIDWIFERY PRACTICE, EDUCATION AND RESEARCH

Feminist theory has allowed the study to highlight some of the issues that impact on midwifery practice with particular emphasis on power and gender. These findings have implications for midwifery practice and education. They have also raised more questions and concerns that warrant further research.

Implications for midwifery practice

The midwives in this study all used unorthodox therapies in their practice as they believed they were useful and empowering to women. Their emphasis, however, was on first developing a real understanding of the woman's life and beliefs. The importance of midwives giving women full information and a wide variety of choices helps women see their situation in a context that is not solely defined by the bio-medical orthodoxy. This is a political act that provides women with an opportunity to not only initiate change in their own lives but also to demand changes in the provision of health care for all women.

Our process of care is as political as the outcomes. There is a need for midwives to question their own use of unorthodox therapies. Most midwives would likely agree with Aakster (1989, p.300) when he states "It is no longer tolerable that one type of medicine should monopolize the health field and national resources" . Nevertheless, we must analyse the social and economic forces that frame the availability and 'choice' of unorthodox therapies and options for childbirth. We need to speak freely of our experience to expose the patriarchal values inherent in both orthodox medical and unorthodox care for childbirth. We, as midwives, need to ask ourselves when we use unorthodox therapies, are we still working unquestioningly within the orthodox system - or are we creating a real alternative for women?

Midwives need to investigate the knowledge base and experience of the practitioners we take courses from, or refer women to. We need to become knowledgeable ourselves and have experienced people we can refer to. It is important to build strong relationships with sympathetic medical practitioners and to support other midwives with information, resources, and help.

In the current political climate, midwives have to be prepared to defend their practice to professional disciplinary bodies, the public and courts of law. This research suggests it would be wise for midwives using unorthodox therapies to have indemnity insurance.

Implications for midwifery education

It is clear from this study that midwives' use of unorthodox therapies does not happen in isolation from the rest of their care and is integrated into practice. It

would follow then that during a student midwives' education the formal teaching of unorthodox therapies should be integrated with the teaching of more orthodox practices. Furthermore both student midwives and registered midwives are keen to develop more skills in the use of unorthodox therapies. The development and presentation of a variety of courses on unorthodox therapies by reputable practitioners would be welcomed by midwives.

Educational facilities need to believe in, and teach about, the power of normal birth. We must lay claim to our experience of pregnancy and childbirth that is currently seen as unorthodox. Women and midwives who believe in the power of women to birth without the bio-medical orthodoxy are powerful and politically dangerous.

There are some areas of knowledge and skills that are critical to the survival of independent midwives working within the bio-medical orthodoxy. These include advanced communication skills, knowledge about competition and small business, an insight into the dynamics of power and control, and strong supportive networks.

Implications for midwifery research

In my review of the literature I found no study that investigated the use of unorthodox therapies by midwives. This study provides a beginning to further research this area. There needs to be more analysis of midwifery care within a political and social context rather than simply as technical, biological and clinical concerns. Some of the research questions that need to be asked are:

* What unorthodox therapies are midwives using?
* In what situations are they being used?
* How often are they employed?
* Are the various unorthodox therapies used safe and effective?
* Is the use of unorthodox therapies by midwives helping initiate change within the bio-medical orthodoxy?

There are also broader areas of research that need investigating.

* It would be useful to have a comparative study between the practice of different midwives - those that use unorthodox therapies and those that do not.

* We need to document the quality and diversity of both childbearing women's experiences and midwives' experiences (Bortin et al, 1994). Midwifery researchers who draw upon the knowledge of those midwives who retain a degree of autonomy in their practice could feed much of value into midwifery education, as well as raising our consciousness by showing us the nature of our own practice (Kirkham, 1988).
* The unorthodox practices of midwives need to be documented to see how they differ from current medical practice and what warrants further research.
* Specifically there is a need to research women's experience of unorthodox therapies. The midwives in this study were very confident that unorthodox therapies do empower women, but we need to know what the women's experiences of these therapies are.
* There is an urgent need for midwives to critically examine, from a feminist perspective, the alternative health movement as it intersects with midwifery practice. This approach requires involving women in a continuous assessment of the existing and emerging unorthodox therapies that we use. A feminist scrutiny of the issues involved in our use of unorthodox therapies will hopefully prevent them being used in a way that exploits women.

How the study has met its aims

The aims of my study (refer Chapter one, p.5) were

1. To make visible midwives' experience of using unorthodox therapies in the existing biomedical orthodoxy.
2. To describe some of the common unorthodox therapies midwives find effective and use regularly.
3. To explore the facilitating and constraining forces on midwives' use of unorthodox therapies.
4. To analyse midwives' use of unorthodox therapies from a feminist perspective.

The findings from this study met three of the four original aims. The second aim (to describe some of the common unorthodox therapies that midwives find effective and use regularly), however, was not entirely met. I realised early in the study (as I entered my second interview) that this was an aim that was not compatible with the way the midwives were describing their use of unorthodox

therapies. At that point I stopped asking questions specific to that aim and considered erasing the aim from my written study. I have chosen to leave it in as I believe it reflects how much *I wanted* to know what the right remedy for each situation was. The midwives whom that I interviewed taught me very early on that they did not use unorthodox therapies in such a simplistic way. Nevertheless, commonly used unorthodox therapies were identified by the midwives as they gave examples to describe their practice. These are scattered throughout the midwives' stories.

The study has met its first aim to make visible midwives' experience of using unorthodox therapies in the existing biomedical orthodoxy. The midwives told me their experience of using unorthodox therapies. I then wrote their chapters and returned them to the midwives for their input. All the midwives have validated their own chapters and are happy for their interviews to be represented in this way. Their chapters comprise the data upon which this study is based but I think their stories have equal validity on their own, distinct from the study findings.

The third aim sought to explore the facilitating and constraining forces on midwives' use of unorthodox therapies. Two of the key points that emerged from this study fulfil this aim. The empowerment of women is a key factor in midwives' practice. They believe that how they offer unorthodox therapies as a choice alongside the usual orthodox therapies, has the potential to empower women. This in itself facilitates their use of unorthodox therapies. Another key point described how midwives who use unorthodox therapies feel professionally vulnerable within the bio-medical orthodoxy. This vulnerability is definitely a constant constraining force on their use. Likewise the midwives expressed a number of concerns regarding knowledge of unorthodox therapies. These concerns included how this knowledge is shared, gained, controlled, commercialised and misused. These concerns involved issues that both limited and promoted their use of unorthodox therapies.

The purpose of the fourth aim was to analyse midwives' use of unorthodox therapies from a feminist perspective. This has been attempted by situating the midwives' use of unorthodox therapies in the wider socio-political context and using the concepts of power and gender to inform our understanding of

their practice. While it provides a structural picture of the present, I hope it also presents a vision of the future.

Limitations of this study

It is acknowledged that generalizations from case studies are limited to like cases. The midwives interviewed in this study were all experienced, white, middle class, city midwives. Therefore any implications from this study for midwifery practice, education, and research must be read within this limited context. The small participant numbers of five midwives was due to the limitation of the time frame for completion of the study.

Reaching conclusions is a social process and interpretation is a political, contested, and unstable activity (Maynard and Purvis, 1994). Therefore, the interpretations and conclusions drawn from the data are not neutral.

CONCLUDING STATEMENT

The empowerment of women is central to the unorthodox care that midwives offer. This type of care will probably never emerge from the prevailing biomedical system, which is predicated upon fundamentally different values and assumptions and tends to be self validating (Sakala, 1993). While the alternative health movement offers women the opportunity of stepping out of the subjugated role, this study has shown that this may be an illusion at times. Therefore midwives must not only challenge the orthodox bio-medical norms but also those of the emerging alternative health movement.

In New Zealand there are a number of strong women-centred political bodies that have already effectively lobbied to change laws and successfully challenged the bio-medical orthodoxy[2]. Their campaigns and community action aim to change current medical, social, and political approaches to childbirth and to provide information and support for all those who need it. The focus of these groups, which has predominantly targeted the bio-medical

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2. Auckland Home Birth Association, P.O. Box 7093, Wellesley Street, Auckland.
New Zealand College of Midwives, P.O. Box 21-106, Edgeware, Christchurch.
Maternity Services Consumer Council, P.O. Box 99-283, Newmarket, Auckland.
Women's Health Action Trust, P.O. Box 9947, Newmarket, Auckland.

orthodoxy, must now be encouraged to also include the alternative health movement. By placing ourselves within these larger contexts, we feel less alone and can act politically for social change making direct links with the media and policy makers. Midwives need to continue to support these organisations, which are working for change in maternity care at a national level.

It is hoped this research will add to the debate within midwifery about the value and impact of unorthodox therapies on both women and midwives. The continuing enrichment of midwives' understanding about the issues surrounding their use of unorthodox therapies can only enhance their practice and provide the necessary impetus to initiate change.

Through the use of feminist case studies, this study has analysed the experiences of five midwives' who use unorthodox therapies in their practice. The power and control held by the male dominated bio-medical orthodoxy was shown to impact unfavourably on midwives' practices leaving them vulnerable to criticism and investigation. However, the midwives all reflected an ability to construct the meaning of birth, to practice midwifery care, and to offer options in a manner that empowered women without limitations imposed by the bio-medical orthodoxy. It is clear from this research that the empowerment of women is central to midwives' care and the foundation from which all unorthodox midwifery care is born.

AFTERWORD

This study has taken me two academic years to complete. The topic has stayed exciting, relevant, and important to me throughout. The feminist aspect of the research method has been most gratifying. It has been very satisfying to me to have the input and continued interest of the midwives I interviewed. Returning the data to the midwives has kept me honest and I feel makes the data credible.

But has this research empowered the participants? As part of the process of being interviewed the midwives all commented that they reflected on and re-evaluated their experience with unorthodox therapies. They were also happy that through their contribution to the research they were making the experiences of midwives, using unorthodox therapies, visible. Even though I cannot measure the impact it has had on the midwives who were participants in this study, it has already been relevant for other midwives.

I presented the findings of this study at the New Zealand College of Midwives National Conference in August 1996. The discussion after the presentation centred on the appropriate use of unorthodox therapies in practice, with several midwives offering their experiences. Others commented that they found the presentation had stimulated them into looking at wider implications of using unorthodox therapies that they had not thought of before. At least ten midwives spoke individually to me after my presentation. They told me it spoke to their practice and their concerns, and they were relieved to hear they were not the only ones.

I intend to write an article for publication from the study for a midwifery journal. I have been asked to present the findings of my study at the Auckland Institute of Technology School of Nursing and Midwifery, as well as to midwives undertaking the masters level midwifery course at Massey University, Palmerston North.

In my independent practice it has made me reflect on my own use of unorthodox therapies. While I offer women a wide variety of choices in their care I realise my bias is to encourage and support them to use their own

resources, and I am now more clear about conveying that to the women I work with.

APPENDIX ONE

INFORMATION FOR PROSPECTIVE PARTICIPANTS

My name is Claire Hotchin, I am a midwife in independent practice, and I am undertaking a M.A. (Midwifery) degree at Massey University, Albany. My area of interest is midwifery practice. In this research I intend to look at midwives' use of unorthodox therapies. Unorthodox therapies include both alternative and complementary therapies. 'Alternative therapy' indicates the use of remedies which replace conventional medical treatment and 'complementary therapy' when they work alongside conventional medicine. These therapies stem from beliefs about the nature and causation of disease which are at variance with orthodox medical knowledge and practice. I will be using a feminist framework for the research. Anonymous extracts from interviews will be used to illustrate the final thesis.

If you take part in the study, you have the right to:

* refuse to answer any particular question
* withdraw from the study at any time
* ask any further questions about the study that occur to you during your participation
* provide information on the understanding that it is completely confidential to the researchers. All information is collected anonymously, and it will not be possible to identify you in any reports that are prepared from the study
* be given access to a summary of the findings from the study when it is concluded.

If you are interested in this project and think you would like to participate, I would like to meet with you to explain it more fully and obtain your written consent. I anticipate at this stage that your involvement would be two interviews of one to two hours. These will be individual interviews which will be audio taped with your consent. They will be transcribed by a typist who has signed a confidentiality form. You will be given a transcript of the tapes for checking and any amendment necessary.

Please phone me if you have any questions and/or you wish to participate in this research. If I have not heard from you, I will phone you in one week to see whether you wish to participate. My supervisor, Valerie Fleming, is also available by phone at 443 9700 ext.9659.

42 Grampian Rd.
St. Heliers, Auckland.
Phone 528-7304.

CONSENT TO PARTICIPATE IN RESEARCH PROJECT
Midwives' Use of Unorthodox Therapies.

I.....have read the information sheet and have had a full explanation of this research and its aims explained to my satisfaction. I understand that I may ask further questions at any time.

I also understand that I have the right to withdraw from the study at any time, or to decline to answer any particular questions in the study. I agree to provide information to the researchers on the understanding that my identity is completely confidential. I understand that I will be involved in two interviews of 1 to 2 hours each.

I understand that my identity will remain confidential and that the information I choose to share will not be revealed to anyone other than the researcher and her supervisors and a typist (for transcription purposes only) but that the final thesis will be a public document in which I will not be identifiable. I understand that the person transcribing the tapes used in this project has signed a confidentiality form.

I wish to participate in this study under the conditions set out on the Information Sheet.

I give my consent to my interviews being taped.

I do not give my consent to my interviews being taped.

Name: .....

Signed: .....

Date: .....

APPENDIX TWO

Letter sent to participants with their draft chapter

Dear .....,

Here is the transcript of our second interview and the **draft** copy of your case study chapter. I have chosen a pseudonym for you but I would prefer it if you chose your own. The intention of the chapter is to let you speak as much as possible in your own words with little comment from me. I have to analyse, comment, relate it all to the literature etc etc in my concluding chapters.

So that you can better understand how your chapter fits into the whole thesis I will give you an overview. There will be 3 chapters prior to the 5 midwives case studies:

1. Introduction
2. Literature Review
3. Method and Methodology

There will then be an introduction page to all the case studies describing the process we went (and are going) through. This I have included and it will appear, in some similar form, in my thesis after chapter 3 and before the case studies. The 5 midwives I interviewed will each have a chapter, which takes it up to chapter 8. Chapter 9 will integrate the 'data' and do an analysis. Chapter 10 is discussions, conclusions, and recommendations.

The transcript is for your information, there is no need to comment on it. However, I want all the feedback you can give me about your **chapter**. At the very least I need to know

** Whether you feel my writing of the chapter has reflected what you said in the 2 interviews. (I have obviously not been able to include all the material so I have selected the themes that seemed to come through most clearly.)

** what you would like included, changed, omitted etc.

** Whether you feel anonymous enough and if not, what you would like changed.

** anything at all you wish to say, general comments, reflections, criticisms etc

** Your reflections on the whole process. Has it had any impact on you or your practise?

I would like to incorporate your comments, reflections, and ideas into the summary of your chapter. (Assuming that I have already changed those things that you think should be changed in the body of the chapter.) I would prefer to meet with you to discuss your feedback. However if you don't wish to do that and you feel you can adequately comment by writing then that is OK too. Whatever way suits you is fine but I do welcome (and need) your feedback. I will phone you in a weeks time to discuss what you wish to do.

It has been fascinating, and a challenge, for me to write this chapter from our interviews. But I do feel apprehensive (about my abilities) as I return it back to you. It is important that you feel what you said is represented by what I have chosen to put in the chapter from your interviews. Feminist research is all about women's voices being heard! Once I have your feedback and have written it into the summary I will send you a copy of what should by then be your (almost) completed chapter.

Thanks again

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