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# **Me aro ki te ha o hineahuone**

**Women, Miscarriage Stories, and Midwifery: Towards a  
Contextually Relevant Research Methodology**

**A thesis presented in fulfilment of the requirements for the degree of  
Doctor of Philosophy in Midwifery**

**at**

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*Mate atu he tē tē kura whakaeke mai he tē tē kura. Ko tē tē kura au.*

This thesis is dedicated to my grandmother ‘Nancy’ Donovan who became kaiwhakawhānau for our family at a very young age, and the senior trustee for our whānau land at Kapiti in her later years. She was an excellent musician, a cherished friend and a beloved mother, and grandmother. Thank you for gently showing me the path.

*Aroha nui Nana.*

Professional ethics and legal competencies require midwives practising in New Zealand to provide care for childbearing women in a partnership characterised by continuity, equality, mutual respect, trust, shared responsibility and decision making. New Zealand is culturally and legislatively a bi-cultural environment and the cultural safety of Māori (indigenous peoples) are prioritised within health legislation. The midwifery philosophy of partnership and bi-cultural legislation, have provided a foundation for developing a research methodology for the profession. This thesis stories the interweaving of multiple epistemologies, theoretical tenets, philosophical concepts, indigenous and Western European world views as well as women's narratives in creating and implementing a contextually relevant qualitative research methodology, 'Te Whakamāramtanga'.

The methodology was trialled in the field of miscarriage; a practice issue for midwives in New Zealand. Research participants were recruited through 'word of mouth' and snowballing methods. Twenty women participated in the research project and of these nine identified as midwives. Twelve participants were of Non Māori descent, including four women who were immigrants to New Zealand, and eight participants identified as Māori. Participants' stories were gathered through dialogical interviews, which recognised the co-construction and exploration of knowledge. Ethical tenets outlined in the methodology involved the use of extensive, ongoing consultation with Māori, midwifery and local communities.

Māori, women, and midwives share an oral culture that values narratives as facilitating the constitution of identities, creation and transmission of knowledge, and the development of social relationships. Whole narrative, thematic and narrative elements analyses of participants' miscarriage-related talk have been developed through drawing on kaupapa Māori philosophy, the social theories of Pierre Bourdieu, Michel Foucault, Bruno Latour, Paul Ricouer, and Rom Harre as well as the narrative concepts of Arthur Frank and Margaret Somers. Substantive chapters explore whakapapa, corporeal temporalities, narrative silences and women's desires for recognition and relationships. A new theory is advanced that methodologies, narratives, genealogies, temporalities, silences and women voices are simultaneously co-constituted metaphysical and material technologies. These heterogeneous and relational entities are collectively perceived as actants, hybrid actors, actor networks as well as technologies, which exist within a range of dynamic and hierarchical networks and/or fields in which this thesis is also embedded. My development of a multicultural midwifery research methodology informed by multidisciplinary theoretical approaches is innovative for midwifery research and theory, and potentially other health disciplines. My research also addresses gaps in midwifery, miscarriage-related, professional development, Māori health and health research literature.

My interest in how midwives constitute knowledge was seeded as an undergraduate student when a lecturer informed me that as an educator, she could provide me with a basic framework for situating disciplinary knowledge, but that the onus was on me as lifelong learner to fill any perceived knowledge gaps. Over time, and with progressive professional experience, I discovered that such gaps in knowledge are dynamic requiring constant reflexivity on the part of the professional midwife in order to enhance her professional development, and to potentially expand her professional horizons. As a midwife this constitution of knowledge is not a process conducted in isolation but an interactive activity requiring *whakawhanaungatanga* (the developing of interpersonal relationships) with women, families, midwifery peers, other health disciplines and the wider community, and *whakapapa* (genealogy); the continuity of knowledge embedded in intergenerational professional, familial, corporeal and cultural narratives that are willingly shared. Acknowledging the value of narratives has facilitated my doctoral research; the development and trialling of a narrative methodology for constituting midwifery knowledge within a bi-cultural framework.

Although my name is assigned as author to the completed thesis, doctoral research is invariably a collaborative process. My journey as a doctoral scholar has been a narrative of partnership with the individuals who participated in and supported the research, and the narrative of this thesis is also their story. The story of the research process also incorporates the crafting of, and contains, a new personal identity; myself as indigenous, woman, midwife, mother, academic scholar and storyteller. Transformation of my identity has been facilitated by my *wāhine* (women) peers and professional sisters, who have so generously shared their stories, secrets and lives whilst co-constructing and evaluating knowledge with me, during the research process. The completed thesis represents an integration of our ontological, public, conceptual and meta-narratives into a theoretical and methodological framework that may operate as a technology for constituting midwifery knowledge in a multicultural context, and may have the potentiality to also operate as an actant within the fields of health and social science.

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*Ko koe ki tēnā, ko ahau ki tēnei kīwai o te kete.  
(You at that and I at this handle of the basket).*

I wish to thank my whānau for their unfailing love and support during this arduous process. My son James, has been steadfastly adamant that I could complete this mahi (work project) even when at times I doubted my own ability to do so. James has been very patient with a mother who, particularly during the later stages of completing the thesis, became periodically distracted, and impatient. My parents Pat and Bill have been equally positive and consistently helpful, often providing sounding boards for my ideas.

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As I have already stated, completing a doctoral thesis is a collaborative process. This thesis would also have been impossible without the support provided by friends, academic and midwifery colleagues, members of various Maori health providers, women's health collectives and miscarriage support groups.

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### A

Aroha – love

Ahua – gods, spiritual essence

### H

Hapū – extended family, state of pregnancy

Hapūtanga – knowledge of pregnancy

He korowai oranga – the cloak of wellness

Hinengaro – mind, intellect

### I

Ipu whenua – Clay receptacle for containing deceased baby

Iwi – tribe

### K

Kanohi kitea – known face

Karakia – prayer, incantation

Kaumatua – elder

Kaupapa – strategy or theme

Kete – basket

Koha – gift

Kōrerō – talk, speech, narrative

Kuia – female elder

### M

Mana – prestige

Manaaki – caring for others

Mātauranga – information, knowledge, education

Mate – death

Matua – parent

Mokopuna – grandchildren

### N

Nga kete o wananga – the baskets of knowledge, the gifts of Tane mahuta

Noa – common, free from tapu

### P

Pākehā – non-Māori, European, Caucasian

Papatuanuku – the earth mother

Pōunamu – greenstone

### R

Ranganui – the sky father

Rangatiratanga – sovereignty, supremacy

Rongoā – traditional Māori medicine

Rongoā – traditional Māori medicine

Roimata – tears

### T

Tane – male, husband

Tane Mahuta – Deity, creator of humanity

Taonga – treasure, property

Tapuhi – midwife  
Tamariki – children  
Tangata whenua – people of the land, indigenous people  
Tangi – mourning ritual for those who have passed away  
Tapu – sacred, forbidden  
Te ao Māori – the world of Māori  
Te ao Pākehā – the world of non-Māori  
Te kete aronui – natural knowledge informed by the physical senses  
Te kete tuauri – theoretical knowledge that explains the reality of the physical senses  
Te kete tuatea – spiritual knowledge constituted from a shared sense of oneness  
Te kore – void, nothingness  
Te pikorua – infinite partnership  
Te reo – Māori language  
Te Tiriti o Waitangi – the Treaty of Waitangi (founding document of New Zealand)  
Te whakamāramtanga – the process of enlightenment  
Te whare ngaro – the lost house, infertility  
Te whare tangata – the house of the people, uterus  
Tikanga – custom  
Tinana – body  
Tino rangatirantanga – self determination, control  
Tohunga – traditional Māori expert  
Tupuna – ancestors

## **W**

Wahine – woman  
Wāhine – women  
Waiora – health  
Wairua – spirit  
Wairuatanga – spirituality  
Wananga – learning series of discussions  
Whakamā – embarrassment, shame, shyness  
Whakaaetanga – achieving acceptance, permission, approval, agreement, consent  
Whakamana – empowerment, validation  
Whakamātautau – examination, scrutiny  
Whakangungu – protection, defence, advocacy  
Whakapapa – genealogy, continuity  
Whakaritenga – negotiation, reconciliation  
Whakarurutanga – ensuring safety, creating safe environments  
Whakatauki – proverb  
Whakataunga – conclusion, findings and implications  
Whakawhānau – the process of making a family, childbirth  
Whakawhanaungatanga – developing relationships, identifying correlations  
Whakawhirinaki – building trust  
Whānau – family  
Whanaungatanga – relationships, social networks  
Whānau ora – family wellbeing  
Whare – house  
Whenua – land, placenta

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# 1

## Storying the Thesis

### Contextualising Māori, Midwifery, Methodologies and Miscarriage

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*He ika kai ake i raro, he rūpaki ake i raro*  
(As a fish begins to nibble from below, so the ascent of a hill  
begins from the bottom)

What persons are fit to become midwives?

A suitable person will be literate and have her wits about her... She must be literate in order to be able to comprehend the art through theory too, she must have her wits about her so that she may easily follow what is said and what is happening; she must have a good memory in order to retain the imparted instructions (for knowledge arises from memory of what has been grasped).

Soranus (Soranus, trans Temkin, 1956, 1.1.3, p. 5).<sup>1</sup>

Who are the best midwives?

We call a midwife faultless if she merely carries out her medical task; whereas we call her the best midwife if she goes further and in addition to her management of cases is well versed in theory. And more particularly we call her the best midwife if she is trained in all branches.

Soranus (Soranus, trans Temkin, 1956, 1.2.4, p. 6).

#### **Mihi (Welcome) and Beginning Introductions**

Although this doctoral thesis has been a collaborative undertaking and therefore encompasses many voices, invariably there is a single scribe; myself as researcher,

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<sup>1</sup> According to Galen, Soranus was a famous Greek physician from Ephesus and leading proponent of the Methodic school of medicine, who practised in Rome, Alexandria and Aquitania during the second century AD. Few of his works survive today. However, his four volumes on gynaecology were translated into Latin in the sixth century and have subsequently been translated into contemporary languages. (Soranus (1956) *Soranus' Gynecology* (O.Temkin, Trans.). Baltimore: The John Hopkins University Press.

mother, midwife and storyteller. I am also Māori (indigenous to Aotearoa, New Zealand) and if I was standing on a marae, I would be called on by those present to give evidence regarding my authority to provide the written voice for women who have collaborated in the research. Amongst Māori, authority to speak derives from whakapapa (genealogy), and therefore it is with whakapapa that my story, and the story of the research outlined within this thesis, begins.

The whakapapa (genealogy) of the material world of Te Ao Maori (the Māori world) is birthed within the metaphysical paradigm and traces from Ranginui, the sky father and Papatuanuku, the earth mother (Marsden, 1992). Tangata whenua (indigenous inhabitants of Aotearoa, New Zealand) are descended from the earth mother through Hineahuone the first woman (Marsden & Henare, 2003) and the sacredness and spirituality of such whakapapa (genealogy) is attested to by the proverb:

***He tapu te tinana o te wahine na te mea te whare tangata.***  
(The woman's body is sacred because it is the house of the people).

Māori perceive te whare tangata (the house of mankind) as being contemporaneously home to the past, the present and the future. Amongst Māori, the paramount role of women is conceptualised as bearing and protecting each generation of whakapapa (Mikaere, 2003). Identities are crafted through whakapapa connections to the land(s) of tupuna (ancestors), and embedded within genetic relationships amongst whānau (families), hapū (sub tribes) and iwi (tribes). As whakapapa encompasses the essential beginning point for creation, continuity and transmission of both life and knowledge, it also constitutes a bridge between history and biography. Therefore in relation to this research, my multiple identities as midwife, mother, woman, researcher and storyteller, and my mandate to develop research methodology, and craft this thesis are founded on, and continuously supported by, my whakapapa.

It is through the successive generations of tangata whenua (indigenous inhabitants) in my maternal line that midwifery is embedded within our whakapapa. The contemporary story of my family begins with my great-grandmother who was born in Mokihinui around 1869. Like many contemporary New Zealand families, my whānau blends indigenous and colonial genealogies. My great grandmother Frances was the daughter of a wahine tapairu (noblewoman) who was descended from senior rangatira (chiefs) of Ngāti Toarangatia, Te Atiawa and Ngāi Tahu (tribal entities). Frances married an English immigrant, Michael Donovan, and the couple moved to live on the

Kapiti coast in 1890 to establish a family (Figure 1, p. 3). Due to her rangatira status Frances owned large tracts of land and she was accorded considerable respect by local Māori, for her knowledge and abilities as both an expert in Māori medicine, and a community leader.



**Figure 1 The Donovan Family**  
*My Great Grandmother Frances Donovan with her family at Waikanae, Kapiti Coast.*

In defiance of the Midwives Act (General Assembly of New Zealand, 1904) and Tohunga Suppression Act (General Assembly of New Zealand, 1907) and at the risk of imprisonment, Frances provided traditional birthing care on the Kapiti Coast for our extended family and local Māori whānau. During her marriage she gave birth to nine children. Her eldest daughter ‘Nancy’ was her successor and, my grandmother (Figure 2, p. 4).

When Frances died in childbirth in 1914, Nancy became senior trustee for our family land, and guardian of the family’s genealogical and cultural knowledge. Although my grandmother challenged successive land grabs by the Crown and property speculators, most whānau (family) land was eventually seized, and the towns of Waikanae and Paraparaumu, have developed on what was once our land. However, Nancy ensured

whānau (family), whakapapa (genealogical) and tribal histories were perpetually acknowledged in the later naming of streets and reserves within the Kapiti region.



**Figure 2 'Nancy' Donovan**  
*My Grandmother, Ann 'Nancy' Donovan (Ngāti Toarangatira, Te Atiawa, Ngāi Tahu).*

Like her mother, Nancy was educated in Māori medicine (rongoa), and skilled in assisting women and families during childbirth. She also risked imprisonment in order to provide care for childbearing women until the end of the First World War, at which

time legislation ensured childbirth was largely relocated into state owned maternity hospitals. My grandmother gave birth to three sons and only one daughter; her youngest child Patricia. I am Patricia's firstborn child and my Grandmother selected me to be her eventual successor as Kaitiaki mātauranga whānau (guardian of the family knowledge). My memories of childhood include days spent listening to and learning from my grandmother's stories about childbirth, rongoa, whānau traditions and ancestors.

My grandmother passed away on my 10th birthday so my professional education and midwifery knowledge have largely been based in or drawn from the western paradigm. As a registered midwife, who over time has gained extensive experience in all areas of midwifery practice, I have become particularly interested in developing midwifery theory and research practice around the constitution of disciplinary knowledge. Sinclair (2007) suggests that although perceived as challenging by most midwives, the practice of crafting theoretical frameworks for midwifery practice is a developmental and experimental process that is essential for disciplinary survival. Sinclair (2007) argues that in order to be "efficacious and effective" (p. 39), midwifery research must be publicly acknowledged as theoretically sound and result in demonstrable improvements to women's health outcomes. However, "the everyday world of clinical practice is filled with paradigms and paradoxes that stem from the issues of who defines knowledge, how it is generated, and how the individual midwife applies it when providing care for women and families" (Kennedy & Lowe, 2001, p. 91). Such paradoxes require consideration when developing midwifery knowledge and the subsequent shaping of practice within any context but are of particular concern when developing research methodologies for application within a multi-cultural environment such as New Zealand.

In accepting the role of being my grandmother's successor, I have taken responsibility for protecting and ensuring the continuity of mātauranga whakawhānau (childbirth knowledge). My commitment to midwifery and this research therefore encompasses contributing to the development of a culturally and contextually relevant midwifery knowledge base that supports best practice, and contributes to the preservation, and disciplinary acknowledgement of related Māori epistemological concepts.

Within Aotearoa, New Zealand as elsewhere the practice of supporting women and families through pregnancy and childbirth has historically been shaped by the

knowledge and actions of women. However, prior to colonisation, within Te Ao Māori, expert knowledge and skills related to childbirth were socially perceived to be the province of particular male or female members of a whānau (family) (Buck, 1949). These expert practitioners simultaneously derived cultural capital from their positions as tohunga within their communities (Mead, 2003) and their relational links through whakapapa (Durie, 2001, p 13). In contemporary New Zealand these expert skills have been devolved primarily to women who provide specialist care and support to childbearing women, are primarily positioned as genealogical outsiders, and are remunerated for their services.

Contemporary midwifery practice in Aotearoa, New Zealand is shaped by knowledge conceptualised as evidence on the basis that it is primarily drawn from the bio-scientific paradigm. Klima (2001) infers that for midwives this demonstrates a substantial paradigmatic shift in relation to what knowledge is considered authoritative and which individuals may access or transmit it. Foucault (1972) conceptualises knowledge as symbiotically related to power. His perspective could be construed as alluding to the need for scrutiny of how power-knowledge is constructed and wielded by social agents such as midwives. In order to scrutinize the power-knowledge base of midwifery it is necessary to examine how midwifery is both conceptualised and constituted as a discipline.

### **Midwifery Knowledge: Constituting both Discipline and Evidence**

In this section Midwifery is conceptualised as a diverse occupation with an unfinished disciplinary identity. Occupational diversity facilitates the extension of disciplinary influence into various fields and potentially the exercising of occupational power a characteristic associated with professions. Foucault (1972, 1977) suggests that power and knowledge are relational. Midwifery professional development and the constitution and/or transmission of disciplinary knowledge may therefore be construed as interrelated activities. 'Professional' midwifery is presented as a theory based occupation and midwives are constructed as theoretically knowledgeable and expertly skilled health practitioners. However, as over time health policies and care provision have become influenced by medicine's discourses about evidence, the nature and context of midwifery have changed. In the field of health care, clinical evidence largely reflects the positivist perspective of medicine as quantitative research methods predominate in the arena of reproductive health. Midwifery critique of such evidence is presented and alternative conceptualisations of evidence are outlined. It is argued

that midwifery philosophies uniquely position the profession to create contextually relevant research methodologies and implement them in ways that enhance the wellbeing of women and their babies as well as the development of the profession. Midwifery as a women-focused profession with an oral history tradition gathers woman's perspectives and stories of childbirth. Reproductive knowledge is co-constructed by midwives and childbearing women (Campbell, Thompson & Lavender, 2002). Globalisation has emphasized the importance of developing reproductive research and knowledge that is informed by multiple and multicultural world views (Kennedy, Schuiling & Murphy, 2007). The intergenerational and cross-cultural co-construction and sharing of narratives is proposed as a particularly relevant research methodology for constituting midwifery knowledge and facilitating childbearing women's voices to be heard.

Midwifery has separately and collectively been described as an art, an inter-generational legacy, an honourable calling, a complex craft, a spiritual occupation, and a form of magic (Flint, 1991; Forbes, 1962; Fox, 1993; Gaskin, 2002; Hall, 2001; Marland, 1993, Mikaere, 2003). Such characterisations infer that historically midwifery has had a dynamic and therefore un-finalised identity, which may have facilitated midwifery's disciplinary influence extending into various fields such as health, public policy, and social justice. Such influence could accord midwifery the potentiality for exercising power within social settings; a characteristic commonly associated with professions. Soranus (1956) suggests that by the 2<sup>nd</sup> century AD, midwifery was perceived as a profession whose members, in addition to providing care for childbearing women, were privileged with, and experts in, constituting a specialised and valuable body of knowledge in disciplinary unique ways. Professional development and the constitution and/or transmission of knowledge are interrelated activities. Historically, the constitution of midwifery knowledge has been progressively co-constructed by midwives in conjunction with childbearing women and transmitted orally and more recently, through documentation, to selected recipients (Bryar, 1995; French, 1986; Page, 2000). Therefore the conceptualisation of the professional identity of midwifery as a theory based occupation whose practitioners, as Page (2000) suggests, are perceived to be theoretically knowledgeable and expertly skilled has persisted. However, both the nature and context of midwifery practice have altered. In the 21<sup>st</sup> century, care provision for childbearing women has become primarily influenced by social and institutional policies derived from discourses about evidence (Sakala & Corry, 2001) developed by the medical profession. The philosophical origins of evidence based medicine trace from "mid-19th century Paris and earlier" (Sackett,

1997, p. 3). Rosenberg and Donald (1995) suggest that evidence based medicine “encompasses the process of systematically finding, appraising, and using contemporaneous research findings as the basis for clinical decisions” (p. 1122). Sackett, Rosenberg, Gray, Haynes, and Richardson (1996) propose that evidence based medicine may also draw on disciplinary knowledge and skills, conceptualising evidence based medicine as:

The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research  
(Sackett et al., 1996, p. 71).

This prioritising of knowledge or evidence as constituted and presented by physicians has been facilitated by the dominance of medicine’s gaze within the field of health (Foucault, 1963). Evidence has largely reflected, the positivist perspective of medicine, and consequently quantitative research methods that test theoretical assumptions or hypotheses predominate in the arena of human reproductive health research (Holloway & Wheeler, 1996). The advantages of various quantitative research designs have been extensively debated within the discipline of medicine. Quantitative research designs have been hierarchically positioned in relation to disciplinary acceptance of their assigned research value, which may be determined by the statistical validity of research findings. Therefore as asserted by medicine, double blinded randomised controlled trials have come to represent the gold standard for research methods in the fields of health, and medicine (Albers, 2001; Kennedy & Lowe, 2001; Murphy, 1997, 2005). However, Sackett et al. (1996) caution that “[E]vidence-based medicine is not restricted to randomised trials and meta-analyses”, and he suggests that “it requires a bottom-up approach that integrates the best external evidence with individual clinical expertise and patient-choice” (p. 72).

Midwifery critics of the concept of evidence based medicine and/or practice have suggested that defining evidence as accepted knowledge constituted solely from positivistic and quantitative research results, is restrictive (Albers, 2001; Murphy, 2005). Evidence based practice may be derived from experiential, professional, and intuitive forms of knowledge and observational, descriptive and qualitative research results (Albers, 2001; Davis-Floyd, & Davis, 1997; Murphy, 2005). Such multifaceted methods for constituting knowledge may ensure that the often complex needs of women are balanced in relation to what is learned from a positivist and empirical research process (Murphy, 1997).

Despite widespread acceptance and privileging of empirical knowledge developed from positivist research<sup>2</sup> in relation to knowledge arising from qualitative research, clinical experience or intuitive ways of knowing, amongst health professionals, such knowledge may not be value free. Unknowingly the bias of researchers may have become embedded in the research process (Stewart, 2001). Personal belief systems and clinical practice styles may influence the privileging of evidence by midwives (Davis-Floyd & Davis, 1997; Page, 1997), and other health professionals. Such privileging may unintentionally create bias or intentionally be used by practitioners to assert control within the caregiver/client relationship. Alternatively, the conduct of research may be disadvantaged by health practitioners who lack awareness, or have limited knowledge of research methodologies (Haines & Haines, 1998; McSherry, Artley & Holloran, 2006, Poat, McElligott & Fleming, 2003). The positivist construction of empirical knowledge may be challenged due to the preponderance of meta-analyses and mixed studies (DeVries, 2004). Evidence for clinical practice may be constituted solely on the results of published research, and therefore subject to both publication bias (Egger & Smith, 1998) and feasibility bias (Zwitter, 2001). Alternatively, the validity of evidence for clinical practice may be undermined if such evidence is constituted in relation to the management of research related costs and/or the subsequent costs of disseminating and implementing (or not) research findings (Meah, Luker & Cullum, 1996).

Despite critique, since the early 90s, developing scientific evidence that may be applied to health care provision has been embraced by health professions (Trinder & Reynolds, 2000), including midwifery (Page, 2000; Stewart, 2001; Downe, 2004; Wickham, 2004a, 2004b, 2005, 2006). Midwives have been encouraged to engage with research that produces scientific evidence that is relevant to clinical practice (Carr, 2000; Kennedy & Lowe, 2001, Raisler, 2000). Consequently, midwifery practitioners have gained proficiency in research methodologies and methods, that have been created by other professional disciplines (Cluett & Bluff, 2006; Hicks, 1996; Rees, 2003,) and that may, when applied in a clinical setting, be contrary to midwives' professional philosophies and ethical tenets (Walsh, 1996). However, Page (1997) suggests that midwifery's disciplinary philosophies of woman-centredness and birth as a natural physiological event, may uniquely position the profession to develop evidence-based knowledge that may be incorporated in practice and that will enhance the holistic

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<sup>2</sup> The researcher acknowledges that empirical knowledge may encompass evidence arising from qualitative and/or quantitative research, clinical practice and professional experience. Within this thesis the term 'empirical' is reserved for positivist quantitative research and research results arising from particular approaches to quantitative research such as randomised trials and experimental research.

wellbeing of childbearing women and their babies. More specifically, Kennedy, Schuiling and Murphy (2007) state that the profession “must identify an agenda and a strategy” (p. 95) for facilitating research that enhances the wellbeing of childbearing women and the development of the midwifery profession. It may therefore be argued that midwifery has a professional, ethical and social duty to engage in health research.

Midwives are motivated to develop new knowledge in order to provide the most effective and appropriate care for childbearing women and their families (Bryar, 1995, Richens, 2002). Traditionally that knowledge or evidence has been constructed through the art of midwifery practice with practitioners using informed intuition and empathy (Bryar, 1995), ongoing reflection (Kirkham & Perkins, 1997), theorising (Wilson, 1996), the constructive application of science (Kennedy & Lowe, 2001), experimentation (Sinclair, 2003) and more recently the adoption of multidisciplinary research methods (Downe, 2004). The essentiality of professional development requires building research capacity amongst midwifery practitioners and the adoption of effective, relevant and reliable research methods for constituting new disciplinary knowledge regionally and internationally (Walsh & Downe, 2006). With increasing globalisation, the importance of developing research methodologies that transcend various cultures is also highlighted (Kennedy, Renfrew, Madi, Opoku, & Thompson, 2006). The urgent requirement to further the constitution of specialised professional knowledge is in-arguable. However, in uncritically adopting multidisciplinary methods and methodologies, the midwifery profession potentially risks developing ‘research’ midwifery; research that does not acknowledge or incorporate midwifery philosophy or ontology. Such research may also not be grounded in the ethical principles and theoretical concepts of the profession.

The wero (challenge) for modern midwifery may be – how do midwives constitute a professional knowledge base that is grounded on midwifery philosophies, theories and ethics in order to enhance the development of midwifery as a profession?

Midwifery is a profession that is intimately centred on women and their wellbeing; that views childbirth as a normal life event and that values the continuity of relationships. Practitioners collaborate with women to facilitate the health and wellbeing of women and their children, therefore qualitative research methods that incorporate the primacy of relationships and the sharing of experiential knowledge are of particular significance (Hunter, 2007). Midwifery is a gendered (Borisoff, 2002; Bourgeault, 2005; Wrede et al., 2006) and gender-focused profession (Benoit, 1994; Zeidenstein,

2007), with an extensive oral history tradition (Leap & Hunter, 1993). Therefore as Kennedy (1995) proposes, to further the development of midwifery knowledge, a researcher should embrace each woman's perspective when exploring and analysing their experiences and stories of childbirth, health and life in general. The conscious adoption of women's perspectives should not dis-empower midwives' ways of knowing but facilitate an abductive approach<sup>3</sup> to research (Blaikie, 2000, 2007) that may enhance the development of contextually situated 'evidence' for practice.

Midwives collaborate with women and their families to constitute a dynamic and un-finalised base of professional knowledge that requires ongoing reflection (Kirkham, 1997; Page & McCandlish, 2006). Reciprocity of respect, trust, and information is integral within the midwife/woman/family relationship (Hunter, 2006). Such reciprocity is established through the exchange of narratives (Wickham, 2004a), which in the practice context, it may be argued, operate as actants<sup>4</sup> in the Latourian sense, in that they facilitate the establishment of interpersonal relationships and the subsequent co-construction of knowledge. The sharing of narratives position midwives, women and their families, equally as both 'knowers' and 'knowees' during the collaborative process of constituting knowledge. Therefore the intergenerational, and cross-cultural, co-construction or sharing of childbirth narratives amongst midwives, women and families may be especially relevant as a research approach for constructing and transmitting knowledge and evidence for practice (McHugh, 2004). Riessman (1993) proposes that narrative research methodologies are not disciplinary specific. Klima (2001) suggests that narrative research methodologies are particularly relevant for the midwifery profession as they facilitate the co-construction of knowledge. She argues that "a partnership between midwifery and feminist philosophies will allow women's voices to be heard, while guiding research in women's health within new directions" (p. 285). In this thesis it is argued that when such research is located within a multicultural context, it should also be informed by multiple worldviews.

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<sup>3</sup> Blaikie (2000, 2007), proposes that abductive research strategies offer a relational approach that assists researchers in describing and understanding social life. Abductive research approaches focus on "the meanings and interpretations given by social actors to their actions, other people's actions, social situations, and natural and humanly created objects" (p. 115). Blaikie (2000) adds "these subjective meanings are not private; they are inter-subjective" (p. 115) and therefore may be both collectively constituted, and shared, amongst individuals.

<sup>4</sup> In this thesis the term *actant* and associated meanings as conceptualised by Latour (1999) refers to non living and non sentient material or metaphysical elements that without intentionality, "perform" (p. 303) and/or influence human behaviour.

Within the thesis it is suggested that research methodologies informed by such multiple and multicultural worldviews, may offer unique theoretical frameworks that are historically, culturally philosophically and ethically appropriate for developing contextually specific research designs/methods for the midwifery profession. Attention is drawn to the relational interaction of social theories, as well as national, disciplinary and cultural identities and epistemologies through which contextually relevant research methodology may be developed and trialled.

### **Aims and Purpose of the Research**

The aims of this research are twofold

1. to develop a contextually relevant research methodology that is based on a Māori worldview and incorporates the theoretical concepts and philosophical principles of Midwifery and
2. to apply the methodology in order to collect and analyse women's and midwives' narratives about first trimester miscarriage in Aotearoa, New Zealand.

Such research facilitates midwifery practitioner understanding of the key issues and contextual relationships associated with women's and midwives' experiences of miscarriage and supports the development of culturally relevant health care provision.

### **Justifying the Research**

Justification for the research is evidenced in an exploration of the midwifery practice, first trimester miscarriage, and the relationship of Māori and the midwifery profession in Aotearoa, New Zealand. Internationally, there is inadequate consensus regarding contextually appropriate guidelines for miscarriage-related care and multi-disciplinary concern regarding health professionals' knowledge gaps in relation to miscarriage. In New Zealand where women commonly choose a midwife as lead maternity care provider, there is a paucity of research that explores women's and midwives' experiences of first trimester miscarriage. There are also few literary or research references regarding miscarriage and no discussion of the implications for Māori women and their families. Midwives in Aotearoa, New Zealand have particular responsibilities in regards to honouring the rights and meeting the health needs of Māori women in accordance with principles developed by the Royal Commission on Social Policy (1988) and research that explores these issues in a contextually appropriate manner is required.

## **Context of Midwifery Practice in Aotearoa New Zealand**

As a direct consequence of the Nurses Amendment Act (Department of Health, 1990), midwives practice as autonomous providers of state funded maternity care for women who experience normal childbirth, and who have legal residential status in Aotearoa, New Zealand. However, in contrast to physicians, midwives provide continuity of care during labour, birth and the postpartum period. Consequently, women have increasingly chosen a midwife lead maternity care provider. Currently, midwives are responsible for lead maternity care provision in approximately 74% of pregnancies (New Zealand Health Information Service, 2008). Women's preference for midwifery care has been supported by the Ministry of Health as care provision by midwives is perceived to be a more economically viable alternative to maternity care provided by general practitioners (Ferguson, 1999).

In Aotearoa New Zealand midwives provide women centred continuity of care for pregnant women, within the framework of a mutually negotiated partnership. This partnership is based on the theoretical concepts of individual negotiation, equality, shared responsibility and knowledge, empowerment, respect, trust, informed choice and consent, and provides a basis for midwives to practice within all spheres of the profession. Ideally, all spheres of midwifery practice are informed by discipline specific philosophies and governed by professional competencies and ethical standards, (Midwifery Council of New Zealand, 2009). Self employed and hospital employed midwives practical demonstration of these underlying professional philosophies and adherence to these professional and ethical standards is evaluated biennially in relation to midwives' professional partnerships with childbearing women (New Zealand College of Midwives, 2007). Practitioners are aware that professional competencies<sup>5</sup> are intended to be applicable to all scopes of midwifery practice including research (New Zealand College of Midwives, 2005).

## **Midwifery and Māori**

Aotearoa New Zealand is legally and socially a bi-cultural county that is without a formal constitution. Te Tiriti O Waitangi (The Treaty of Waitangi), the founding

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<sup>5</sup> The competencies for midwifery practice in New Zealand are:

- a. The midwife works in partnership with the woman/wahine throughout the maternity experience.
- b. The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care.
- c. The midwife promotes practices that enhance the health of the woman/wahine and her family/whānau and which encourage their participation in her health care.
- d. The midwife upholds professional midwifery standards and uses professional judgment as a reflective and critical practitioner when providing midwifery care" (Midwifery Council of New Zealand, 2009).

document of nationhood, was signed during 1840 and gazetted in London on the October 2<sup>nd</sup>, 1840. Historically, the Māori version of Te Tiriti has been judged the pre-eminent version.<sup>6</sup> However, interpreting how the articles of Te Tiriti may be translated in relation to ongoing local jurisprudence has remained problematic. The Royal Commission on Social Policy (1987) translated the articles of Te Tiriti into the principles of partnership, protection, and participation and stipulated that the Māori version of the Treaty would be given jurisprudential precedence. These principles have since been (not unproblematically) adopted within most Government legislation and policies including within the field of health. The colonisation of Aotearoa, New Zealand has had a deleterious effect on the health of Māori (indigenous peoples) (Durie, 2001) and therefore, in addition to incorporating these principles, the New Zealand Health Strategy has prioritised achieving Māori health and wellbeing as a key goal (Ministry of Health, 2000a).

Midwives in Aotearoa, New Zealand have particular responsibilities in regards to honouring the rights and meeting the health care needs of Māori women in accordance with the principles of the Treaty as outlined by the Royal Commission on Social Policy (1987 1988). These responsibilities include providing midwifery care in a partnership that is characterised by mutual trust and that is culturally safe for Māori women and their families. Weaver, Nikora and Moeke-Pickering (1997) suggest that such partnerships acknowledge and protect Māori customs, and knowledge. Ideally, the position of whānau (family) during pregnancy and childbirth is also respected within the partnership (Midwifery Council of New Zealand, 2007).<sup>7</sup> In order to meet the professional and ethical competencies associated with the partnership framework of midwifery practice, midwives are legally required to affirm Māori as tangata whenua, and actively honour the principles of partnership, protection and participation as an affirmation of the Treaty of Waitangi. Despite these legislated responsibilities, and specific performance criteria that are associated with related

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<sup>6</sup> A basic tenet of international law states that in any bilingual treaty when there are differences between two language versions, precedence is given to the text that is not in the language of the drafter. This is known as the rule of “contra proferentum”.

<sup>7</sup> Several members of the board of Ngā Māia (Māori Midwifery Association) collaborated to develop Ngā Turanga Kaupapa, (principles to be considered when providing care for Maori women). The principles were incorporated into a memorandum of understanding between Ngā Māia and the New Zealand College of Midwives, which was signed in 2006. Although the principles were presented to, and have been adopted by the New Zealand College of Midwives and subsequently integrated into governance literature by the Midwifery Council of New Zealand, the principles were not developed in consultation with Māori communities. As a result they are not widely accepted amongst Māori and have been subjected to considerable oral critique during hui (meetings) conducted by hapu (sub tribes) and Iwi (tribes) within the various regions of New Zealand.

professional competencies, there is no representation of any Māori worldview within either the visual depiction, or written description of the midwifery partnership model for practice in Aotearoa, New Zealand (See Appendix A). The lack of acknowledgement of tikanga and mātauranga Māori is a contradiction of the legal designation of Aotearoa, New Zealand as a bi-cultural country, and suggests that the current model of practice is contextually inadequate. Within this thesis it is argued that the development of a Māori model of partnership that may be used as a framework for research and healthcare provision, and adapted to function within the bi-cultural environment of Aotearoa New Zealand, may be a legally and ethically appropriate alternative to the current model.

### **Māori and Miscarriage**

Published research that specifically examines the care provision received by Māori women who experience miscarriage is minimal. Binney and Chaplin (1986) conducted life story research with eight Māori women, and within the analysis researchers made reference to childbearing and the anguish and tragedy experienced by the participants and their whānau (family) in relation to te whare ngaro (the lost house; ending of a descent line). Although Rimene, Hassan and Broughton (1998) initiated qualitative research that explored Māori women's experiences of childbearing, their research analysis incorporated minimal discussion of Māori women's experience of miscarriage. More recently, Palmer (2002) has conducted a survey of Māori women's views regarding hapūtanga (pregnancy and childbirth). Survey results provide an initial description of aspects such as wairua (spirituality), whānau (family) and whanaungatanga (relationships) that are deemed to be important to Māori women's wellbeing during pregnancy, but there are few references to miscarriage and no discussion of the implications of miscarriage for women and their whānau (families).

### **Midwifery and Miscarriage**

Anecdotal evidence from self-employed midwifery practice suggests that women initially contact potential lead maternity care providers when pregnancy is confirmed during the first trimester. First trimester miscarriage<sup>8</sup> occurs in 1 in 4 pregnancies

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<sup>8</sup> Within the thesis miscarriage refers to the spontaneous ending of pregnancy before 20 weeks gestation, the age of legal viability in New Zealand. First trimester miscarriage is defined as the spontaneous demise of a human embryo or foetus during the initial 14 weeks after conception. Chromosomal abnormalities that affect embryogenesis are the commonest causes of first trimester miscarriage. However disease, drugs and or toxins and maternal, uterine, endocrine, and immunological factors may also facilitate miscarriage. Signs and symptoms of miscarriage include frank vaginal bleeding, abdominal cramping,

(Farquharson, 2002), and research (Durnwald & Mercer, 2003) suggests that this incidence may increase as a direct consequence of an escalation in the rate of birth by Caesarean section. In Aotearoa, New Zealand, women who experience a first trimester miscarriage can and may predominantly request care from midwives. Midwives provide continuity of care, work in partnership with women, and have expertise in women's reproductive health. They are uniquely qualified health care providers and may be promoted as the most appropriate health professionals to provide assessment, management and follow-up care to women experiencing first trimester miscarriage (Krause & Graves, 1999; Thorstensen, 2000). Despite the apparent suitability of the midwifery profession for providing miscarriage-related care, nationally and internationally, there is minimal research that evaluates the role of the midwife and/or efficacy of midwifery care associated with miscarriage. Two main international studies (Fleuren, Grol, De Haan & Wijkel, 1994; Reed, 1990) have been conducted in Holland, and a survey of independent midwives' practices was conducted in Canterbury, Aotearoa, New Zealand (Kenney, 2003).

### **First Trimester Miscarriage: An Introduction to Research Literature**

Prior to 1980 there is scant published literature that examines first trimester miscarriage. Hutti (1986), Oakley McPherson and Roberts (1984), Reed (1984) and Swanson Kaufman (1983) conducted initial research exploring women's experiences of early miscarriage. Key findings that emerged from these early international research studies suggested that the majority of women experience miscarriage as a traumatic event, and that the associated distress is exacerbated by dissatisfaction with, and/or inadequate, health care. The personal trauma caused by miscarriage, and the perception of inadequate care by health professionals, remain consistently occurring themes in studies conducted more recently (Abboud & Liamputtong, 2003; Mander 1994; Moulder, 2001; Wong, Crawford Gask & Grinyer, 2003).

Although amongst health professionals there is growing awareness that there are psychosocial and emotional sequelae associated with miscarriage for women and their families (Brier, 1999), women are viewed collectively with no acknowledgement of their cultural, spiritual and ethnic diversity. There is also still a tendency to minimise the significance of early miscarriage, evident in the view that miscarriage is a minor medical event. These attitudes may have contributed to research specialisation within separate fields of expertise. For example, an obstetrician's clinical researching of

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pain, and passage of 'products of conception' (the baby) (Beischer, Mackay, Colditz, 1997; Blackburn & Loper, 1992; Farquharson, 2002).

surgical, medical, and/or pharmaceutical management of miscarriage (Blohm, Friden, Platz-Christensen, Milsom & Nielsen, 2003; Moore, Shillito & Walker, 2002; Luise et al., 2002; Tang, Lau, Ng, Lee & Ho, 2003; Wieringa-De Waard, Vos, Bonsel, Bindels & Ankum, 2002). Consequently, a comprehensive multidisciplinary, culturally appropriate approach to care provision for miscarriage is not evidenced internationally or in New Zealand, and an adequate consensus regarding contextually appropriate guidelines for best practice, has not been achieved.

The inadequate consensus regarding appropriate clinical care for women who experience first trimester miscarriage has disadvantaged undergraduate and ongoing professional education for health care providers. Evans, Lloyd, Considine and Hancock (2002) and Prettyman and Cordle (1992) have evaluated primary health care providers' views regarding what constitutes appropriate psychosocial care for women who experience miscarriage. Their research findings indicate that approximately 20% of health professionals perceive themselves inadequately educated to provide psychosocial care for women who experience first trimester miscarriage. These findings are supported by Scroggins, Smucker and Krishnen (2000), who propose that health professionals are inadequately educated in terms of theoretical knowledge and practical skills, and McLaren and Shelley (2002) who suggest there is evidence of knowledge gaps amongst Australian general practitioners regarding appropriate care for women experiencing miscarriage. Devlin (1997) proposes that midwives providing miscarriage care in Northern Ireland perceive themselves to be inadequately educated and unprepared to counsel or provide any other forms of psychosocial care for women experiencing miscarriage. Similar perceptions are reported by midwifery practitioners within Aotearoa, New Zealand (Kenney, 2003).

Despite consistent research findings from international studies which suggest care provision is a major issue for women, consensus regarding evidence for care provision is absent. There is also disciplinary concern regarding health professionals' knowledge about miscarriage, and professional development in relation to providing miscarriage-related care. The aforementioned concerns in conjunction with the paucity of research (Kenney, 2003; Ravindrananjan, 2004) that comprehensively explores women's and midwives experiences of first trimester miscarriage in Aotearoa, New Zealand, has provided support for the research outlined in this thesis.

## **Contribution to the Literature**

The stories about and experiences of receiving and providing miscarriage related care in New Zealand, that have been shared by women participating in this research, address a gap in health related knowledge in this area. Additional gaps in the literature in relation to health research knowledge and contextually relevant research theory and methods are addressed, specifically in the areas of midwifery, miscarriage, and Māori women's health. Women's reported recommendations for both professional practice and miscarriage care provision strengthen existing health and social policy literature. The research also presents a new contextually relevant, methodological framework that is innovative for health and cross-cultural research, which has potential for further development as a model for health care provision. The integration of midwifery and Kaupapa Māori philosophies and theoretical concepts within the methodology to construct a multicultural research model contributes to the development of a midwifery professional and theoretical knowledge base in Aotearoa, New Zealand. Within the thesis, an argument is also advanced that methodologies, genealogies, temporalities, voices and silences are simultaneously metaphysical and material technologies, relational actor/networks and/or dynamic un-finalised fields. The argument is crafted through interweaving the ideas and theoretical concepts of Michel Foucault, Bruno Latour, and Pierre Bourdieu and may constitute further development of their existing social theories.

## **A Research Overview**

Within this thesis, a new qualitative research methodology that draws on narrative research and social theory, Kaupapa Māori (indigenous peoples) concepts, and midwifery philosophies and theoretical concepts is presented. This methodology is trialled within the field of miscarriage, a significant practice issue for midwives in New Zealand. Twenty research participants were recruited via word of mouth and snowballing. Women's and midwives' stories were shared using a dialogical approach to interviewing, which recognised the co-construction and exploration of knowledge. Ethical tenets associated with researching indigenous and/or vulnerable populations resulted in extensive, ongoing consultation with Māori, midwives and local communities. The research analysis has drawn on the narrative analysis concepts of Margaret Somers (1994) and Arthur Frank (2000a, 2000b, 2005) and the kaupapa research concepts of whakapapa (continuity) and whakawhanaungatanga (developing relationships) (Bishop, 1996; Graham, 2005; Royal, 1998). Narrative analyses have also drawn on the theories of Pierre Bourdieu (1977, 1990, 1996; Bourdieu &

Wacquant, 1992), Michel Foucault (1963, 1972, 1976, 1979, 1988b), Bruno Latour (1993, 1999, 2005), Paul Ricouer (1981, 1984, 1988), and Rom Harre (Davies & Harre 1990, Harre & van Langenhove, 1999). It is not my intention to provide a comprehensive discussion of the theories developed by each of the aforementioned theorists, in every chapter in this thesis. Theorists' concepts and ideas will be selected and applied as they relate to an analysis of the issues that are identified in the substantive chapters. My development of a multicultural midwifery research methodology, informed by multidisciplinary theoretical approaches, may be conceptualised as an innovative technology for midwifery research and theory, and potentially other health disciplines.

### **Framing the Thesis**

This first chapter provides an introduction to the researcher, to Māori and midwifery epistemologies, and the conceptual debates amongst health disciplines regarding theoretical approaches to research and the constitution, validity and trustworthiness of evidence. Midwifery practice in the bi-cultural environment of Aotearoa, New Zealand is discussed, through focusing on the midwifery model of partnership (the foundation of disciplinary practice in New Zealand), and the model's contextual inadequacies. Both the research aim, developing a contextually relevant research methodology and an overview of the narrative research methodology, are presented. Justification for the research is framed through drawing attention to the paucity of culturally relevant and safe, midwifery practice, as well as midwifery and miscarriage-related research. The structure of the thesis is described and draws attention to methodological development and implementation.

**Chapter Two:** Although the development and trialling of a contextually relevant research methodology is the focus of this thesis, this chapter presents a literature review of the substantive area: First trimester miscarriage. The literature review constitutes an initial scoping review of research literature published prior to commencement of the research interviews and encompasses a critical reflection of literature that explores women's and care providers' experiences of first trimester miscarriage. Research findings suggest that first trimester miscarriage may be traumatic for most women, and that inadequate and insensitive health care has a negative impact on women's psychosocial and physical wellbeing. Health care providers' attitudes to pregnancy loss, information provision, and care delivery are also discussed. Women's recommendations for care are identified and their specific concerns regarding care issues are explored.

**Chapter Three:** Chapter three outlines the development and theoretical framing of Te whakamāramatanga; the research methodology/ model presented within this thesis. An argument is presented that constitutes Te whakamāramatanga as a culturally and contextually relevant process for facilitating the development of multicultural research partnerships. Kaupapa Māori philosophical tenets and Midwifery theoretical concepts are outlined and recommendations for their integration within the methodology are presented. Elements that may be integrated within the methodology such as whakapapa (genealogy), whanaungatanga (relationships), continuity, and partnership are specifically discussed. Theoretical approaches to narrative analysis are identified. The potential application of the narrative theories of Arthur Frank and Margaret Somers are explored, and Michel Foucault's, Bruno Latour's, and Pierre Bourdieu's social theories are examined with regard to their analytical relevance to an analysis of the substantive themes at work within the thesis.

**Chapter Four:** In this chapter the methodological principles of 'Te Whakamāramatanga' are evidenced in discussion of the research design and embedded in the overview provided of the research process. The chapter illustrates the procedures undertaken from initial research design to research completion, in developing a narrative research thesis that is creative, yet methodologically and theoretically sound. Particular attention is drawn to the intimately relational methods used to develop the research. Methodological elements, community consultation, research participation, collection of narratives through dialogical interviewing and the narrative analytical framework are discussed. Ethical tenets are addressed, including recruitment of culturally diverse participants and issues associated with maintaining the confidentiality and anonymity of participants and their personal stories. Measures for establishing reliability, trustworthiness and credibility of analytical findings are presented. A detailed discussion of the emerging issues involved in undertaking the research for the study is also provided.

**Chapter Five:** This chapter presents an exemplar of an in-depth whole narrative analysis of a participant's story. The analysis of Matipou's story examines the 'who what when and how' associated with the relating of her story. The metaphorical and relational interactions of whakapapa (genealogy), temporalities and spatial settings embedded within the story are discussed. The nesting of additional narratives and their associated meanings as well as the location and constitution of actors, identities and actants within the ontological narrative are examined. The chapter also explores how

the participant's ontological narratives constitute and are constituted by genealogical, public, and meta-narratives which may be conceptualised as never finalised actants that shape the participant's various identities, narratives and practices as well as her worldview and her wider social milieu. An argument is advanced that within her story, Matipou unconsciously theorises whakapapa as multi-layered and simultaneously constitutive of self and other, technologies of power, the ontological story and related setting(s).

**Chapter Six:** There are multiple and contradictory temporalities associated with women's reproductive health. This chapter explores the theme of corporeal or embodied temporality and discusses how such temporalities shape and are shaped by ontological, public, conceptual and meta-narratives. Women's and midwives' corporeal time(s) or temporalities are measured and/or evaluated by actors, depending on the context in which miscarriage narratives are disclosed. Different dimensions of corporeal temporality are incorporated into medical, social and institutional discourses. Within the chapter, an argument is advanced that such temporalities may constitute and/or shape un-finalised identities, measure health status, health risk, moral and cultural values, and determine access to miscarriage related knowledge, care, care choices, and care providers. Particular attention is paid to the intimate relationship of temporalities to the exercising of, and exertion of resistance to the dictates imposed by, institutional and disciplinary power. Drawing on the social theories of Michel Foucault, Pierre Bourdieu and Bruno Latour it is also hypothesized that such temporalities may simultaneously constitute technologies, actor networks and fields, as well as acting as material and metaphysical actants that hierarchically position actors within fields and/or actor networks and shape or influence the actions of actors.

**Chapter Seven:** This chapter considers women's and midwives' expertise in the crafting and strategic application of voiced, un-voiced and embodied self silences and silencing practices in the shaping and storying of ontological experiences about miscarriage. Attention is drawn to the use of verbal, non-verbal, lexical, non-lexical, tonal, embodied, metaphorical and cultural silences. An argument is advanced that practices such as hiding by showing, minimising, exiting care relationships and/or voicing disagreement may enable and/or constrain the discursive positioning of selves and other actors within ontological, disciplinary and public narratives and various social public, professional and/or health related fields. Women's use of silence as a technology is hypothesized as governance or management of multiple risks to

‘ontological selves’ within private and public settings. A case is presented for conceptualising silence as actant/hybrid actor/network, constituting technologies in the Foucauldian sense, and enabling and/or constraining women’s agency and/or subjectivity, as well as their construction, performance and maintenance of identities.

**Chapter Eight:** In this chapter a case is constructed for the recognition of both care providers and care recipients within New Zealand health care settings. An argument is advanced that women who experience miscarriage, desire recognition and validation of their individual needs, conceptions, pregnancies, unborn babies, families, culture, and their personal and social identities as both mothers, and autonomous agents. Careful attention to midwives’ stories suggests that practitioners desire disciplinary, institutional and public recognition of both their profession, and as individual and professionally autonomous health professionals. Care recipients’ and care providers’ perspectives on professional and public recognition of their disciplinary, embodied, and cultural knowledge bases, skills, personal practices, values and beliefs are explored. Women’s perspectives on the influence of relational interactions in facilitating institutional, legislative and public recognition of women’s wishes, professional development, ethical care practices and equitable health outcomes for women and their families are also examined. An argument is advanced for care provider/care recipient interactions that are characterised by mutual trust, intimacy, interpersonal respect and effective communication. Consideration is also given to the importance of care provider’s support, empathy, cultural respect, and provision of contextually relevant information. Disciplinary practices are contextually evaluated. Linguistic practices deriving from the interpretive repertoire of medicine are critiqued, and initial recommendations for care are suggested.

**Chapter Nine:** This chapter concludes the thesis. The final discussion draws together the various elements presented in the thesis such as methodological development, theoretical integrations and a tiered approach to narrative analysis. The integration of multiple epistemologies, theoretical tenets, philosophical concepts, and indigenous and Western European worldviews in the development and trialling of the contextually relevant research methodology is reviewed. An overview is provided of the arguments within the thesis in relation to narratives, genealogies, temporalities, voices and silence, and a final reflection on the research is presented. The main argument for the thesis, which draws on the work of Michel Foucault, Bruno Latour, and Pierre Bourdieu is revisited.

The chapter draws together the co-constitutive roles of methodology, time, silence, voice, narrative and genealogy and presents them in an integrated summary. The core argument/ new theory that emerges from the thesis is that methodologies, narratives, genealogies, temporalities and silence may be simultaneously construed as metaphysical and material actants, hybrid actors, actor networks and technologies. It is argued that these relational entities are contemporaneously situated within multiple dynamic and hierarchical relational networks or fields. In reviewing the main arguments of the thesis the complexities of integrating diverse theoretical frameworks becomes apparent. The chapter concludes with an outline of the implications of the research for Māori health research, miscarriage care provision, and midwifery student education, professional development and research practice. Study limitations reflect the contextual specificity and qualitative design of the research and are also addressed.

# 2

## First Trimester Miscarriage

### An Initial Review of the Literature

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*He puta taua ki te tūne, he whūnau tamariki ki te wahine*  
(*The battlefield for man, childbirth for woman*)

E kore te roimata e puritia	Tears are not to be withheld
Me tuku tonu atu kia maringi,	let them pour forth,
Me he wai;	like water,
Me kuku ki roto rā	if they were repressed
Koromaki mai ai	to surge within
Kei haeoratia koe i taiaritia.	I would be riven and rent asunder

Te Rangihiroa<sup>9</sup>

### Introduction

This chapter presents a critical review of relevant clinical, theoretical and research literature that examines first trimester miscarriage from international and national perspectives, and that was published prior to gaining ethical approval in December 2005 (see Appendix B) to conduct the research discussed within this thesis. Where deemed appropriate, literature published subsequent to this date has been integrated to support arguments in chapters five, six, seven and eight. The review explores women's experiences of first trimester miscarriage and associated care; the impact of early miscarriage on women's psychosocial health and wellbeing, current clinical

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<sup>9</sup> I assert that the quotation on this page encompasses the first verse of a waiata aroha (love song) that was written by the researcher's great, great, great, great, uncle, Te Rangihiroa on parting from his beloved wife Te Herepu. The poem is published as He waiata aroha na Te Rangihiroa (no: 79, p. 350) in Ngata, A. (1958, 2004). *Nga Moteatea (The Songs): Part One (Trans. P. Jones)*. Auckland: Auckland University Press. The researcher has included this verse in the thesis in acknowledgment of the sorrow that arises in women and whānau in response to enforced separations from beloved whānaunga (relatives), including tamariki mate (deceased children) through te whare ngaro (infertility and miscarriage).

management of first trimester miscarriage; the implications for midwifery practice and miscarriage-related research within the Aotearoa, New Zealand context. It concludes with a summary of key ideas expressed within the literature regarding women's experience of first trimester miscarriage, and identifies potential areas for development in relation to clinical care provision, and midwifery practice.

Bibliographic reference lists and electronic databases were searched to identify books, research reports and clinical and theoretical literature that examined pregnancy loss and miscarriage. The following databases were accessed: Index Aotearoa, New Zealand, CINAHL, Cochrane, Myriad, Psych Info, Web of Science, Lancet, Medline, Dissertations Abstract, Best Evidence, and Sociological Abstracts. These databases were searched using the following key search terms: Miscarriage, spontaneous abortion, first trimester miscarriage, inevitable miscarriage, *and* Nursing, Treatment, Therapy, Care provision. Database searches of the relevant published research literature, identified extensive publication of quantitative research encompassing the causes, pathology and treatment of miscarriage. The first published qualitative (Hutti, 1986; Oakley et al., 1984; Swanson Kauffman, 1983) and quantitative (Reed, 1984; Wall-Hass, 1985) research studies that explored women's and their families' experiences of first trimester miscarriage were published in the 1980s. Social science literature (Letherby, 1993, 1994; Lovell, 1983; Reinharz, 1988) that broadly explored women's cultural experiences of, and identities arising from miscarriage, was also published during this period. Therefore within this chapter, key qualitative and quantitative research that has been published between January 1980 and October 2005 is reviewed.

Health research literature exploring the experience of miscarriage, and consequently care provision, suggests that women find miscarriage traumatic and that the associated distress is exacerbated by inadequate health care (Moulder, 1998, 2001; Oakley et al., 1984; Reed, 1984; Wong et al., 2003). Despite growing awareness of the psychosocial and emotional sequelae associated with miscarriage, health professionals still minimize the event's significance for women through conceptualising miscarriage as a minor medical event. This attitude may have resulted in fragmented and impersonal care, and contributed to women's and their partner's perceptions that health professionals provide inadequate psychosocial and emotional support, particularly after discharge (Abboud & Liamputtong, 2003; Atik, 2002; Moulder, 1998, Rajan, 1994). Recommendations for health professionals include validating motherhood, by recognizing pregnancy loss and encouraging women to grieve (Corbet-Owen & Krueger, 2001; Oakley et al., 1984), providing comprehensive information about

miscarriage and relevant resources (Leoni, 1997), adopting a collaborative and woman-centred approach to care provision (Jacobs & Harvey, 2000), advocating on behalf of women (Malone & McElwain, 1987) and offering women continuity of care (Mander, 1994).

### **Women's Experience of First Trimester Miscarriage**

Wall-Hass (1985) conducted the initial quantitative survey of women's experiences of first trimester spontaneous abortion in the United States of America. The research design had limitations as study findings incorporated data collected from survey questionnaires completed by only nine women, and therefore results could not be generalised. The research methodology was also not clearly explained in subsequent publications arising from the research, so the study could not be replicated. Despite research limitations, results suggested that women participants perceived they had received insensitive care, minimal information and inadequate support from health providers during and after miscarriage. A more holistic approach to miscarriage-related care was recommended, and further research to explore the implications of miscarriage was advocated.

Qualitative health research was initiated by Hutti (1986), who piloted an exploratory study with two participants. Information was collected through two open ended interviews in order to begin to define the forms of significance that women attached to their miscarriage experiences. Interview texts were analysed through drawing on Dougherty's Model of Cognitive Representation<sup>10</sup>. Key events were chronologically sequenced in order to compare and contrast the similarities and differences between participants' experiences. The research findings suggested that participants experienced similar physical events, but attached different meanings to those events and that the differences in participants' worldviews influenced their actions during and subsequent to their miscarriages. The results of this pilot study prompted further research and the subsequent development of the Perinatal Grief Intensity Scale<sup>11</sup> (Hutti, de Pacheco & Smith, 1998). The scale was designed to screen for women with a high risk of developing severe distress and grief in response to first trimester miscarriage. A retrospective trial was conducted with a convenience sample of 186 women who had experienced first trimester miscarriage in the previous 18 months. Although beginning

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<sup>10</sup> Dougherty's model of Cognitive Representation (1984), examines the ways in which people perceive events, the relationship between these events and the link between perceptions and subsequent behaviour. Dougherty, E. (1984). *Cognitive Models of face to face interaction: A semiotic approach*. Unpublished doctoral dissertation, Indianapolis: Indiana University.

<sup>11</sup> The scale is based on Dougherty's model of Cognitive Representation (1984).

reliability and validity of the measure was established, further refinement of the scale has been recommended.

Qualitative health research that broadly explored women's experiences of miscarriage was also conducted by Koziol-McLain et al. (1992). The perceptions of 45 women regarding the miscarriage event, and emergency department care at the University Hospital, Colorado were ascertained through semistructured interviews and subsequent analysis of interview texts to identify key themes. The research found that women felt uncertain and apprehensive about conceiving again, and perceived the lack of empathic care within emergency departments as contributing to women's feelings of inadequacy. Elements of grounded theory analysis were applied by Cormell (1992) to explore the miscarriage experiences of 13 women in England in order to identify key themes. However a substantive theory in relation to women's experiences was not advanced by the researcher. The research findings suggested that participants perceived their health care providers as construing miscarriages as minor disruptions to patients' lives and that therefore primary, and hospital based care was consistently unhelpful. The research results also suggested that health professionals did not appreciate the significance, and emotional impact, of miscarriage for women, and their families. Bansen and Stevens (1992), Harvey, Moyle, and Creedy (2001), and Adolfsson, Larsson, Wijima and Bertero (2004) used phenomenological methods to explore women's experiences of first trimester miscarriage. More specifically, the emotional impact of early miscarriage and hospital care provision. Ten women were interviewed in the United States of America (Bansen & Stevens, 1992), three women in Australia (Harvey et al., 2001) and thirteen women in Sweden (Adolfsson et al., 2004).

Results from the qualitative study by Bansen and Stevens (1992) suggested that women perceived miscarriage to be socially silenced and this factor contributed to their experience of receiving inadequate miscarriage-related support. Women reported feeling profound loss and grief in relation to changes in identity and the death of their unborn babies (Adolfsson et al., 2004; Harvey et al., 2001). First trimester miscarriage was construed as a traumatic event and the associated distress was perceived to be aggravated by women's experiences of insensitive health care (Adolfsson et al., 2004; Bansen & Stevens, 1992; Koziol-McLain et al., 1992). Participants also stated their need for individualized empathic health care during, and after, miscarriage and comprehensive information regarding the miscarriage process (Adolfsson et al., 2004; Bansen, & Steven, 1992; Cormell, 1992; Harvey et al., 2001; Koziol-McLain et al., 1992).

The aforementioned qualitative research studies (Adolfsson et al., 2004; Bansen & Stevens, 1992; Cormell, 1992; Harvey et al., 2001; Hutti, 1986; Koziol-McLain et al., 1992) examined the experiences of only a small number of women. Some studies did not explain the research methodology (Koziol-McLain et al., 1992), study limitations (Adolfsson et al., 2004; Cormell, 1992) or participant recruitment procedures (Adolfsson et al., 2004; Bansen & Stevens, 1992). Cormell (1992) and Koziol-McLain et al. (1992) recruited research participants via their health care providers, so it is possible that participation in the research may have been coerced. Despite these limitations the studies reported results that were consistent with the key findings proposed by Wall Hass (1985), that miscarriage-care is commonly insensitive and inadequate.

### **Women's Perceptions of Miscarriage Support and Care**

In response to practice evidence, and research findings which have suggested that miscarriage-related health care is problematic, and that health care professionals are dismissive of women who experience miscarriage, further research has been initiated. Quantitative (Freidman, 1989; Moohan, Ashe & Cecil, 1994) and qualitative studies (Cecil, 1994, Conway, 1995; Speraw, 1994) were conducted to ascertain women's perceptions of miscarriage-related health care and/or support. Moohan et al. (1994) surveyed women's views of miscarriage-related care in a hospital in Northern Ireland. Survey results indicated that women perceived that medical staff were particularly dismissive of them as individuals and minimized their miscarriages and related experiences. Friedman (1989) explored women's levels of satisfaction with general practitioner care in England through surveying the views of 67 women. Survey results suggested that women perceived general practitioners as providing competent medical care. However, similar to the findings of the study by Moohan et al. (1994), women's experiences were not acknowledged, and minimal information about miscarriage was provided by practitioners. A descriptive ex post facto study was also conducted in the United States of America. Semi-structured interviews were undertaken with forty women and their partners to ascertain their views of miscarriage-related health care (Speraw, 1994). Research participants expressed similar views regarding care providers' attitudes and behaviours to the views expressed in the studies by Friedman (1989) and Moohan et al. (1994).

Results from qualitative (Speraw, 1994) and quantitative (Friedman, 1989; Moohan et al., 1994) studies suggested that women believed family members and health professionals lacked appreciation for the personal significance of miscarriage. Women

agreed that health professionals minimized early pregnancy loss, exhibited dismissive attitudes, used insensitive terminology, and provided inadequate emotional support and information regarding miscarriage, hospital procedures and self-care after discharge (Friedman, 1989; Speraw, 1994). The findings recommended that health care should include recognition of miscarriage as a traumatic event, validation of motherhood, explanations for the miscarriage, comprehensive information provision, empathic and compassionate care, psychosocial and emotional support, technical competence, and improved antenatal care.

However, within publications arising from the aforementioned studies, research limitations were not addressed. Speraw (1994) clearly described the qualitative research design and implementation, but did not address potential research bias due to the self-referral of research participants. The results from Friedman's (1989) quantitative study could not be generalised due to the small research sample (n = 67). Friedman's (1989) survey also incorporated some qualitative elements, in the form of open-ended questions, but the qualitative research analysis is not discussed in the published literature. During Friedman's (1989) study, standardized mental health testing was conducted to ascertain women's cognitive competence. Justification and/or ethical approval for conducting this assessment is not evidenced within the research publications arising from Friedman's (1989) study therefore the ethical integrity of the research may be challenged. As the studies by Speraw (1994) and Friedman also relied on direct recruitment of research participants by their health care providers, research participation may potentially have been coerced.

The aforementioned results demonstrate women's access to support during miscarriage may also influence how they manage miscarriage-related grief and loss (Rajan, 1994; Wall-Hass, 1985). Anthropologist Rosemary Cecil (1994) carried out an ethnographic study of women who had experienced miscarriage in Northern Ireland with a particular focus on exploring miscarriage as a culture. Semi-structured interviews were conducted with fifty women to explore their experiences of, and perceptions regarding, miscarriage-related social support. Substantial information regarding women's perspectives on health care and miscarriage related support was obtained. The religious denomination of the majority of the research participants (82% Catholic) was noted within the participant profile, but the potential influence of Catholicism in shaping women's experiences was not considered, and so potential cultural biases in research findings were not addressed. Conway (1995) also explored the role of social support systems in facilitating women to cope with miscarriage through conducting

the first research project to explore Australian women's experiences of miscarriage-related support. Twenty-four women were interviewed and analysis of their interview texts suggested that while social support from family and friends was helpful, support from health professionals and the wider community was not adequate. Conway's (1995) study also reinforced the link between miscarriage and psychosocial ill health and stress. More recently, Conway and Russell (2000) have explored 32 couple's experiences of psychosocial distress, grief and support after miscarriage. Initial findings suggest that couples commonly experience grief up to four months after miscarriage, and that miscarriage may constitute a major stressor to relational interactions within families.

In Aotearoa, New Zealand midwifery is a woman-centred profession and women's care experiences and preferences such as supporting family members, are ideally supported by midwives in all spheres of practice including research. The aforementioned research findings which suggest women experience miscarriage as traumatic and miscarriage related care is problematic because of the dismissive attitudes of providers, insensitive care, inadequate information and minimal follow-up, is of significance to this research. During interviews conducted for the research discussed within this thesis, participants were encouraged to voice their experiences of miscarriage, and wishes in relation to miscarriage-related care. Participants' stories were analysed in order to identify similarities and differences between participants' experiences and worldviews, and published research findings.

### **Women and the Psychosocial Implications of Miscarriage**

The potential impact of miscarriage on women's and their families' psychosocial wellbeing has also been investigated. Leppert and Pahlka (1984) and Seibel and Graves (1980) conducted initial research exploring the link between women's experiences of miscarriage and related health care with women's psychosocial health. The studies were disadvantaged by small numbers of participants, respectively 22 and 93 women. As Leppert and Pahlka (1984) obtained information during counseling sessions with women patients and Seibel and Graves (1980) through direct individualized questioning of patients, data gathering methods were not standardised. Friedman and Gath (1989) suggest that as both the confirmability and auditability of the research process are problematic the research findings may be considered unreliable (p. 810).

Brier (1999) explored the relationship of miscarriage to women's wellbeing and mental health through a meta-analysis of patient satisfaction surveys from NHS

hospitals throughout England. However, Brier's (1999) study evaluated results arising from assessment categories, which were potentially shaped by institutional risk management policies, and did not directly ascertain women's views. The research findings should therefore be viewed with caution. Meta-analyses of the research literature have also evaluated the reported incidence and prevalence of minor depression (Geller, Klier & Neugebauer, 2001), affective disorders (Klier, Geller & Ritsher, 2002) and anxiety-related conditions (Geller, Kerns & Klier, 2004), amongst women and families affected by miscarriage. A recent meta-analysis of the cross-disciplinary research literature by Brier (2004) recommends that practitioners screen for signs of anxiety as well as depression.

There is extensive commentary in the clinical literature regarding the impact of miscarriage and measures for managing the psychosocial and emotional responses of women and their families to miscarriage. Athey and Spielvogel (2000) reviewed the literature regarding cases of extreme miscarriage-related distress in the United States of America that were detected through screening with the General Health Questionnaire (GHQ). Wheeler (1994) explored the relationship between women's emotional and psychosocial status and hospital care in California, through evaluating anecdotal information from health professionals in relation to pre-existing clinical literature regarding the psychosocial needs of women during miscarriage and ectopic pregnancy. Madden (1994) also reviewed the clinical literature and interviewed 65 women approximately four months after their miscarriage. Her study focused on comparing women's reported miscarriage-related emotions and experiences with relevant commentary in the clinical literature. Participants remembered feeling sadness, frustration, disappointment, and self-blame and anger immediately post miscarriage, but only sadness persisted at the time of the interview. These findings were inconsistent with commentary in the clinical literature. More recently, Smart (2003) has conducted semi-structured interviews with 13 women, ten years after their miscarriage. Thematic analysis of women's accounts has identified that four participants, who never conceived subsequent to their miscarriages, have experienced ongoing feelings of grief and loss. The studies by Madden (1994), Wheeler (1994) and Smart (2003) have identified risk factors for mental illness, prolonged grieving and maladjustment due to pregnancy loss. Their research suggests that women may have difficulty finalising their experiences of miscarriage and this lack of finalisation impacts on women's psychosocial wellbeing.

Neugebauer et al. (1992) conducted the first substantial mixed methods research study to assess if miscarriage increases depressive symptoms in the early weeks following loss. Eight hundred and thirty three women were interviewed regarding their views on potential determinants of depression. During the interviews, participants also completed the Centre for Epidemiologic Studies Depression (CES-D) Scale. Results suggested that regardless of gestation, in the weeks following miscarriage, women experienced depressive symptoms at 3.4 to 5.7 times the rate experienced by pregnant women and 4.3 to 11 times the rate experienced by non-pregnant women. Childless women who experienced miscarriage proved to be the most at risk group for depression, which suggested that the absence of relational interactions within familial groupings may impact on women's psychosocial health subsequent to miscarriage.

Further to the research conducted by Neugebauer et al. (1992), Bradley, Levitas, Smith, Garcia, and Frost (2001), and Wong et al. (2003) respectively interviewed 80 and 100 women. Research results indicated that approximately 30% (Bradley et al., 2001) to 33% (Wong et al., 2003) of women experienced psychiatric symptomatology that is diagnostic of severe anxiety or depression. However, as the studies were conducted in small geographic regions, contextually specific factors such as poverty and environmental resources may have shaped women's psychosocial status. Both studies also involved only small numbers of participants who were recruited by their care providers and therefore potentially coerced to participate in the research. The role of relational interactions in shaping women's psychosocial health was further examined by Swanson, Karmali, Powell, and Pulvermakher (2003). Swanson et al. (2003) explored the interrelationship of miscarriage and dysfunctional interpersonal interactions within families that resided in the United States of America through examining the impact of miscarriage on the intimate relationships of 185 women. Interview data was content analyzed and relationship differences were evaluated using MANCOVA<sup>12</sup> with adjusted pairwise comparisons. Research results suggested that 32% of women experienced a deterioration of their personal relationships in conjunction with corresponding mental illness following a miscarriage. Despite the research limitations, the researchers (Bradley et al., 2001; Swanson et al., 2003; Wong et al., 2003) suggest miscarriage is a contributing factor to psychosocial ill health and have

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<sup>12</sup> ANCOVA refers to the analysis of covariance in quantitative research. It is a linear model for analysis with one continuous and quantitative outcome variable and one or more qualitative factor variables. MANCOVA (Multivariate analysis of covariance) extends analysis of covariance in research findings to encompass situations where there is more than one dependent variable and where the dependent variables cannot be combined

recommended screening for maternal psychiatric morbidity after miscarriage in order to facilitate appropriate care.

Although there are a variety of instruments for measuring psychosocial wellbeing (Hutti, 1998; Theut et al., 1989; Toedter, Lasker & Alhadeff, 1988) in childbearing women who miscarry, researchers have primarily used broad diagnostic assessments validated for use within the general population. For example the Edinburgh Postnatal Depression Scale (EPDS) and the General Health Questionnaire (GHQ) are commonly used for diagnosing depression and/or other affective disorders in women who experience miscarriage, stillbirth or neonatal death (Moulder, 2001). Lee et al. (1997) evaluated the diagnostic efficacy of the EPDS and GHQ. Although both assessments identified women at risk of severe psychosocial illness, the assessments did not address cultural or contextual factors unique to Chinese nationals residing in Hong Kong, which impacted on assessment outcomes. As a result Lee et al. (1997) concluded that the EPDS and GHQ were not effective, and that a more specific screening tool was required to identify maternal mental illness that was directly attributable to miscarriage. Further refinement of assessments in order to address contextual factors was also recommended. Subsequent to the evaluation by Lee et al. (1997) the GHQ has been adapted for generalised use in detecting rates of psychiatric morbidity amongst women who have experienced miscarriage or childbirth and who reside in China. A further study by Lok et al. (2004) re-evaluated the modified GHQ-12 as a screening tool for post-miscarriage psychiatric morbidity. Initial research findings have suggested that the GHQ-12 is an effective screening tool for detecting psychiatric morbidity in women who have experienced miscarriage. However, the research findings may be challenged as the cohort study conducted by Lok et al. (2004), involved a small number of participants ( $n = 222$ ), and of these, only 27 women were identified as affected by psychiatric illness. The morbidity rate of 12.1% reported in the research findings is also contrary to the average rate of 30-33% suggested by previous studies (Bradley et al., 2001; Wong et al., 2003). It may be argued that further research to develop contextually and culturally relevant screening methodologies is required and that for reasons of research reliability and validity such studies should be conducted with larger research populations.

Despite the lack of specific and reliable tools with which to assess for psychosocial distress and morbidity in relation to miscarriage, health providers are aware of the psychosocial and emotional effects associated with miscarriage (Frost & Condon, 1996; Moore Shillito, & Walker, 2002). There is also increasing acceptance amongst health

professionals that compassionate support from health care providers encourages women's recovery after pregnancy loss (Lee & Slade, 1996; Malone & McElwain, 1987; Scroggins, Smucker, & Krishnen, 2000). Follow-up support programmes have been initiated to address women's needs. Jacobs and Harvey (2000) evaluated the effectiveness of a miscarriage support programme based in Brisbane over a one year period. An audit was conducted of outpatient services through surveying women's level of satisfaction with telephone follow-up care after miscarriage. The research findings indicated that women were predominately satisfied with the provision of information, emotional support, resource referrals and care after discharge.

Caring based counseling and/or psychological debriefing have also been recommended to assist women to develop coping strategies (Cameron, 1997; Karolle, 1998; Swanson-Kauffman, 1986). Studies by Evans et al. (2002), Lee, Slade and Lygo (1996), and Swanson (1999) have suggested that caring based counseling can enhance women's wellbeing subsequent to miscarriage, but the research findings should be considered in relation to study limitations. The survey questionnaire used by Evans et al. (2002) was nonspecific therefore survey data obtained from the 109 women research participants may have been irrelevant to miscarriage care. Lee et al (1996) conducted a randomized trial in which research participants were randomly allocated to a control group or intervention group and evaluated in relation to measures of anxiety, depression, the impact of life events, participants' reactions to miscarriage and perceptions of care. Participant evaluations occurred one week, and four months after the miscarriage. Only participants in the intervention group were offered counselling two weeks post miscarriage. Lee et al.'s (1996) quantitative study also incorporated direct recruitment of 39 participants by their health care providers, and therefore potentially coerced research participation. Swanson (1999) conducted a randomised longitudinal Solomon four-group experimental investigation using ANCOVA<sup>13</sup>. Outcomes included overall emotional disturbance, overall miscarriage impact, personal significance, devastating event, lost baby, self esteem, anger, depression, anxiety, isolation, and confusion. Although the study results indicated the effectiveness of caring in reducing women's emotional distress in relation to miscarriage, the researcher reported a substantially increased risk of Type 1 error. The sample (n = 185) was small and lacked ethnic diversity in relation to the multiple comparisons of variables (caring, counseling, measurement and time). The research findings (Evans et al., 2002; Lee et al., 1996; Swanson et al., 1999) were also based on

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<sup>13</sup> ANCOVA refers to the analysis of covariance in quantitative research. It is a linear model for analysis with one continuous and quantitative outcome variable and one or more qualitative factor variables.

responses from small numbers of research participants, and therefore generalization of results is problematic. Research involvement may also have had unintended benefits for participants that are separate from caring based counseling and/or psychological debriefing, due to contact with, and the interest expressed by the researchers (Evans et al., 2002; Lee et al., 1996).

The usefulness of psychological debriefing or counseling as care measures is influenced by the knowledge and expertise of health professionals. Prettyman and Cordle (1992) surveyed 200 primary health care providers in England in order to ascertain their views regarding appropriate psychosocial care for women following miscarriage. Survey respondents recommended caring based counseling, however 20% of respondents (n = 41) reported they lacked adequate skills to provide this care. Scroggins et al. (2000) have also suggested that counseling might be ineffective due to a lack of adequately educated and experienced counselors, and patient's non-attendance at counseling sessions. Researchers (Lee et al., 1996; Scroggins et al., 2000) have proposed that health professionals may perceive psychological debriefing as less effective than counseling, because maternal distress may occur when traumatic experiences are re-visited during debriefing sessions. Further research regarding these interventions has been recommended (Cameron, 1997; Lee & Slade, 1996; Scroggins et al., 2000).

The aforementioned research studies primarily focus on health care providers' views in relation to what assessments accurately screen for or detect psychosocial morbidity (Hutti, 1998; Lee et al., 1996; Lok et al., 2004; Theut et al., 1989; Toedter et al., 1988, 2001). Measures required to support women experiencing miscarriage-related psychosocial ill health have also been scrutinised (Evans et al., 2002; Lee et al., 1996; Prettyman & Cordle, 1992; Swanson, 1999). The significance of social support as a resource that facilitates women's strategies for coping with psychosocial ill health is acknowledged within the research literature (Nikcevic, Kuczmierczyk & Nicolaidis, 1998; Rajan & Oakley, 1993). However, the voices of women are largely absent from the discussion and issues such as women's agency in relation to care choices for psychosocial distress are not addressed. The research presented in this thesis offers commentary on the usefulness of care measures, as women and midwives theorize relevant coping strategies and appropriate care measures in their stories of first trimester miscarriage in Aotearoa, New Zealand. The women's voices and analysis of women's stories provide information to address the gaps in the miscarriage-related literature.

## **Clinical Management of Miscarriage**

Despite researchers' interest in women's psychosocial wellbeing in relation to miscarriage, health research has primarily focused on methods for clinically managing first trimester miscarriage. There are diverse surgical, medical and expectant management options for, and physicians' opinions regarding the correct clinical management of spontaneous miscarriage. The first randomised trials that explored expectant management (Chipcase & James, 1997; Nielson & Hahlin, 1995) and medical management (DeJonge, Makin, Manfeldt, Wet & Pattinson, 1995), in comparison to surgical management focused on clinical outcome measures and women's preferences were not considered. However, health providers' concerns for women's views regarding care options have also influenced the research regarding clinical management of first trimester miscarriage, and potentially care provided by physicians. Research (Ogden & Maker, 2004; Wieringa-de-Waard et al., 2003) suggests that acknowledgement and facilitation of women's preferences for expectant (natural physiological process) or medical (pharmacotherapy) management of first trimester miscarriage, improves women's psychosocial and emotional health after miscarriage. To this end, Ankum, Wieringa-de-Waard and Bindel (2001) have conducted a meta-analysis to explore the application of shared decision making by physicians and women in regards to miscarriage management. As a result of clinical conversations with women and their families regarding care preferences, physicians from Europe, Asia, and North America are, where appropriate, supporting non-interventionist treatment measures. For example, physicians are using expectant and/or medical management to treat first trimester miscarriage, in preference to surgical interventions. As a result of the trend towards less interventionist treatments, research that explores and compares the efficacy and safety of expectant management in relation to surgical and medical management and that considers women's preferences has been conducted.

Luise, Jermy, May et al. (2002) completed an observational study of 1096 women who experienced first trimester miscarriage. Women were recruited for the study through the emergency departments of two hospitals in London and offered a choice of expectant or surgical management as treatment for their miscarriage. Four hundred and ten women experienced complete miscarriages prior to assessment. The majority of the remaining participants (n = 70%, 478/686) chose expectant management. Although 27 women were lost to follow-up, expectant management was successful in 81% of the cases (n = 367/451) that were successfully followed. Results suggested that

women found expectant management to be a more acceptable care measure and associated with better health outcomes than surgical intervention.

Blohm, Friden, Platz-Christensen, Milsom and Nielsen (2003) conducted a hospital based clinical trial in Gothenburg, Sweden. Clinically stable women who sought hospital treatment for incomplete miscarriage were invited to participate in the study. Two hundred and sixty three women participated in the research, and expectant management was successful in 83% of cases. There was also a marked differential in rates of infection; five women who experienced surgical management developed infections in comparison to two women who had expectant management. The results suggested that expectant management is a safe and an efficient method of managing first trimester miscarriage in clinically stable women. The studies by Luise, Jermy, May et al. (2002) and Blohm et al. (2003) did not address potential bias due to research participant self-selection. In order to prevent selection bias, Wieringa-De Waard, Vos, Bonsel, Bindels and Ankum (2002) conducted a randomised trial in Amsterdam to evaluate the efficacy of expectant management in relation to surgical management. The outcomes for women who refused randomisation and were managed according to their own preferences were also studied. One hundred and twenty two women were randomly assigned to treatment groups and 305 women received their preferred treatment option. The results for the preference group and randomised groups were comparable. Research findings suggested that after 6 weeks expectant and surgical management are respectively 92% and 100% successful for treating first trimester miscarriage and therefore similarly effective.

The research findings from the aforementioned studies should be considered in relation to study limitations. Although the study by Luise, Jermy, May et al. (2002) suggested a high degree of maternal satisfaction with expectant management, women's high satisfaction levels may have resulted because the majority of research participants received the treatment they preferred. The clinical trial of expectant management by Blohm et al. (2003) did not address informed choice, as patient compliance with treatment allocation was required from the 263 women who participated in the research study. The research conducted by Wieringa-De Ward et al. (2002) incorporated a small sample of 122 women, only 64 of whom received expectant management. Despite study limitations, the researchers (Blohm et al., 2003; Luise, Jermy, May et al., 2002; Wieringa-De Waard et al., 2002) agree that women prefer to miscarry naturally, that the success rate for expectant management is 81-83% and propose the post miscarriage infection rate for women who miscarry naturally is

comparable to or better than the rate for women who receive interventionist management. In response to disciplinary contestation of findings Wieringa-de Waard et al. (2003) conducted a second study in which 188 participants experienced expectant management. Research findings suggested that increased bleeding might be associated with rapid and complete pregnancy loss during first trimester miscarriages (p. 707).

Research studies (Bagratee, Khullar, Regan, Moodley & Kagoro, 2004; Beucher et al., 2004; Blohm, Friden, Milsom, Platz-Christensen & Nielsen, 2005; Coughlin, Roberts, Haddad & Long, 2004) have also compared outcomes of expectant management with medical management. Bagratee et al. (2004) conducted a small randomised controlled trial, to compare outpatient medical and expectant management of first trimester miscarriage by staff attached to a hospital in England. Out of a potential sample pool of 131 women experiencing first trimester miscarriage, 104 women agreed to be randomized to either receive 600mcg of misoprostol or a placebo intra-vaginally in order to compare health outcomes. Study results suggested that misoprostol 600mcg (medical management) is more successful (87%) than expectant management (29%), at ensuring that a miscarriage is complete, and that the participating women preferred medical management. However, as the study incorporates a very small number of participants (n = 104) who were recruited within a small and localised region, and contextual variables were not controlled for, the results may not be generalised. Research participation was also arranged through direct recruitment of participants by health care providers and may have been coerced. The results (Bagratee et al., 2004) are supported by other research findings (Beucher et al., 2004; Blohm et al., 2005; Coughlin et al., 2004). However, the substantive debate regarding the correct dose of misoprostol to administer vaginally when medically managing first trimester miscarriage, remains ongoing. Beucher et al. (2004), Bagratee et al. (2004), Blohm et al. (2005) and Coughlin et al. (2004) have recommended 800 mcg, 600 mcg, 400mcg and 200 mcg, respectively. Unfortunately, these recommendations are based on findings from studies that are potentially biased as the research samples were small; 102, 104, 126 and 104 women respectively. The research subjects were also recruited by their care providers and may have participated in the studies under duress. Although not statistically evaluated, the aforementioned researchers commented on the significantly increased levels of pain, and associated pharmacotherapy, experienced by women who received medical management, in comparison with those who received expectant management.

Reducing the painful side effects associated with interventionist management of first trimester miscarriage is a key concern for healthcare providers. Tang, Lau, Ng, Lee, and Ho (2003) conducted a randomised trial with 80 women to evaluate oral and sublingual misoprostol treatment for miscarriage. Study findings suggested oral and sublingual treatments may be as effective, cause less side effects and be associated with less pain than vaginal misoprostol. Women in the study also perceived sublingual treatment to be less interventionist, and more acceptable, than vaginal treatment. However, due to the small number of research participants, further research regarding the efficacy of sublingual misoprostol is recommended.

Due to physician's concerns regarding the risks of infection and coagulation disorders that result from retained products of conception, surgical management is still commonly used, and justified by some physicians as the most rapid and effective method of managing first trimester miscarriage (Griebel, Halvorsen, Golemon & Day, 2005). The recommendation for all women who experience first trimester miscarriage to receive immediate surgical management in order to reduce miscarriage-related morbidity is contentious. Zhang et al. (2005) completed a randomized controlled trial with 652 women to compare the efficacy of medical management of first trimester miscarriage (800 mcg misoprostol) with surgical management. The study found that 84% of participants were treated successfully with medical management within a week of first trimester miscarriage, and that there was little difference in the efficacy of medical and surgical management. In contrast to expectant management, both methods of management were associated with increased risks of infection, and haemorrhage, and experienced by women as more painful than expectant management. These findings were replicated in a small research study conducted by Shelley, Healy, and Grover (2005), but due to the limited sample size (n = 40) the validity of research findings, which suggested that expectant miscarriage was sufficiently safe to be offered as a care option and that medical management might carry a higher risk of inter-uterine infection, is questionable.

As expectant management appears to be associated with less pain, and side effects than medical or surgical management, is it a safe method for managing first trimester miscarriage? A meta-analysis of randomized controlled trials and cohort studies has suggested that 80% of women who experience first trimester miscarriage have a complete miscarriage in two to six weeks without medical intervention (Butler, Kelsberg, St Anna & Crawford, 2005). The associated rate of complications for expectant management compares favourably with rates of complications from surgical

and medical management, and may be reduced by screening for additional risk factors to women's health. Cahill (2001) and Daly and Prenderville (1997) recommended ultrasound and serum progesterone level screening to identify potential risk factors that may adversely affect expectant or medical management and women's health. The role of ultrasound imaging in diagnosing and investigating early pregnancy failure is contentious. Luise, Jermy, Collins, and Bourne (2002) used transvaginal ultrasonography with 312 women to identify those women with an incomplete miscarriage. Thirteen women were lost to follow-up, so the study population comprised 221 women. Of these, 201 women (91%) completed their miscarriage without intervention. The researchers reported that during the research process ultrasound scans were inconclusive in relation to identifying incomplete miscarriage and predicting miscarriage outcomes. The research results therefore suggest there is no correlation between miscarriage outcomes and ultrasound findings. They recommend women who choose to miscarry naturally, or receive medical management, should receive continuity of care and ongoing support from community health professionals. Alternatively, in cases of incomplete miscarriage, Janiaux, John, and Burton (2005) promote high resolution, transvaginal ultrasound (TVS) as a highly effective method for identifying maternal physiological factors that are favourable for expectant management. The efficacy of serum progesterone screening as a predictor of pregnancy outcome is also debatable. Recent studies suggest that progesterone levels do not consistently predict future pregnancy loss (Condous, Okaro & Bourne, 2003; Ogasawara, Kajiura, Katano, Aoyoma & Aoki, 1997), and that endocrinological abnormalities are present in only 25% of women who have a miscarriage (Li et al., 2000).

The diversity of treatments available for managing first trimester miscarriage and the lack of consensus regarding what constitutes the most effective evidence-based care may be confusing for care providers. A survey by McLaren and Shelley (2002) has suggested that there is evidence of knowledge gaps amongst Australian general practitioners regarding appropriate care for women experiencing miscarriage. Due to the high incidence of maternal morbidity associated with miscarriage the researchers propose that health professionals adopt a cautionary approach to miscarriage management. Generalisation of survey findings is limited because only practitioners in the State of Victoria were surveyed, and the response rate was 60%. It is also interesting to note that a disproportionate percentage of survey respondents were women practitioners. It may be argued that the gendered response of survey participants infers that miscarriage is a care provision issue that may be more

appropriately managed by a gendered, and woman centred profession such as midwifery.

### **Midwifery and Miscarriage**

Mander (1994) and Moulder (1998) have suggested midwives are the most ethically and professionally qualified health professionals to provide care to women experiencing miscarriage. English midwives, Arber (1985), Lewis (1992) and Murphy (1996) recommend community based midwives as the most appropriate health professionals to provide assessment of imminent miscarriages, information and explanations regarding the miscarriage process, psychosocial and emotional support, and follow-up care. More recently Krause and Graves (1999) and Thorstensen (2000) have outlined evidence-based care plans for midwifery care during first trimester miscarriage, because they argue that midwives recognize the significance of pregnancy loss, validate women's perceptions of motherhood, and provide competent health care, empathic social support, relevant education, and counseling during and after miscarriage.

There is a paucity of research literature evaluating midwifery care provision for miscarriage. Swanson-Kauffman (1983) used a modified grounded theory methodology to explore 20 women's experiences of miscarriage and in her dissertation proposed a caring theory for midwives. She suggested that the caring categories were: "*knowing*", women's need to be understood; "*being with*", women's desire for empathic care; "*enabling*", permission for and facilitation of grieving; "*doing for*", women's need for caregivers to provide material services; and "*maintaining belief*", women's need for others to believe in their ability to cope. However, the method of data coding and analysis that was used to develop these theoretical categories was not sufficiently described or explained, and to date a care provision model based on this theory has not been developed. In contrast, a dissertation by Devlin (1997) examined the needs of 60 midwives who provide miscarriage care in Northern Ireland. Her findings suggest midwives feel unprepared and inadequately educated to counsel women experiencing miscarriage. She recommends changes to midwifery education to facilitate improved midwifery care provision.

Three quantitative research studies (Fleuren, Grol, De Haan, & Wijkkel, 1994; Kenney, 2003; Reed, 1990), have evaluated midwifery perceptions of care provision for women experiencing miscarriage. Reed (1990) conducted a postal survey of 309 hospital midwives in the United States, to identify if women's age and parity influenced the

emotional care provided to women. Results suggested that midwives considered emotional care to be important for all women experiencing miscarriage, but that miscarriage had a greater emotional impact on childless women. Research findings were potentially biased by the self-reporting of survey respondents, as these midwives may have desired to be seen as caring and or attempted to satisfy the researcher.

Fleuren, et al. (1994) used a postal questionnaire to survey 278 midwives and 495 general practitioners who resided in Holland, to assess their adherence to the standards for caring for women experiencing imminent miscarriage that were established by the Dutch College of General Practitioners. Approximately 241 midwives and 313 general practitioners participated in the survey. Results suggested a difference between health professionals regarding care provision, and that midwifery compliance with recommended standards was minimal due to midwifery collaboration with women's preferences for individualized care, non-invasive assessments and extensive follow-up care. However, the survey results are questionable because the target populations and subsequent response rates were not comparable. Thirty percent of Dutch midwives were surveyed and 87% of the targeted midwives responded. In contrast, 8% of Dutch general practitioners were surveyed and only 63% of the targeted physicians responded.

### **Midwifery, Māori and Miscarriage in Aotearoa, New Zealand**

In Aotearoa, New Zealand, self-employed independent midwives practice autonomously, and provide continuity of care to women within the context of partnerships as Lead maternity care providers. Kenney (2003) conducted a pilot study, and surveyed 50 midwives (59% of self employed, independent midwives who resided in the Canterbury region), to identify and describe the initial assessment, management, and follow-up care they provided to women experiencing first trimester miscarriage. Survey results indicated that the majority of survey participants (96%) provided care for women who experienced first trimester miscarriage, and that midwives perceived themselves to be adequately educated, and appropriately experienced to provide that care. However, survey participants also expressed concerns regarding the inadequate legislative recognition of midwives as autonomous care providers during the first trimester; and the lack of remuneration, and the absence of consensus regarding evidence based guidelines, for providing such care. The research study had limitations in that contact with potential participants relied on a publicly accessible resource, the Ministry of Health register of self employed midwives that provided autonomous maternity care within the Canterbury region; which was not current. However, as the

pilot study was exploratory in nature it has established the need for further national midwifery research to be conducted in Aotearoa, New Zealand.

The need for more midwifery research in Aotearoa, New Zealand is compounded by the paucity of research that specifically examines Māori and non-Māori women's experiences of miscarriage and related care provision. To date quantitative research conducted in Aotearoa, New Zealand has predominantly explored the demographics associated with, and potential causes for, miscarriage (Yang, Stone & Stewart, 2006). Initial research that explores Māori women's health and wellbeing was conducted by Murchie (1984), and has focused on examining women's cultural security in relation to the impact of introduced stressors such as alcohol, drugs, smoking and altered nutritional resources. The research findings have subsequently provided a basis for epidemiological studies (McLeod, Pullon & Cookson, 2003; Williamson, Gunn, Johnson & Milsom, 2001) that draw on lifestyle models of health to explore the link between environmental risk factors and the fertility of Māori women. Binney and Chaplin (1986) have provided the first commentary on Māori women's experiences of miscarriage. The life stories of eight Māori women were collected and although these stories were not specifically about childbearing, the researchers commented on the anguish and tragedy experienced by women and whānau (family) associated with the end of a descent line. Rimene, Hassan and Broughton (1998) initiated qualitative research with Māori women that specifically explored childbearing. The research findings have discussed all aspects of the childbearing experience. Although brief comments about miscarriage were obtained from five women during the research and documented in the report, no textual analysis of these comments was conducted and only minimal information was gathered regarding Māori women's experience of miscarriage. More recently, the Rapuora II study has attempted to update Murchie's (1984) exploration of Māori women's health, through researching Māori women's conceptualisations of sexuality. Pregnancy and childbirth, although associated with female sexuality, have not been addressed in the research.

Palmer (2002) conducted the initial quantitative survey of 31 Māori women's childbearing experiences. Survey results provide an initial description of many aspects that are deemed to be important to Māori women's wellbeing during pregnancy, but there are few references to miscarriage and no discussion of the implications of miscarriage for hapūtanga (pregnancy). Moreover, the research was specifically designed to gather information in order to develop a tool for psychological assessment.

Collecting women's stories as an acknowledgment of their genealogical and embodied knowledge was not a consideration in the research process. In contrast, Wilson (2004) has acknowledged the importance of Māori women's embodied and genealogical knowledge in her research, which explores 23 Māori women's conceptualisations of health and wellbeing, ontological descriptions of health and their interactions with health care providers. This research was designed to generate a Māori-centred grounded theory, so specific reproductive issues such as miscarriage are not addressed in the research design. However, research findings suggest that without adequate access to culturally respectful and competent care, Māori women's health outcomes will remain marginalised. Attention is therefore drawn to the importance of determining women's cultural perspectives and behaviours when designing care measures.

### **Summary**

The international literature suggests first trimester miscarriage is traumatic for most women, and that inadequate health care aggravates the associated distress. Women perceive that health professionals minimize pregnancy loss, provide inadequate information, insensitive care, and minimal follow-up after miscarriage. Recommendations for care provision include recognition of miscarriage significance, acknowledgement of women's loss and validation of motherhood. Collaborative, woman-centred, and technically competent care provision is advocated. Women and their families require comprehensive information, explanations regarding miscarriage, anticipatory guidance and counseling following miscarriage. Compassionate social support is recommended to facilitate women's psychosocial and emotional wellbeing. Midwifery assessment, management, and follow-up care is advocated for women experiencing first trimester miscarriage; because midwives are specialists in women's reproductive health, provide continuity of and women-centred care, and act as advocates for women during childbearing (Arber, 1985; Krause & Graves, 1999; Lewis, 1992; Mander, 1994; Moulder, 1998; Murphy, 1996; Thorstensen, 2000). Although minimal research has been conducted to explore midwifery care provision and women's experiences of miscarriage in Aotearoa, New Zealand, initial research findings suggest the aforementioned issues may have ongoing relevance for Māori and Non-Māori women. In this thesis, women's voices provide comment in relation to women's miscarriage experiences, concerns and related care in Aotearoa, New Zealand.

# 3

## Developing Methodology

### Creating a Path to Knowledge and Wellbeing

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*Mū te rongo, ka mōhio; Mū te mōhio, ka mūrāma. Mū te mūrāma, ka mātauranga, Mū te mātauranga, ka waiora.*  
(Through resonance comes awareness; through awareness comes understanding; through understanding comes knowledge, through knowledge comes life and wellness)

It is rather a method that at the outset of inquiry creates the space for an absent subject and an absent experience that is to be filled with the presence and spoken experiences of actual women (Smith, 1987, p. 107).

#### Introduction

This chapter presents a comprehensive overview of the development and theoretical underpinnings of Te whakamāramatanga; the research methodology/ model developed and trialled within the doctoral research project and presented within this thesis. Narratives and the value of narrative research as a mode of inquiry within multicultural contexts are discussed. A partnership framework for the research methodology is showcased and the methodology/model's relational links to kaupapa Māori research and Māori centred research are established. Core Māori theoretical concepts and principles are identified, and explanations are provided regarding their conceptual relevance to the research design. Midwifery theoretical concepts are also outlined and recommendations for their integration within the methodology are stated. Theoretical approaches to narrative analysis are discussed, specifically the application of Arthur Frank's and Margaret Somer's narrative research ideas and the social theories of Michel Foucault, Bruno Latour, Pierre Bourdieu, Bronwyn Davies, and Rom Harre are also considered in regards to their analytical relevance. Te

whakamāramatanga is promoted as a culturally and contextually relevant response to Midwifery professional governance requirements. It is proposed that through implementing the methodology within research, the development of multicultural research partnerships may be facilitated.

### **Constituting Narratives and Stories**

Within academia, there is considerable debate regarding the elements and organisational schema that may constitute a narrative (Frank, 2000a; Garro & Mattingly, 2000; Labov & Waletzkey, 1967; Linde, 1993; Plummer, 1995; Polkinghorne, 1988; Riessman, 1993, 2008). Historically, disciplinary conceptualisations of narrative have largely been drawn from the field of literary criticism; specifically from literature on narratology<sup>14</sup> (Bahktin, 1981; Frank, 2002; Maines, 2005; Mishler, 1986; Page, 2006; Sarbin, 1986). Definitions have also arisen from the field of sociolinguistics (De Fina, 2003; Gee, 1991; Thornborrow & Coates, 2005); where narrative tends to be characterised as a class of discourse, and the term story is reserved for an archetypal form.

Narratives are variously described as reports of temporally sequenced events (Bruner, 1991; Elliott, 2005; Paley & Eva, 2005), personal accounts (Robinson, 2005) sources of subjective truth (Riessman, 1993), ways of giving meaning to experience (Garro & Mattingly, 2000), modes of explanation (Bruner, 1986, 1987), and organizational schema expressed in story form (Polkinghorne, 1988). Within research, these multiple characterisations of narrative have resulted in the categorisation and structuring of narratives (Labov & Waletzkey, 1967) based on their form and content.

Health researchers frequently employ the terms ‘narrative’ and ‘story’ interchangeably (Greenhalgh & Hurwitz, 1999), inferring a degree of synonymy. Researchers (Barton, 2004; Paley, & Eva, 2005; Riessman, 1993) who consider this practice to be problematic have attempted to distinguish stories from narratives. Stories have primarily been constructed as subjective accounts that contain interwoven plots and characters, and are designed to elicit a particular response from listeners; whereas narratives are perceived to be objective reports of causally connected and temporally sequenced events.

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<sup>14</sup> Narratology refers to the theory, and study of narrative structure and the ways in which narratives influence individual and collective perceptions of selves and experiences. The literary study of narrative form emerged in the 4<sup>th</sup> century BC with Aristotle’s *Poetics*. However, modern narratology has developed from the work of Russian formalists such as Vladimir Propp’s (1928) *Morphology of the folktale*.

The absence of disciplinary consensus regarding the constitution, classification and structuring of 'health research narratives' is perhaps due in part to a perception amongst researchers that stories of illness or disease may be tales of power and morality (Crossley, 1999; Frank, 1998). Denzin (1989) remarks that due to the element of plight and/or tragedy commonly found in such stories, they may contain "interactional moments and experiences which leave marks on peoples lives" where "character is manifested" (p. 70). Illness narratives are therefore individualized and not really generalisable as 'data' (Frank, 1993). Denzin (1989) and Frank (1993, 1998) suggest that illness narratives are moral tales of the 'self' and infer that researchers are subject to a moral mandate to honour the narrative voices of research participants when re-telling participants' stories.

Original storyteller's narrative constructions are on occasion displaced or discounted by researchers (Labov & Waletzky, 1967; Riessman, 1993) who constitute such accounts as narratives based on their conformity to a specific arrangement of narrative elements. Due to the ethical tenets associated with research some health researchers (Bishop, 1996; Frank, 2005; Garro & Mattingly, 2000) have opposed the imposition of such classifications on narratives. Researchers (Bishop, 1996; Frank, 2005) have also viewed the use of analytical frameworks for, as Riessman (2008) suggests, constructing (suitable) narratives for inquiry; as contributing to the de-contextualisation of narratives. In his critique of narrative inquiry methods Barthes' (1974) suggests the reconstruction and reshaping of narratives by researchers, facilitates the homogenization of narratives. He perceives researchers' construction of the "grand narrative structure" as self aggrandizement and the imposition of structure "as exhausting...as it is ultimately undesirable, for the text thereby loses its difference" (p. 3). Following Barthes, Polkinghorne (1988) de-problematizes the delineation of narrative from story by constituting narrative as broadly inclusive; encompassing "any spoken or written presentation" (p. 13), which by default may include stories. More recently, Phibbs (2008), drawing on Plummer (1995, pp. 17-20), has viewed narrative through a broad but alternative lens and suggested that narratives may be perceived as "stories and action" in relation to "times, selves and settings" (p. 47).

In this thesis, the debate within health research regarding what elements and/or format constitute a health narrative is regarded as irrelevant, because such practices attempt to settle on paper that which is not settled in reality (Latour, 1999). As Frank (2000b) suggests "[P]eople do not tell narratives they tell stories: let me tell you a narrative sounds strange" (p. 354). In choosing to whom, where, when and how, we

tell stories and in the act of storytelling we create and enable un-finalised and dynamic relationships. “One person may be speaking but stories are told with - not only to listeners who are part of the storytelling” (Frank, 2000b, p. 354). Telling a story is therefore a “relational act” (Linde, 1993, p. 112) that implicates a narrator’s audience. Ochs and Capps (2001) theorise everyday storytelling relationships as conversations, that facilitate acknowledgement of, as well as exploration of our responses to, and the meanings associated with, identities and experiences. It is suggested that the researcher as listener and co-constructor of the ‘interview’ story, has a responsibility to ensure that participants’ narrative ‘voices’ and ‘storied’ meanings are heard and respected (Frank, 2000a; Ochs & Capps, 2001).

### **History of Midwives, Women and Māori: The Role of Narrative**

We live in a storied world. Women share stories, and in doing so, disclose to each other, their identities, experiences, beliefs, secrets, and deepest desires. Through the telling and retelling of stories, women nurture, create, accept, rationalise, adjust, invest in, and re-invent their identities and lives, in order to develop, refine and maintain, social networks and social worlds. As Frank (2000a) proposes, there are no places outside stories.

It is therefore unsurprising that whenever midwives meet, reciprocal storytelling is unconsciously initiated, because the commonality of narrative habitus<sup>15</sup> (Frank, 2005) forms bonds between midwifery practitioners and facilitates the building of trust and respect. The storytelling exchange frequently involves reflecting on events in professional practice, and is used as a way to both safely self evaluate professional performance, and identify the philosophical and professional beliefs of peers. This reciprocity in storytelling and hearing also occurs within the midwife/woman/family relationship with childbearing women. Midwives disclose to women who they are as women and health care practitioners via their stories, and assess women’s wellbeing via, and care for women’s needs in response to, women’s stories (Leap & Hunter, 1993; McHugh, 2004; Wickham, 2004a). Midwives may also collect stories of pregnancy and child birth and as Mol (2008) suggests “pass them on from one person to the next” (p. 17), potentially shaping professional practice, clinical research and health policy (Steiner, 2005).

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<sup>15</sup> Frank draws on the concept of habitus as conceptualised by Pierre Bourdieu (1977) Bourdieu defines habitus as the body made social through “systems of durable, transposable *dispositions*” (p. 72), or in other words habitual, or a predisposition to particular ways of being.

The oral tradition of passing down mātauranga Māori (traditional knowledge) and tikanga (cultural traditions) via he kōrero kanohi ki te kanohi (face to face communication) is a highly valued aspect of Māori culture (Binney, 1987). Researchers (Bishop & Glynn, 1992; Cram, 2001; Cram, Phillips, Tipene-Matua, Parsons & Taupo, 2004; Irwin, 1994; Mead, 1996; Royal, 1998; Smith 1999b) suggest that research involving Māori knowledge and people needs to be conducted in culturally appropriate ways and in keeping with Māori cultural preferences. In this instance the taonga of women's narratives may best be served by respecting the narratives in their entirety. The narrative analysis may be collaboratively constructed by research participant and researcher, and can disrupt the power relationship of who within the research process is known and who is the knower. Drawing on a post-colonial paradigm, this form of narrative analysis is concerned with the collaborative 'We' (interviewer and interviewee) not the individualistic 'I' (researcher) and may promote the whakamana (empowerment) and tino rangatiratanga (self determination) of both Māori and non-Māori women.

### **Development of Te Whakamāramatanga**

Midwifery practitioners in Aotearoa, New Zealand regardless of their sphere of employment are required to embrace the philosophical underpinnings, theoretical concepts and ethical requirements that inform, and provide the basis for professional practice (New Zealand College of Midwives, 2005). Consequently, this qualitative research methodology has been developed and trialled, within a partnership framework that is woman and whānau (family) centred. The research process has encompassed the midwifery ethical concepts of negotiation equality, empowerment, respect, trust, shared responsibility, informed choice and consent.

In accordance with the stipulated performance criteria for the first professional competency of midwifery practice and ethical responsibilities to the wider community, midwives must demonstrate that they recognise Māori as tangata whenua, and practice in accordance with the principles of protection, partnership and participation as an affirmation of the Treaty of Waitangi.

In order for midwives to acknowledge a Māori world view, it is essential that relevant cultural concepts/processes, particularly whakapapa (genealogy) and whakawhanaungatanga (building and maintaining relationships), are encompassed within the creation of midwifery research and care provision frameworks. Such

concepts may have cross-cultural significance and accordingly, have been incorporated into the development of the methodology 'Te Whakamāramatanga'.

I demonstrate throughout the thesis that this framework has been perceived by Māori and European research participants as providing a contextually relevant and safe process for participants to share their stories and co-constitute new narratives of midwifery knowledge. I also propose that the methodology/model provides a framework that may be adapted for application to clinical midwifery practice, and that it has the potential to facilitate change in the field of health care.

### **Te Whakamāramatanga**

The title of this partnership model 'Te Whakamāramatanga' (Figure 3, p. 53) draws from the Māori whakatauki (proverb) *I te kore, ki te po, ki te ao Mūrama* (From darkness through the night into the world of light) which acts as a metaphor for both the creation of humanity and childbirth. Within the thesis the title of the methodology reflects the spiritual call to us as human beings to embrace our part in the movement of the universe and move from darkness into the light of knowledge and relational connection as human beings. As such this model has the potential to be adapted and applied as a framework for healing and new growth in a variety of settings.

Within the research paradigm the term 'Te Whakamāramatanga' encompasses all aspects associated with research design. *Definition*<sup>16</sup> of that which needs to be identified, examined. *Elucidation* of the complexities associated with the research process and *Enlightenment* through the gifting of knowledge within the research partnership. *Interpretation* of reciprocal knowledge to uncover the deepest embedded *Meanings*, and recognising their intrinsic value. Seeking and at the conclusion of the research process, crafting *Solutions* to the questions and problems identified. The following section outlines the key ideas within the research model 'Te Whakamāramatanga' through considering the philosophical underpinnings of 'he pikorua' and the theoretical concepts that make up the model.

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<sup>16</sup> Ngā kupu me Te Reo Māori (Māori language terms) are frequently associated with more than one meaning depending on context. In this chapter italics are used to indicate English translations of possible contextual interpretations of Māori terms. For example, within Te Ao Māori (the Māori world) 'Te whakamāramatanga' may be interpreted as meaning *Definition, Elucidation, Enlightenment, Interpretation, Meanings* and *Solutions*.

## **Philosophical Underpinnings**

### **Te Pikorua (Entwined Pikopiko Ferns)**

I have visually represented ‘Te Whakamāramatanga’ with he pikorua pounamu. Taonga crafted in pounamu are highly valued by all Māori. Stories from my childhood attest to the life force of pounamu, and the protective and creative influences it has enacted on individuals; keeping them safe on their journeys and/or spiritually changing them from within.

Te pikorua is commonly explained as two autonomous pikopiko ferns that are continuously entwined with no beginning and no end. As such they are a representation of an infinite partnership. The triple twisted pikorua more frequently refers to the interconnectedness of two cultures or two peoples and their challenges and reconciliations over time. In Greymouth this interpretation of he pikorua was applied to the conceptualisation, and actuality, of a partnership that was co-constructed by Tangata whenua, health professionals and District Health Board employees from Grey Base Hospital. This partnership was formed with the intent of developing and conducting workshops for community members and health care providers. The workshops focused on supporting the continuity of cross-cultural knowledge and respect, within the field of health care provision (West Coast District Health Board, 2004). The pikorua may therefore be applicable for symbolising the creation of the research partnership and the continuity of that research partnership maintained over time, and throughout the research process.

For the purposes of ‘Te Whakamāramatanga’, the pikopiko ferns represent multiple partnerships (Māori/Europeans, research participants/researchers, women/midwives), and may appear as various combinations within those partnerships, such as Māori midwifery researcher/European woman research participant.

The pikopiko ferns may also represent interpersonal communication; an integral element within the research process, particularly within narrative research. The elements of creativity and protection traditionally attributed to the pikorua enhance a cultural framework that may facilitate the development of intimacy, and encourage reciprocity between researchers, research participants, women and midwives. The continuity of korero may therefore be considered inherent within the pikorua, at both macro (societal, community), and micro (individual/whānau) levels.

### **Nga Kete o te Wananga (Baskets of Knowledge)**

Women's and midwives' narratives contain nga kete o te wananga (the baskets of knowledge); the gifts of Tāne Mahuta. This is the knowledge that guides the research process, the knowledge that is uncovered within the research process, and the knowledge that will be created by the research partnership. Such knowledge may be summarised as knowledge of the physical senses (te kete aronui), knowledge that is beyond the physical senses (te kete tuauri), and knowledge that is born from the sense of oneness that develops amongst members of the partnership (te kete tuatea).

Knowledge of the physical senses contains all the knowledge of the natural world that we see, hear, smell, taste, and touch. For the purposes of this study, such knowledge is created from women's embodied experience of childbearing, loss, and caring for that loss, as expressed in the stories that are shared by all participants in the research process.

The knowledge that is beyond the physical senses encompasses theoretical knowledge, comprehends, discloses and explains the reality behind what is experienced in the natural world, and for the purposes of this thesis, helps explain and inform the research process. Such knowledge may be described as sense perception; and is frequently difficult to grasp, and/or may even be hidden. Midwifery knowledge of the normality of pregnancy is hidden knowledge based on midwives' ability to identify the patterns of changes, and rhythms of energy, associated with pregnancy, without the benefit of, or recourse to, medical technology. Pelvin terms this "midwifery's art of knowing" (1996, p. 14).

Childbearing women also have personal, private ways of 'knowing' in relation to their pregnancies; their embodied knowledge of each pregnancy, and the physical intimacy they experience with their individual bodies. Women collectively may refer to this knowledge as intuition. For women who miscarry and the midwives who care for them, knowledge of a problem may become evident in the co-recognition of the subtly changing patterns associated with a pregnancy. Changes may be benign on an individual basis, but collectively they tell a different story. This knowledge is therefore embedded in women's and midwives' narratives.

The knowledge that is born from a sense of whakaaro kotahi (unity) develops gradually amongst members of the research partnership. The reciprocity of ritual story sharing between researcher and research participant creates knowledge that is beyond

time and space; that is deeply spiritual in nature, and informed by forbears, history and culture. Such spiritual knowledge, co-created by the whanaungatanga of researcher and research participant, facilitates the building of mutual trust and respect. Revelation of spiritual knowledge during the research process, and within the research findings may be proportional to the levels of intimacy and trust that are achieved within the research partnership.

In the next section of the chapter a visual representation of the model is presented, followed by a discussion of the theoretical processes and concepts of 'Te Whakamāramatanga'. The theoretical processes are Whakamātautau (examination) and Whakataunga (conclusions, findings, implications). The theoretical concepts are Whakapapa (genealogies), Whakawhanaungatanga (building relationships), Whakarurutanga (safety), Whakaaetanga (acceptance, approval, agreement), Whakiritenga (negotiation), Whakangungu (protection, advocacy), Whakawhirinaki (building trust), Whakamana (empowerment), Ōritetanga (equity) and Mana Motuhake (autonomy, self determination).



Figure 3 Te Whakamāramatanga (Research methodology model)

## **Theoretical Processes and Concepts**

### **Whakamātautau (Examination)**

All knowledge ascertained during the research process must be subjected to careful scrutiny; examination as to the value or trustworthiness of that information. For this process to occur, the researcher may act as both research tool, and be personally involved within the process. Each researcher brings unique professional, emotional, psychological, spiritual, intuitive, physical, gender-based, and embodied knowledge and experience to research. Bishop (1999) suggests that within Kaupapa Māori research the personal involvement of the researcher may be determined by mutual agreement of all research participants, including the researcher.

Within the context of this thesis, the research partnership examines human plight and tragedy. Stories of anguish are often painful for both storyteller and listener. Therefore in order to be effective as both research tool and research partner the researcher requires a sense of coherence (Antonovsky, 1993), a sense of place and the ability to value subjectivity and appreciate, not just tolerate differing individual and cultural perspectives. This requires an understanding of self as both a bearer of professional and cultural power within the research partnership. My involvement in progressing and conducting the research, and relationships with research participants, are further discussed in chapter four and where appropriate, referred to in the substantive chapters.

### **Whakataunga (Conclusions, Findings, Implications)**

Whakataunga represents the conclusion of the research process. The final interpretation and agreement with participants of knowledge gained during the research process identifies the research findings and discussion regarding these research outcomes allows the acknowledgement of limitations to the research and further implications of the research process to emerge. The findings and associated recommendations for future actions may be discussed and accepted within the research partnership, and a plan for future actions agreed. Within the thesis, a chapter summary of key findings is provided for each of the substantive chapters. The main arguments and implications arising from the research findings are presented in the concluding chapter of the thesis.

### **Whakapapa (Genealogy)**

The ebb of our lives flow continuously like water over rocks through the tree trunks, down slips, and all the while nourishing the roots of those to follow after us. I believe our children are seeded within us as the cherished event of our own births. Through their growth our tupuna assist us, support us and guide us with whole heart (Gibson, 2005).

Artist, Jesihana Gibson (Ngati Porou), has provided a narrative metaphor for whakapapa as an interface between history and biography. Inherent within this narrative is the concept of whakapapa; genealogy as the essential beginning point for the creation, continuity and transmission of knowledge. As such this concept has relevance for all women regardless of ethnicity.

The intrinsic value of whakapapa as a research methodology for creating mātauranga Māori (Māori knowledge)<sup>17</sup> has been acknowledged (Royal, 1998). However, such acknowledgement focuses on whakapapa as an exclusive methodology in that mātauranga Māori are constructed as phenomena that shape the representation and sets of understandings of one phenomenal world, Te Ao Mārama (the world of light/enlightenment). Additionally, in drawing on biological (genealogy) and mathematical ( $A+B = C$ ) metaphors to frame the construction of knowledge, the methodology does not adequately address the inherent and timeless spirituality of whakapapa (genealogy) and mātauranga (forms of knowledge).<sup>18</sup>

Within this thesis, whakapapa provides the beginning and facilitates continuity of the research process, through the birth and growth of women's stories. Whakapapa is embedded within women's stories and the mātauranga that informs, is embedded in and created by these stories may be defined as a "blessing on our mind, it makes everything clear and guides you to do things the right way" (Stirling & Salmond, 1980, p. 205). Such mātauranga therefore encompasses the moral/spiritual dimension of existence that is essential to both European and Māori constructs of health and wellbeing.

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<sup>17</sup> The term 'mātauranga Māori' is singular and plural and may refer to multiple forms of knowledge.

<sup>18</sup> In Māori cosmogony, whakapapa genealogy and mātauranga Māori (forms of Māori knowledge) have divine origins as evidenced in the creation narratives that trace the lineage of all Māori from Io the eternal progenitor and the gifting of the baskets of knowledge to man by Tane.

### **Whakawhanaungatanga (Building Relationships)**

Mead states “Whanaungatanga embraces whakapapa” (2003, p. 28). Therefore whanaungatanga focuses on relationships, and places obligations on those that share kinship to provide support and help when requested. Whanaungatanga may be extended to include relationships with those that are not related by whakapapa, and individuals that are members of larger collectives. For the purpose of this thesis, whanaungatanga requires that members of the research partnership, are mutually supportive, and collaborate to facilitate the research process.

The building of relationships within the research partnership may be carefully nurtured by *te kanohi kitea*, the known face. Potential researchers need to be seen in person by potential research participants, and begin to develop mutually respectful relationships before commencement of research can occur. Nurturing of whanaungatanga is ongoing during the research process, and the relationships that are established will continue after the research is concluded.

Whakawhanaungatanga facilitates the creation of women’s stories; the principle of whanaungatanga is evidenced within the stories and the correlations of thoughts, sorrows, events, silences, and selves that are identified in the minutiae of narrative analysis.

### **Whakarurutanga (Safety)**

Whakarurutanga represents the researchers need to satisfy the ethical requirements associated with conducting research; prior to commencing research, whilst conducting research, upon, and after completion of the research. There are extensive guidelines for conducting research with Māori (Bevan Brown, 1998; Durie, 1994; Health Research Council, 2008; Massey University Human Ethics Committee, 2005; Smith, 1999b), and comprehensive consultation is required before commencement of, and during, the research process to facilitate ethical accountability.

Within the context of this research study, whakarurutanga represents the assurance that the partnership is a safe place to mutually disclose and explore, selves and stories; that women’s and midwives’ narratives will be valued and protected. Ownership of each story resides permanently with the original storyteller; therefore in principle a story may not be shared, or passed on, without the express permission of the author of that story. However, the act of storytelling creates a uniquely new narrative that guarantees the listener as well as the storyteller will become relationally connected

with the story and an argument may therefore be made that the listener through paying attention to the story also acts as co-creator or co-author of the story.

### **Whakaaetanga (Acceptance, Approval and Agreement)**

Within the research paradigm, this process incorporates acceptance of the researcher, the intentions or aims of the research, and the research process, by potential research participants. Whakaaetanga includes gaining approval to commence research i.e. consent from the Massey University Ethics Committee and receiving informed consent regarding taking part in the research from participants. This concept also encompasses the collaborative agreement of researcher and research participants, regarding the interview transcripts, interpretations, and research outcomes; the sanctioning of research conclusions and the permission to release/publish knowledge that has been shared during the research process.

For a researcher and/or research participants, the act of sharing their stories, and the selves disclosed in those stories may facilitate acceptance of self/selves or may trigger catharsis. Therefore within the research partnership, whakaaetanga is intimately linked to both whakarurutanga the requirement that partnership occurs in, and is, a safe place, and whakawhirinaki in which partnership creates and values mutual trust.

### **Whakaritenga (Negotiation)**

The proposed research process incorporates the negotiation of power relationships, and differing perspectives within, and external to, the partnership. With regard to research methodology, this concept may encompass negotiating access to, and informed consent to participate in the research process from, prospective research participants. Additional aspects associated with research that may require negotiation include timeframes, i.e. timing of interviews, time budgeted for collecting narratives, and collaborative agreement regarding locations where the research will be conducted and who will be present. A researcher and research participants experience reciprocal challenges that require negotiation. A research participant may not accept a completed transcript as accurate, nor agree with the results of the narrative analyses conducted. In some instances despite offering initial approval of the research process, research participants may decide that their stories are taonga that should be kept private, and upon completion of research, refuse to permit a researcher to release any knowledge gained during the process. Such challenges within the research partnership frequently require reconciling differing perspectives regarding the meaning and value of narratives.

### **Whakangungu (Protection and Advocacy)**

Whakangungu encompasses the moral obligations imposed on individuals by whanaungatanga to protect, defend and shield those who are vulnerable. Within the research paradigm, the reciprocal obligations of all participants in the research process are; to actively protect the participants, the partnership, and the knowledge that is generated by the partnership, and to advocate for change based on the recommendations that emerge from the research partnership. The concept of advocacy on behalf of women is also encompassed by the practice philosophy of midwifery in Aotearoa, New Zealand.

### **Whakawhirinaki (Building Trust)**

Whakawhirinaki encompasses the entrusting of selves, stories, and speaking silences within the research partnership. It is a dynamic process that assigns roles (she/he who may be depended on/relied upon/trusted, she/he who depends on/relies upon/places trust in), and requires both research participants and researcher to continuously exchange these roles within the research partnership in the quest for knowledge. The mutual trust that may be engendered in researcher and research participant is not limited by the duration of the research process, but remains an ongoing duty.

### **Whakamana (Empowerment)**

Smith states “[S]o much of the method..., gets written out, that the voices of the researched become increasingly silenced as the act of organising, analyzing and interpreting data takes over” (1999a, p.18). In this research, through acknowledging and honouring women’s stories in their entirety, as respectful of their knowledge and as justification for my privileged access to participants’ narratives; I have enabled women’s voices to be heard in circumstances where ‘silences’ may have been the tradition. By paying respect to women’s knowledge, collaborative research conducted within the framework of partnership may facilitate tino rangatiratanga, professional development for midwifery practice and improvements to healthcare provision.

### **Ōritetanga (Equity)**

Ōritetanga broadly incorporates the concepts of equality and equity, and may encompass the rights of citizenship. Equity as a concept is broadly encompassed within the methodology which has been specifically designed for application in research that primarily explores the experiences of those individuals and/or groups that are marginalised, oppressed and silenced. The foundation for the research design is a

partnership format which enables equitable participation by research participants during all stages of the research process.

### **Mana Motuhake (Autonomy and Self Determination)**

Mana motuhake encompasses the self determination and autonomy of researchers and research participants. It ensures that the individual mana (prestige and dignity) of each research partner is reciprocally respected, and includes the acknowledgement and valuing of cultural diversity. During the research, ensuring mana motuhake specifically requires acknowledgment of participants' ownership of ontological narratives. Acceptance of participants' self theorisation and textual interpretations is also an essential part of the analytical process. The research methodology has been designed to acknowledge individual participants' autonomous rights including if required, facilitating participant withdrawal from the research project at any stage of the process prior to finalisation of results.

### **Theoretical Influences**

Development and trialling of a methodology that is applicable within a bi-cultural context requires the interweaving of theoretical influences from multiple epistemologies. Through drawing on theoretical concepts and research approaches from Western European and Māori paradigms, a research methodology that is contextually relevant for conducting research within Aotearoa, New Zealand has been created and implemented.

Te whakamāramatanga is a qualitative research methodology that draws on narrative research theory, midwifery philosophies and theoretical concepts as well as kaupapa Māori research methodologies. Research analysis has specifically drawn on the kaupapa Māori concepts of whakapapa (genealogy, continuity) and whakawhanaungatanga (developing relationships). Interpretation of participants' stories has been informed by whole narratives (Ezzy, 2002; Riley & Hawe, 2005), narrative elements (Phibbs, 2008; Plummer, 1995), and thematic approaches (Ryan & Bernard, 2003; Thorn, Reimer Kirkham & O'Flynn-Magee, 2004) to research analysis. Analysis has also been enhanced by the social theories of Michel Foucault, Pierre Bourdieu, Bruno Latour, Rom Harre and Paul Ricouer and the narrative analysis theories of Arthur Frank and Margaret Somers.

### **The Partnership Model**

Te whakamāramatanga is a methodology/model designed for application within the field of midwifery. As the concept of partnership is philosophically, ethically, and professionally integral to midwifery practice in Aotearoa, New Zealand, the methodology/model has been developed to fulfil that professional requirement and constitutes a partnership framework for conducting midwifery research. 'Te whakamāramatanga' draws on the midwifery model of partnership developed by Dr Sally Pairman, and Karen Guilliland, that was initially presented to the profession at the New Zealand College of Midwives conference in 1994, and which currently provides the foundation for midwifery practice in Aotearoa, New Zealand.

The midwifery model of partnership developed as an extension of the political partnership formed by midwives and women to advocate for legislative change regarding maternity care provision in Aotearoa, New Zealand. The partnership resulted in the Nurses Amendment Act (1990) that radically altered the Nurses Act (1977) to ensure that midwives regained their professional autonomy. The Nurses Amendment Act (1990) facilitated the refocusing of maternity care upon the premise that childbearing is a normal part of life, not a medical event that requires management.

Having demonstrated the political effectiveness of such a partnership, the concept has become part of the identity of midwives in Aotearoa, New Zealand. Since inception the model has evolved (See Appendix A) and been incorporated, initially into the professional Code of Midwifery Ethics and Standards for Midwifery Practice, and more recently into the professional competencies that have been developed to meet the requirements of the Health Practitioners' Competence Assurance Act (2003).

The partnership model has been criticized within the profession, and in various instances collectively referred to as 'professional rhetoric', 'a cherished ideal', and a concept that has been overused or rather 'thrashed to death' (Fleming, 1998; Lauchlan, 1996; Skinner, 1999). Alternatively, those that support the partnership model (Benn, 1999; Daellenbach, 1999; Donley, 1998) argue that the midwifery partnership provides a framework for practice that is in keeping with the underlying philosophical beliefs of the midwifery profession in Aotearoa, New Zealand.<sup>19</sup>

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<sup>19</sup> The philosophical underpinnings are: birth is a normal physiological process and life event, midwives provide the total childbirth service, midwifery is a profession characterised by autonomy and

From a personal perspective, midwives frequently say that they work in partnership, however, the midwifery partnership is not an easy way to practice professionally, and does not just happen without ongoing professional and personal reflection and commitment (Kirkham & Perkins, 1997). The challenge for midwives is in comprehensively understanding the essence of the midwifery partnership.<sup>20</sup> Such understanding includes acknowledgement of what the partnership requests of midwives spiritually, physically, emotionally and psychosocially, and responding to these requests by practising partnership in all areas<sup>21</sup> of the profession, within a bi-cultural framework.

### **Midwifery within a Bi-cultural Environment**

In Aotearoa, New Zealand, the Midwifery Council acts as the legislative and registration authority for midwifery practitioners. The New Zealand College of Midwives is the professional body, and as such has the responsibility for developing and/or refining ethical responsibilities, professional standards and more recently the four key competencies for practice.

The first professional competency developed for midwifery practice in response to the Health Practitioners' Competence Assurance Act (2003) states: "The midwife works in partnership with the woman throughout the maternity experience" (New Zealand College Of Midwives, 2005, p. 5). This competency reflects the Anglo-Saxon linguistic and historical origins of professional midwifery in Aotearoa, New Zealand, as the word midwife has developed from the old English term 'mid wif'. The term therefore has the inherent meaning "with woman". This is potentially problematic in a nation with a second official oral language (Te Reo) and an alternative indigenous culture. Within the Māori worldview, the word midwife does not exist as such, and those who support and facilitate childbirth in culturally traditional ways do not perceive their role as being 'with women'.

Currently, however performance criteria are established for each competency. The first criterion for competency one states "[T]he midwife centres the woman as the focus of care" (New Zealand College Of Midwives, 2005, p. 5). Within the context of the

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responsibility, midwifery is women centred and midwifery provides women with continuity through their childbearing experience (Guilliland & Pairman, 1994, p. 6).

<sup>20</sup> The theoretical concepts of the midwifery partnership are: Individual negotiation equality, shared responsibility, empowerment, informed choice and consent, mutual respect and trust (Guilliland & Pairman, 1994, p. 7).

<sup>21</sup> Areas in which midwifery as a profession is active include but are not restricted to clinical practice, education, research, professional administration, health services management, policy development and analysis.

criterion, and generalised to all competencies, the term woman is extended to include a woman's baby, partner, family and whānau. However, this generalisation is documented as a small footnote to the legislated professional competencies. Therefore within the practice environment of Aotearoa, New Zealand, midwifery professional discourses continue to focus on the individual, defined as a woman, in ways that predominantly exclude the whānau. The individualised focus of midwifery is evidenced in governance literature posted on the New Zealand College of Midwives website, specifically the section of the website that is aimed at providing information for childbearing women. For example,

New Zealand midwives work in a partnership model of care with women. In this model each woman and her midwife are partners, working together to ensure that the woman has care that meets her individual needs. The woman and the midwife get to know each other well over the whole maternity experience (New Zealand College of Midwives, 2009).

In keeping with the recommendations made by the Royal Commission on Social Policy (1988) with regard to the articles of the Treaty of Waitangi, the following performance criteria are also applicable to competency one:

Criterion 1. 3. "The midwife applies the principles of cultural safety to the midwifery partnership" (New Zealand College Of Midwives, 2005, p. 5).

Criterion 1. 4. "The midwife recognises Māori as tangata whenua of Aotearoa and honours the principles of partnership, protection and participation as an affirmation of the Treaty of Waitangi" (New Zealand College Of Midwives, 2005, p. 5). Criterion 1. 4. is also listed in 'The Midwifery Code of Ethics' as a midwife's first responsibility to the wider community (New Zealand College Of Midwives, 2005, p. 10).

The various debates regarding the authority and application of the Treaty are comprehensively documented (Durie, M., 1998; Kelsey, 1984, New Zealand, Law Commission, 1999; Mikaere, 2003; Orange, 1987; Royal Commission on Social Policy, 1987, 1988) however current legislation supports the Māori version, Te Tiriti O Waitangi taking precedence over the English version. Fox (2000) asserts that the midwifery model is not adequate as it excludes the principles of protection and participation. I would argue despite good intentions, the current midwifery partnership model and professional competencies do not comprehensively honour any of the aforementioned principles.

The partnership model (see Appendices I), has been developed by two highly educated European women. Indeed midwifery, according to Māori women with whom I have shared the experience of childbirth, is seen as a middleclass European woman's profession. This perception appears to be supported by the salaries earned by midwives and the small minority of women who are Māori and/or not European that practice professionally.<sup>22</sup> If midwifery is inherently a European dominated middleclass profession then it is extremely unlikely that the profession will comprehend the nuances of mātauranga Māori and this appears to be reflected in the governance language of the profession. In contradiction to the aforementioned competency performance criterion 1.4, there is no acknowledgement of any Māori worldview in the visual representation (See Appendix A) and written explanation of the midwifery partnership model (Guilliland & Pairman, 1994; Pairman, 1999).

How then has the facilitation of childbirth been alternatively embraced within the world of Māori; tangata whenua? Prior to 1907, in Aotearoa, New Zealand highly skilled, and respected, tohunga (Mikaere, 2003) of either gender facilitated the creation of families, and more usually, these experts in childbirth were related to the prospective parents. With the passing of the Tohunga Suppression Act (1907), which remained un-repealed until 1962, tohunga were prohibited from practising in any sphere of expertise. Tohunga found guilty of contravening this legislation were imprisoned, and with the exception of a few isolated communities, the active involvement of Tohunga in childbirth was undermined (Mikaere, 2003). This cultural oppression by the colonising immigrants resulted in the radical and permanent loss of whānau and hapu specific mātauranga (knowledge) and tikanga (cultural traditions) associated with childbirth, (Jenkins, & Pihama, 2001), and has led to the involvement of Tohunga in childbirth being currently the exception, rather than the rule (Mikaere, 2003; August, 2004; Palmer, 2002).

In the 21<sup>st</sup> century, tangata whenua who assist whānau during childbirth are more commonly known as 'Kaiwhakawhānau' ('childbirth helper' or literally, 'guardian of, and during, the creation of a family'). This term designates a birthing assistant who lacks the spiritual wisdom and mana of a Tohunga, suggesting that tangata whenua

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<sup>22</sup> Currently there are approximately 110 Māori midwives and 35 midwives of pacific origin (Midwifery Council of New Zealand. Downloaded from <http://www.midwiferycouncil.org.nz>, 20/08/2009). In contrast to the limited numbers of Māori midwives, Māori comprise approximately 15% of the population and Māori births comprise more than 28% of the total number of childbirths (New Zealand Health Information Service, 2008).

still view birth as located within, and the responsibility of, the whānau (family). This familial model of care is in direct contrast to the legislated model, which defines childbirth care within a professional framework that incorporates the associated colonial philosophy of woman-centred midwifery.

Despite apparently opposing perspectives on the nature, and the location, of childbirth care, there are philosophical grounds for consensus between Māori, and midwifery worldviews. Miriama Kupe-Wharehoka suggests “the holistic practices and beliefs of Māori are universal, and do not belong to just one people but to all” (2000, p. 29). This is a generalisation and does not take into account the diversity of tikanga within various iwi or hapu. However, as a profession, midwifery agrees with and embraces the perception that holistic practices should be available to all women. Consequently, in regards to the conduction of research by midwives in Aotearoa, New Zealand, it is proposed that any effort to address the cultural misunderstandings evidenced between Māori and European worldviews requires the development of a research methodology/model that is constituted in accordance with midwifery competencies and performance criteria. Such a methodology would also integrate and or apply theories, concepts, and philosophies relevant to Māori and European worldviews and be implemented through contextually relevant research methods.

### **Māori, Research, and Māori Research Methodologies**

Māori have historically experienced research involvement as regularly insensitive, disrespectful, unethical and as a forum in which Māori cultural identities, knowledge, and values, are marginalised (Jackson, 1996; Irwin, 1992; Smith, 1999b). It has also been suggested that researchers commonly offer participants little in the way of recompense for participation-related costs (Durie, 1996). In order to remedy what August (2004) characterises as ethno-cultural ‘othering’ (Weiss, 1995), the essentiality of decolonising existing research methodologies and methods has been comprehensively argued (Bevan- Brown, 1998; Bishop, 1999; Durie, A., 1998; Irwin, 1994; Jackson, 1996, 2007; Penetito, 2001; Smith, 1995; Smith 1999b). The principles of partnership, protection and participation developed by the Royal Commission on Social Policy (1988)<sup>23</sup> provide a legal argument for shaping culturally appropriate research methodologies through integrating Māori theoretical and cultural principles

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<sup>23</sup> As previously mentioned in the thesis the principles of partnership, protection and participation were developed from the articles of the Treaty of Waitangi by the Royal Commission on Social Policy (1988).

or concepts. Smith (1997) has asserted that kaupapa Māori theory<sup>24</sup> provides a foundational base for developing Māori research methodologies which may address culturally related inequities within contemporary research. Kaupapa Māori research is not yet clearly defined and it has been informally conceptualised as, research “[B]y Māori, for Māori and with Māori” (Bevan-Brown, 1998, p. 231; Smith 1995). Irwin (1994) categorises Kaupapa Māori research as, “[R]esearch which is culturally safe, which involves mentorship of kaumatua (elders), which is culturally relevant and appropriate while satisfying the rigour of research, and which is undertaken by a Māori researcher not a researcher who happens to be Māori” (pp. 27-28).

It is therefore argued that kaupapa Māori research draws on the essence of ‘being Māori’ and encompasses both Māori philosophies and principles and the researcher’s Māori dispositions (Smith, 1997; Smith, 1999b). As cultural dispositions vary amongst Māori, whakapapa associations are also integral to Kaupapa Māori research (Bishop 1994). In contrast to the methodological stance of Graham Smith (1997) and Linda Smith (1999b), Bishop (1994) advocates for the involvement of non-Māori researchers in Kaupapa Māori research as a method of meeting Treaty of Waitangi related obligations to facilitate Māori research.

The various and extensively debated views as to ‘who’ may conduct Kaupapa Māori research (Bishop, 1994; Cunningham, 2000; Durie, 1997; Smith 1997; Smith, 1999b) remain unresolved. However, in that Kaupapa Māori research is perceived as being informed by Māori epistemological concepts, facilitating Māori self determination and/or autonomy and enabling Māori aspirations it represents a valuable resource for both preserving existing, and developing new, cultural knowledges. However, the process of developing culturally relevant research methodologies remains continuously disadvantaged by the hegemonic influences of western European epistemologies and methodologies both within academic institutions, and research (Connell, 2007; Connor, 2006; Mead, 1996). Acceptance of indigenous ontologies and epistemologies within the academy is also problematic (Henry & Pene, 2001). Cunningham (2000) argues that as Māori research methods are restricted and not always validated within

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<sup>24</sup> Smith suggests that Kaupapa Māori Theory encompasses the following 6 principles: self determination or relative autonomy, validating and legitimating cultural aspirations and identity, incorporating culturally preferred pedagogy. Mediating socio-economic and home difficulties, shared collective vision and incorporating cultural structures –which emphasize the collective rather than the individual such as the notion of the extended family (Smith, 1997; Smith 2003).

the academy, ‘traditional’ research methodologies/methods that are commonly available may be used when conducting research with Māori. Durie (1997) asserts that if such methods are adopted by researchers working with Māori, Māori aspirations within the research process should be prioritized. In accordance with this view, Durie (1992) and Durie (1997) have advocated for a Māori centred approach to research that acknowledges and values the cultural identity, attitudes, values and knowledge of Māori. Durie (1997) suggests that such an approach should include the principles of mana Māori (control), whakapiki (enablement), and whakatuia (integration).

Although Durie’s (1997) research principles have been key influences during the developmental phase of te whakamāramatanga, my attention has also focused on integrating kaupapa Māori theory concepts such as whakapapa (genealogy) and whakawhanaungatanga (building relationships), and mana motuhake (autonomy, self determination)<sup>25</sup> within the methodology and/or the research process. Additional factors such as establishing and developing communicative rapport and trust, through kanohi ki kanohi (face to face) interactions and, Māori involvement from research inception to completion have also been considered. In that Te whakamāramatanga draws from both methodological approaches, the methodology/model could be considered a hybrid entity or actant that may constitute a culturally informed technology for exploring research concerns and creating new knowledge in new ways.

Kaupapa Māori and Māori centred research approaches are advocated for conducting research with Māori. However, the increasing globalisation of knowledge technologies facilitates non-indigenous researchers in accessing and potentially implementing indigenous methodologies. Non-indigenous researchers who use indigenous research methodologies may be construed as appropriating the research spaces of indigenous researchers and/or academics. An alternative path for developing knowledge technologies in culturally appropriate ways may be to:

[f]ocus on the interface between indigenous knowledge and other knowledge systems such as science to generate new insights built from the two systems. The interface approach recognises the

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<sup>25</sup> The researcher acknowledges that in bi-cultural discourses the term ‘Tino rangatiratanga’ is also commonly translated as or associated with the concept of ‘self determination’. However within this thesis the researcher understands the term ‘Tino rangatiratanga’ as inherently meaning ‘absolute sovereignty’, and has used the term Mana motuhake which viewed through a Māori lens more appropriately encompasses the concepts of autonomy, self determination and personal agency.

distinctiveness of different knowledge systems, but sees the opportunities for employing aspects of both, so that dual benefits can be realised and indigenous worldviews can be matched with contemporary realities (Durie, 2005b, p. 301).

In accordance with Durie's (2005b) and Connell's (2007) perspectives on furthering a global knowledge system, theoretical concepts and research approaches from the western paradigm have been examined as regards their relevance to the research methodology/model presented in the thesis.

### **Theoretical Influences from a Western Paradigm**

Development and trialling of a methodology that is applicable within a bi-cultural context requires the interweaving of theoretical influences from multiple epistemologies. Theoretical influences from a western paradigm have contributed to conceptualising and framing the methodology and research analysis. The theoretical ideas of Michel Foucault, Pierre Bourdieu, Bruno Latour, and Rom Harre have been choreographed in conjunction with the analytical narrative theories of Arthur Frank and Margaret Somers. The integration of diverse theoretical ideas enabled crafting interpretations of participants' stories, demonstrated the viability of the research methodology/model, and potentially showcased new interpretations of social and narrative theories. As this thesis has adopted a bricolage approach to analysis, in the following section of this chapter, rather than give a comprehensive overview of each theorist's work, key ideas that have been used within the thesis are outlined. A summary is also provided, that draws attention to the ways in which theoretical ideas have been brought into conversation in order to enable interpretation of narratives and the crafting of theoretical arguments.

### **Bruno Latour**

Bruno Latour's theories regarding actants, hybrid actors and actor networks have facilitated the crafting of arguments about corporeal and metaphysical technologies throughout the thesis. Technology and the social are perceived as complementing each other, in a mutually shaping interaction (Latour, 2000, Latour 1993; Law & Callon, 1988).

Latour (1993) and Callon (Law & Callon, 1988) suggest that non-human elements or objects are not passive vehicles for human interests but actors within their own right through presenting material technological actants as relational entities. Latour (1999) defines technological actants as hybrid entities or actors, constituted by 'hard' material

and by the social universe in which they operate and which they help create. Michel Callon (1987) asserts that such an ensemble constitutes “simultaneously an actor or entity whose activity is networking heterogeneous elements and a network that is able to redefine and transform what it is made of” (p. 93).

In this thesis the term actant and associated meanings as conceptualised by Latour (1999) refer to non living and non sentient material or metaphysical elements that without intentionality, “perform” (p. 303) and/or influence human behaviour. Latour (1999) uses the term ‘hybrid actor’ to refer to the interface between actants that encompass both hard non sentient material and sentient and/or organic material, including human beings. As an example, a car driven on the road constitutes a hybrid actor constructed from both non-sentient technology (the mechanical components that constitute a car) and cognitive corporeality (human actors that ‘drive’ the car). In the same way within the thesis a clay ipu (receptacle) containing a deceased baby may constitute a hybrid actor.

Latour, through drawing on linguistic analogies argues that the social and material may, through translation and inscription, be moved or folded from one temporal and/or spatial setting to another. Translation is perceived as the transformation of the physical into the symbolic, such as the translation of the materiality of blood into numerical language on a laboratory report.<sup>26</sup> Translating from one setting to another is influenced by ‘inscriptions’ (Akrich, 1992; Akrich & Latour, 1992) as symbolic artefacts that shape the means by which heterogeneous elements are translated. Inscription may be interpreted as embodying patterns of usage; the way in which “[T]echnical objects..., simultaneously embody and measure a set of relations between heterogeneous elements” (Akrich, 1992, p. 205). Laboratory reports therefore act as an archive for the conservation and representation of blood that establishes a ‘reversible route’ (Latour, 1999) from computer file, to paper, to blood, to an individual enabling simultaneous movement backwards and forwards through space and time. At each point in the translation the object becomes more mobile, blood test results recorded in an electronic computer file, for example, are more easily transported than blood samples.

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<sup>26</sup> Latour presents laboratory reports as both inscriptions and material actants that he refers to as immutable mobiles in that they may be circulated both locally and globally and the symbolic language is consistently understood by interpreters. However, as the symbolic language is interpreted within a specific context the associated meanings are therefore contingent. For example, embodied states such as pregnancy and localised determination of pathology such as measures for determining postpartum haemorrhage.

## **Michel Foucault**

Michel Foucault summarises his theoretical interests as follows:

I've always tried to articulate among modes of veridiction, techniques of governmentality and practices of the self... such an undertaking entails analysis of complex relations amongst three distinct elements that neither are reduced one to the other nor absorbed one by the others, but whose relations are constitutive of one another. These three elements are: knowledge studies in the specificity of the veridiction; relations of power, studied... in procedures by which the conduct of men is governed; and finally modes of constitution of the subject across practices of the self. It is by carrying out this triple theoretical displacement of the theme of knowledge toward that of veridiction, of the theme of domination toward that of government, and of the theme of the individual toward that of practices of the self that it seems to me one can study the relations between truth, power, and the subject without ever reducing one to the other" (as cited in Flynn, 2005, p. 262).

Foucault's ideas about the genealogy of knowledge, disciplinary power and resistance, governmentality, notions of subjectivity, technologies or practices of the self and other technologies of power have been drawn on during textual interpretation and crafting of the theoretical arguments presented within this thesis.

Foucault (1984) argues that genealogies constitute knowledge that is contingent and temporally, socially and historically situated and that therefore there is no such thing as absolute truth, because the privileging and meaning of speech acts are influenced by various agendas. He states:

The body is the inscribed surface of events (traced by language and dissolved by ideas), the locus of a dissociated Self (adopting the illusion of a substantial unity), and a volume in perpetual disintegration. Genealogy, as an analysis of descent, is thus situated within the articulation of the body and history (Foucault, 1984, p. 82).

Foucault's argument draws attention to the relational interactions of power and knowledge which he perceives as inexorably linked and constituted as a dyad, which he designates power-knowledge (Foucault, 1976, pp. 92-95, 102). He alludes to power as ephemeral, contingent in that it is "exercised from innumerable points" (p. 94), and argues that the exercising of power/knowledge is mediated by resistance and metaphysical technologies of power.

Foucault (1976) in suggesting that "[W]here there is power there is resistance" argues the "relational character of power relationships" depends upon the existence of

multiple “points of resistance” (p.95). The inference is that resistance may be perceived as a precondition of power, and power may not operate in a social vacuum.

Technologies of power are classified as technologies of the ‘self’ and technologies of production, domination, and signification or communication. Technologies of the self are the forms of knowledge and strategies that “permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (Foucault, 1988b, p. 18). Technologies of the self are therefore associated with what is colloquially referred to as, ‘being normal.’ A norm is that which commonly occurs, is personally desirable and socially acceptable. Social norms are often considered the natural state of affairs and the cultural discourses that shape such norms go unquestioned. It may therefore be argued that social norms are the product of hegemony.

Foucault (1988b) asserts that individuals who wish to achieve normality and therefore social acceptance employ technologies of the self to construct and shape their bodies, identities, behaviours and attributes, in order to conform to socially accepted codes of conduct. Foucault (1988b) conceptualises this specific process or technology of the self as normalisation. He alludes to such technologies as being employed by individuals in response to the application of technologies of domination (Foucault, 1977).

“Domination is a particular type of power relationship that is both stable and hierarchical, fixed and difficult to reverse” (Lemke, 2002, p. 53). Within diverse settings a state of domination may result when power is exerted over individuals (Foucault, 1977). Domination is therefore commonly characterised as power; more particularly the unbalanced connections of power between individuals who are hierarchically situated in relation to one another and in which the “margin of liberty is extremely limited” for subordinated individuals (Foucault, 1988b, p. 19). As Lemke (2002) remarks “states of domination are the effects of technologies of government” (p. 53). Foucault (1988b) suggests that the interface between technologies of domination and the self constitute governmentality. He proposes that the relational interactions of temporally and spatially situated individuals and the social structures of power they are subject to, shape contingent and un-finalised realities in which individuals and bodies are positioned as subject (Foucault, 1977, 1991).

Governmentality may therefore be interpreted as the reasoned principles or rationales and social structures that are drawn on by both state and individuals to regulate and police bodies, thoughts, and behaviours, and through which they codetermine each other's existence. Within the thesis participants' storied experiences of health care within health institutions are examined to evaluate how governmentality is directly facilitated through technologies of domination such as surveillance (Foucault, 1977), particularly through what Foucault (1963) characterises as medicine's gaze. Foucault infers that the social authority assigned to medicine imposes obligations as he states in his description of the gaze:

One must, as far as possible make science ocular. So many powers, from the slow illumination of obscurity, the ever prudent reading of the essential, the calculation of times and risks, to the mastery of the heart and the majestic confiscation of paternal authority are just so many forms in which the sovereignty of the gaze establishes itself – the eye that knows, and decides, the eye that governs (Foucault, 1963, p. 89).

Foucault (1976) coins the term bio power to “designate what brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transformation of life” (p. 143). He argues that bio power is exercised as regulatory power and disciplinary power. Regulatory power operated through the “juridical system of law” (p. 144) which needs “continuous regulatory and corrective mechanisms” (p. 144) in order to govern populations. Foucault (1977) perceives disciplinary power as exerted within institutions such as prisons, schools, and as relevant to this research, health institutions. Foucault (1976) also suggests that “power and desire are joined to one another...where there is desire the power relation is already present” (p. 81). He characterises desire as both productive and contingent and argues that as a technology of self it works to induce ‘desires’ in individuals which individuals then work to satisfy. Sawicki (1991), drawing on Foucault (1977), adds that disciplinary practices go unnoticed and secure subject compliance by in addition to creating desires, establishing norms against which individuals, bodies, behaviours and conduct are judged (p. 68). She suggests individuals may internalise and practice self governance (Foucault, 1977, p. 201) in relation to such norms becoming in effect “docile bodies” (Foucault, 1977, p. 138).

### **Pierre Bourdieu**

Narrative analyses presented in the thesis have also drawn on Pierre Bourdieu's conceptualisations of field (1977, 1996), habitus (Bourdieu & Wacquant, 1992), forms

of capital (Bourdieu, 1984, 1990), and symbolic violence (Bourdieu, 1977, 1996). Bourdieu (1996) defines a 'field' as:

A structured social space, a field of forces, a force field. It contains people who dominate and others who are dominated, Constant permanent relationships of inequality operate inside this space, which at the same time becomes a space in which various actors struggle for transformation or preservation of the field. All the individuals..., bring to the competition all the relative power at their disposal. It is this power that defines their position in the field and, as a result, their strategies (p. 40).

Bourdieu's definition infers that a field constitutes a metaphysical and hierarchically ordered network of social relations that, in being shaped by the exercising of power, are never finalised and therefore framed within porous boundaries. Fields shape the relational interactions and positioning(s) of those situated within the field. Positioning of individuals within fields, although subject to external influences is, Bourdieu (1977) argues, preconfigured by habitus. Bourdieu (1977) suggests that structures, for example class specific material conditions which in this thesis may include disciplinary narratives, produce habitus which he defines as "systems of durable, transposable dispositions" (p. 72). Put more concisely, dispositions may be characterised as habitual, or a predisposition to particular metaphysical, material and embodied (bodily hexus) ways of being. Bourdieu and Wacquant (1992) have characterised habitus as separately social, and class related, and suggested the two forms of habitus collectively and unconsciously shape an individual's identity and personal, social and embodied agency. Habitus, through shaping social agents' identities and agency, position actors, and therefore influence power relations within fields.

An individual's accrual of capital may also influence their relational position within a field. Bourdieu (1984) conceptualises capital as the symbolic, cultural, economic and social resources that an individual may draw upon during relational interactions within fields. Symbolic capital incorporates the resources available to an agent based on social perceptions regarding their personal prestige and level of social recognition. Social capital is accrued through social relationships, networks and group memberships. Cultural capital includes personal skills, educational achievements and ontological knowledge, and economic capital may be understood as equating to financial assets. Symbolic capital refers to the degree which other forms of capital are valued or recognised as legitimate.

The attainment of capital within a hierarchically framed arena facilitates the enacting of privilege and exercising of violence by social agents. Bourdieu (1996) defines the process of privileging one perspective on an issue over another as ‘hiding by showing’. He applies the phrase in theorising media representations of reality. Within this thesis the concept is applicable to analytical discussion of research participants’ narrative constructions of identities.

The term symbolic violence (1977, 1996) is applied in relation to social agents who having accrued social or other forms of capital, exercise power against other agents in the field that are perceived as having less, and who perceive their subordination within the field to be the natural state of things (Bourdieu, 1996). As the fields of health, and health care, constitute hierarchically arranged networks within which inequitable power relations exist, participants’ stories are explored in relation to the potential for symbolic violence.

### **Ron Harre**

The term ‘positioning’ has been used to encompass multiple, dynamic, and relationally constructed and situated, conceptualisations of ‘selves’. Davies and Harre (1990) and Harre and van Langenhove (1999) have interpreted the conceptual process as a dynamic change from the static concept of role. Positioning is “understood as the discursive construction of personal stories that make a person’s actions intelligible...as social acts within which the members of a conversation have specific locations” (Harre & van Langenhove, 1999, p. 395). Conversations are collaborative and progress as participants create reciprocal understandings of the interaction. However, as individual worldviews are shaped by the discursive practices in which they are embedded, the interactive process of subject positioning is also shaped by particular worldviews. As Davies and Harre (1990) assert “[I]ndividuals emerge through the process of social interactions...not as fixed products” (p. 46). As narratives may also be described as interactive conversations (Ochs & Capps, 1996, 2001), discursive practices may facilitate actors in self positioning, positioning others, being positioned by others and resisting being positioned within narratives. Harre and van Langenhove (1991) differentiate personal positioning from social positioning. They suggest that personal positioning represents how individuals shape and tell moral stories about their lives, whereas social positioning is a reflection of cultural and institutional restrictions that constrain personal agency through limiting narrative constructions of the ‘self’.

The research participants' ontological stories are explored in relation to the potential employment of self positioning as a tool to facilitate agency. The influences of social positioning, such as the marginalisation of women within narratives that encompass miscarriage, childbearing, health, midwifery medicine, culture, ethnicity and the wider society are also examined.

### **Arthur Frank**

Arthur Frank's perspectives on both the constitution and functions of stories, and narrative research have informed the research process. Frank (2000a) theorises that there is no place outside of stories; that we exist as narrative selves in a world full of stories and that the world is knowable only within the framework of certain stories about what happens. Frank (2000b) asserts that although the terms stories and narrative may be used interchangeably, people tell stories not narratives and while narrative structures are interesting "an exclusive focus risks leaving out what is most important to the storytellers" (p. 354). Stories "are relationships in that storytellers reaffirm, possibly create or redirect the relationship within which the story is told" (Frank, 2000b, p. 354). Frank also argues that the relationality of stories enables the co-constitution of tellers and listeners (Frank, 2005) inferring that narrative selves are dialogical selves (Frank, 2005, p. 967). Therefore researchers cannot comprehend the identities of research participants as fixed in any self narrated representations.

During the research, narrative analyses have been informed by Frank's (2005) conceptualisation of narrative identities as perpetually contingent on setting, and therefore subject to revision, redistribution and perpetual generation in future stories. It is argued that in relation to this research and within this thesis, narrative analyses do not finalise participants' identities, stories, or the meanings arising from, or functions of their stories.

Frank (2002) proposes that storytellers may draw on stories and distribute ontological stories to others as a tool for "maintaining a relational self that is threatened by crisis" (p. 109). He argues that such stories may be construed as a technology of 'caring for the self' (Frank, 1998, p. 329). Although Foucault (1988a) proposes that storytelling is not a neutral or straightforward activity, Frank (1998) asserts "situating illness narratives within the relations of power does not obviate their use as a way that selves take care of themselves" (Frank, 1998, p. 345). He specifically argues that such narratives may empower narrative formulations of identity (1998, p. 329). Stories of illness in archiving transitory and interactional events that imprint on people's lives

may therefore facilitate personal change and transformation (Frank, 1993, p. 41). In theorising narratives as elements that may influence human activity, Frank (2006) draws from Latour's (1999) actor network theory to suggest that narratives may be construed as actants or hybrid actors that subjectify health and connect the disparate (Frank, 2006, p. 421).

Frank's theories regarding stories as tools for influencing human activity, maintaining relational selves, mediating distress, facilitating change and enabling agency are particularly relevant to analysing women participants' construction and narration of miscarriage stories.

### **Margaret Somers**

Somers (1994) argues that "all identities must be analysed in the context of relational and cultural matrixes because they do not exist outside these complexities. Individualism after all is itself socially and relationally constructed" (p. 622). In asserting that stories or narratives may be classified as ontological, public, conceptual and meta-narratives, she presents a narrative framework for shaping narrative identities and narrativity itself.

Ontological stories are the personal narratives that social agents craft and narrate in order to understand their lives. Somers (1994) suggests that such stories are used to "define who we are; this in turn is a precondition for knowing what to do...doing will in turn produce new narratives and...actions" (p. 618). Such stories therefore construe selves and identities as entities in the act of becoming. Somers (1994) argues that actors within narratives are also embedded within temporal and spatial relationships (p. 618). Her argument suggests that ontological stories are simultaneously personal and social in that they are relationally shaped by interpersonal, temporal, cultural and spatial influences, including narratives that are not discrete to the individual. Somers (1994) classifies such stories as public narratives; "narratives attached to cultural and institutional formations larger than the single individual to inter-subjective networks ...however local or grand" (p. 619). Exemplars of social or public narratives evidenced within this thesis include 'the good mother', 'midwives are woman-centred' and 'the doctor knows best'. Conceptual narratives used within this thesis include Foucault's ideas about power, knowledge and governmentality and Bourdieu's arguments about habitus and field. For example, conceptual narratives are evidenced within participants' accounts of interdisciplinary

tensions between midwifery and medicine as well as disciplinary-based stories such as the rise of self employed or independent midwifery.

The fourth tier of narrativity encompasses meta-narratives such as justice and truth, or as in the case of this thesis, potentially birth and death. Meta narratives are master narratives in which social agents are embedded (Somers, 1994, p. 619). Somer's (1994) argument that all forms of narratives are relationally co-constitutive is evidenced in the stories of research participants, which transcend various fields as conceptualised by Bourdieu (1996), including health, midwifery, childbearing women and miscarriage.

### **Blending Theories and Epistemologies**

Harre's theory regarding the creation and positioning of selves as a discursive process intertwines with Frank's perspective that we exist as narrative selves, know our world through stories, and are in turn embedded in stories. Selves and stories exist in space and time and are located within what Bourdieu refers to as 'the field' (Bourdieu & Wacquant, 1992). He uses this concept to describe social arenas where individuals manoeuvre and struggle over desirable resources. For the purpose of this thesis fields include but are not restricted to: Health, the midwifery profession, midwifery knowledge, kaupapa Māori, women, whānau, first trimester miscarriage or spontaneous abortion, the Aotearoa, New Zealand context including history and cultural differences, medical discourses, state legislation, and/or state actors. Bourdieu's theory of 'field' may be extended to incorporate the stories or narratives that constitute, are constituted by and circulate within these fields, because stories themselves hold 'selves' positioned according to perceived, and assigned, symbolic capital. Stories are therefore sites of struggle, where identities are contested, and actors are subjected to hierarchical positioning by various actors, actants and discourses. Additionally, an argument may be advanced that other metaphysical elements such as temporalities, associated with these varying narratives, exist as sites of potential contestation and struggle over resources and therefore also constitute fields.

As stated, stories hold selves which are characterised by Latour (1993, 1999) as actors; as well as holding other heterogeneous elements. Therefore stories or narratives may be classified as equally hybrid actors and actor networks. Selves can also hold stories which may be perceived as actants (Frank, 2006). The storied nature of the midwifery profession is a case in point. Midwives are assigned and assign themselves multiple identities as women, mothers, care providers, midwives, and in association with each

of these identities, further selves are perpetually crafted and re-shaped by ontological, public, conceptual and meta-narratives. Latour's (1991) actor network theory has applied to the analysis in the sense that the temporalities and silences associated with narratives, and the narrated stories themselves that are disclosed during the research process, may operate as metaphysical non-sentient actants that without intentionality, influence actors' or agents' behaviours.

The actors or actants are discursively positioned by others, or position themselves (Davies & Harre, 1990), within narratives and through the relational interactions of ontological, public and meta-narratives (Somers, 1994), within various Bourdieusian fields. These fields are social networks where social positioning is associated with assumed or assigned capital (symbolic, social, cultural, and economic). For example, those actors with the most capital tend to be positioned centrally within the field and their discursive habitus which is relatively uncontested, becomes to all effect, the field's habitus. Actors within these fields are aware of other actors' positions within the various fields, and the positioning influences of particular narratives such as the discursive assignation of symbolic, social and cultural capital. Medicine's positioning within the field of health provides an exemplar. The social privileging of medicine is founded on disciplinary and public narratives which favour medicine's gaze and consequently medicine accrues capital. Other actors such as midwifery and women in the field of health must discursively challenge or contest medicine's disciplinary and public narratives, in order to position themselves and/or retain position within a location or space within the field or network. The various fields or networks are therefore sites of struggle over identities and resources and as such are un-finalised; therefore the borders of fields may be perceived as both porous, and fluid.

Within the analysis, the potential exists to craft additional analytical conversations through integrating Foucault's (1984) ideas about genealogies, Latour's (1993, 1999) conceptualisation of material technologies and Kaupapa Māori theorising of whakapapa as an epistemology. Despite their differing philosophical stances, Foucault's (1988b) perspective of technologies as metaphysical is also linked with Latour's (Akrich & Latour, 1992; Latour, 1999) ideas of material technology in order to craft the thesis arguments. I acknowledge that interweaving such diverse theories may be considered contentious in relation to existing theoretical critique, for example Latour's critique that Bourdieu uses structured categories to explain away the social. However, it was the researcher's hope that through introducing Bourdieu's theories about fields and capital into a conversation between Latour and Foucault, potential

accusations of relativism might be avoided, as drawing on the ideas of Orwell (1945) and Bourdieu suggests, that some stories may be ‘more equal than others’.<sup>27</sup>

### **Te Whakamāramatanga: Justification and Potential**

‘Te Whakamāramatanga’ incorporates processes that facilitate the development of bi-cultural partnerships. Whilst the intention of this thesis is to develop ‘Te Whakamāramatanga’ as a research methodology/model, the potential exists for this framework to be further developed and adapted as a model for constituting clinical relationships within midwifery practice. He whakahoatanga tikanga rua (building bi-cultural partnership/s), may be developed in the first instance, as a model of practice for the midwifery profession in Aotearoa, New Zealand. As an indigenous model for both health research and clinical practice, the model may have significance and be adaptable for application with other indigenous peoples that share similar cultural traditions, knowledge and worldviews to Māori.

### **Summary**

This chapter focused on the development of ‘te whakamāramatanga’ a culturally relevant research methodology/model. Kaupapa Māori philosophical underpinnings and theoretical processes (Te pikorua, ngā kete o te wananga, whakamātatau, whakataunga) for the model are presented. Theoretical concepts that encompass philosophies relevant to midwifery practice and which facilitated development of the methodology are discussed. Multiple epistemologies and theoretical ideas from a western paradigm have been incorporated in the creation and application of ‘Te Whakamāramatanga’. A bricolage approach is applied in analysing and crafting interpretations of participants’ stories. The theories of Michel Foucault Pierre Bourdieu, Bruno Latour and Rom Harre are choreographed with the narrative ideas of Arthur Frank and Margaret Somers and interwoven with Māori philosophical concepts.

The theoretical concepts of the methodology whakapapa, whakawhanaungatanga, whakarurutanga, whakaaetanga, whakaritenga, whakangungu, whakawhirinaki, whakamana, ōritetanga and mana motuhake have been re-evaluated as research has

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<sup>27</sup> The concept that some stories are more equal than others is drawn from George Orwell’s (1946) book *Animal Farm* which provides a metaphorical commentary on political tyranny. In the book attention is drawn to the power of language as a tool of ideology and control and evidenced in the story through propaganda, surveillance, misinformation, denial of truth, and manipulation. In relation to this thesis, the Orwellian perspective acknowledges the political power of disciplinary narratives which may entrench inequalities of power amongst the health disciplines as well as at the micro level of health care in interactions between health professionals and health care recipients.

progressed, and subsequently constructed as relational and dynamic. Careful reflection by myself as researcher and research participants has facilitated cohesion of the research partnership, and progression of the research. Ensuring reflexivity, through ongoing consultation with Māori has enabled refinement of 'Te Whakamāramatanga'. The research design, implementation of the methodology, and the theoretical framework used for analysing participants' narratives, are further discussed in chapter four.



Figure 4a.

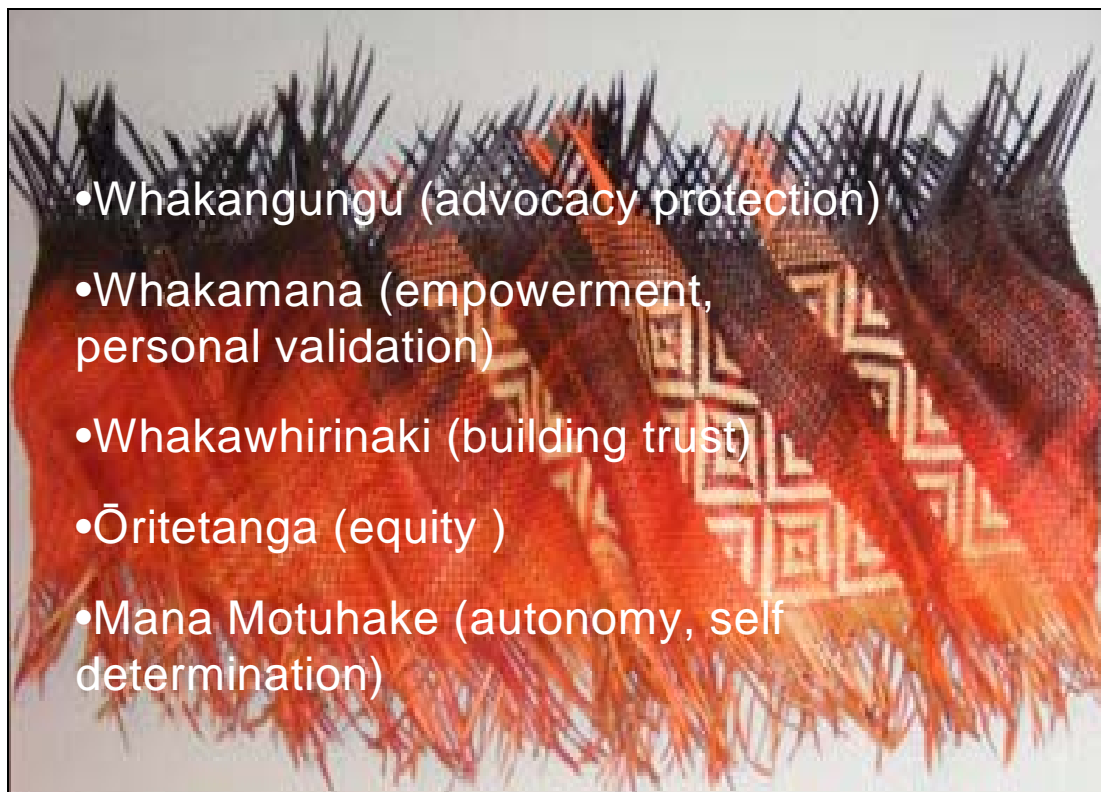


Figure 4b.

*Figure 4a and b. Te Whakamāramatanga: Theoretical concepts*

# 4

## Conducting Research

### Partners, Methods and Exploration

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*E hara taku, I te toa takitahi. Katahi o taku toa, he toa takitini*  
(Mine is not the strength of one alone, it is the strength of many)

“The trouble with the world is not that people know too little, but that they know so many things that ain't so” (Mark Twain, 1835-1910).

“Knowledge becomes evil if the aim be not virtuous” (Plato, 428 BC-342 BC).

“By seeking and blundering we learn” (Johann Wolfgang Von Goethe, 1749-1842).

“Investigation may be likened to the long months of pregnancy, and solving a problem to the day of the birth. To investigate a problem is, indeed, to solve it.”  
(Mao Tse Tung, 1893-1976).

#### **Introduction**

This chapter presents an overview of the development and implementation of the qualitative research design. The target population, and participant selection criteria are defined, and the process of recruiting and developing collaborative relationships and a research partnership with research participants is described. The way in which women's and midwives' experiences of miscarriage have been explored, and their narratives collected during research interviews, is outlined. The interview agenda topics are stated and rationales for the application of a dialogical interviewing approach to the research process explicated. A framework for narrative analysis is presented and whole narrative, narrative elements, and thematic, approaches to

analysis are discussed. Measures for ensuring the trustworthiness and/or reliability of narrative analysis and the ethical integrity of the research process are outlined, and issues of credibility and reflexivity are addressed.

### **The Research Process**

Discussion regarding the development of the research project commenced with initial informal consultations at Māori and midwifery Hui (meetings), about developing a contextually relevant methodology for conducting midwifery research in Aotearoa, New Zealand. Further development and application of the methodology to explore women's experiences of miscarriage or *te whare ngaro*<sup>28</sup> (the lost house) was a collaborative decision that eventuated from numerous discussions with key stakeholders, including representatives from Māori communities, health service providers, women's organisations, and health professional associations.

Although all research participants were aware of my role as 'researcher', this positioning tended to be de-emphasized by participants in research interviews. During the research process I was alternatively positioned as a cultural, professional and gendered insider by both Māori and non-Māori participants. Participants' positioning facilitated the development of interactive dialogue and relational interactions within and external to the interviews because as Raukaraka a Māori woman states in her interview story, I was conceptualised by participants as 'one of us'. It is therefore arguable that my positioning may have facilitated the establishment of relational equity amongst research partners. However, although a co-constructor of the interview narrative, through listening to women's miscarriage narratives, I am an outsider to their ontological experiences.

My multiple identities<sup>29</sup> in conjunction with whakapapa affiliations have been collectively perceived by Māori kaumatua<sup>30</sup> (Māori elders), kuia (senior women), and localised community and health services representatives as legitimising my position within the research partnership. Hapū and whānau affiliations placed additional responsibilities on me to seek approval regarding the integration of contextually

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<sup>28</sup> In this thesis the term 'te whare ngaro' is translated primarily as the lost house to incorporate the concept of infertility represented by the empty 'te whare tangata' (house of the people, barren uterus) and the corporeal, psycho-social and emotional losses associated with the ending of genealogies, and individual and collective identities.

<sup>29</sup> Registered midwife, Māori woman, childbearing mother, and a woman who experienced miscarriage.

<sup>30</sup> Kaumatua who voiced their support for, and have remained helpful in relation to, the research have whakapapa links to Rangitāne, Ngāti Toarangatira, Ngāpuhi, Ngāi Tahu, Tainui, Ngāti Porou, Te Whanāu ā Apanui, Te Atiawa, and Ngāti Kahungunu.

appropriate mātauranga and tikanga within the research methodology/model; Te Whakamāramatanga. Valuing and respecting cultural traditions was deemed essential by both Māori and non-Māori research participants and was ensured through ongoing consultation with, and monitoring of the research progress, by midwives and designated representatives from Māori communities.

Research is frequently informed by solely Western European epistemologies (Poland & Pederson, 1998). In order to prevent cultural hegemony Māori centred research principles <sup>31</sup>(Durie, 1997), kaupapa Māori research perspectives <sup>32</sup>(Bishop, 1996; Irwin, 1994, Mead, 1996, Smith, 1999b) and midwifery philosophical and ethical practices have informed the shaping and implementation of the research design. The research process has subsequently been characterised by ongoing consultation within and external to the research partnership and collaborative decision making by researcher and research participants within a partnership framework. Research practices have included member checking of transcripts and narrative interpretations, collaborative agreement regarding choice and use of pseudonyms, interpretations of Te Reo (Māori language), and the textual representations of participants' narratives. Hapū and or whānau decisions regarding research participation and the interpretation of tikanga (cultural traditions) have been respected throughout the research process as recommended by Cunningham (2000). Respecting midwifery cultural traditions and philosophies has been evidenced in the conceptualisation, development and implementation of the research design as a collaborative partnership. The research process has therefore aspired to encompass the methodological concepts of Te whakamāramatanga, particularly whakawhanaungatanga, whakaritenga, whakaaetanga, and ōritetanga.

### **Research Design**

As mentioned, consultation with key stakeholders, communities, professional and women's organisations, my whānau and hapū as well as the research participants<sup>33</sup> have shaped and influenced the ongoing refinement and application, of the research

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<sup>31</sup> Durie(1997) developed the Māori-centred principles of mana Māori (control), whakapiki tangata (enablement) and whakatuiia (integration) to inform Māori centred research in a manner that would keep Māori participants and concepts central to the research process.

<sup>32</sup> Kaupapa Māori theorists and researchers assert that any research with Māori should draw on relevant cultural traditions and practices and be acceptable to Māori participants and their local communities (Bishop, 1996; Irwin, 1994; Smith 1995, 1999).

<sup>33</sup> The research model 'Te Whakamāramatanga' was shown to and discussed with participants towards the end of each interview.

design. Whakapapa and whakawhanaungatanga have therefore provided the social foundation for, and facilitated creation of the research design. As previously stated in chapter three, storytelling is an essential mode of knowledge transmission (Bruner, 1986, 1987; Jordan, 1997; Polkinghorne, 1988) and method for processing life experiences (Garro & Mattingly, 2000) within midwifery (Leap & Hunter, 1993, McHugh, 2004; Murphy, 2005; Wickham, 2004a) and amongst Māori (Bishop, 1996; Connor, 2006) and women (Devault, 1990; Oakley, 1981; Stanley & Wise, 1993). Collaborative decision making by those consulted in relation to the research determined that the development of a qualitative research design that drew on narrative research methods would elicit depth, rather than breadth of information. A narrative approach would also support women to share their experiences in a safe environment. In keeping with the midwifery philosophy of partnership and in order to gain a wider perspective regarding the significance of first trimester miscarriage in Aotearoa, New Zealand, women and midwives were invited to share their stories of miscarriage and/or providing health care for women experiencing miscarriage.

### **Ethical Concerns**

Developing research methodology based on women's narratives of miscarriage draws attention to the psychosocial trauma that some participants may have experienced in relation to miscarriage. As revisiting distressing experiences during the research process might facilitate research participants becoming re-traumatised, ethical strategies were integrated into the research process to minimise and, where this proved unsuccessful attempt to ameliorate, participants' distress. Within the research process my commitment and actions to ensure a safe environment for all members of the research partnership demonstrates the methodological principle, whakarurutanga.

The research proposal and ethics application were both submitted to the Massey University Human Ethics Committee (MUHEC), Palmerston North for approval and approved without emendation in December 2005 (Appendix B). The approval period took approximately 5 weeks. The only requirement imposed subsequent to the review was that research participants must be 'diagnosed' as having a miscarriage in order to be eligible to participate in the research. As the MUHEC did not designate that a specific health professional should 'diagnose' miscarriage, following consultation with supervisors it was decided that I as a registered health professional and expert practitioner in women's health was suitably qualified to undertake this responsibility. This decision ensured that a midwifery approach to women's experiences informed the research process and facilitated recognition of women's embodied and expert

knowledge in relation to their own life experiences. No additional ethical reviews were required during the remainder of the research process. Ensuring anonymity for participants and maintaining the confidentiality of interview stories was considered essential. Risk management strategies such as the use of pseudonyms and the removal of geographical and institutional identifiers were employed to minimise potential breaches of privacy. However, at participants' request exceptions were made to facilitate whānau or other individuals providing support for research participants during interviews and other stages of the research, for example, when member checking transcripts and reviewing and agreeing transcript interpretations.

As it is my intention to shape and publish articles around the arguments presented in the thesis, anonymity and confidentiality will be maintained after research completion and finalisation and release of the thesis. Due to participants' shared perspective such that publications through providing new knowledge may facilitate improvements to health care provision, it has been collaboratively agreed that I may publish research findings. Members of the research partnership have been offered a summary report that outlines the research findings and any recommendations arising from the research process as well as the opportunity to view the finalised thesis.

### **Privacy**

In order to protect the privacy of research participants, I travelled where requested to participants' towns or cities of residence throughout the North Island of Aotearoa, New Zealand. Interviews were conducted in Whangarei, Auckland, Palmerston North, Levin, Otaki, Gisborne, Hawke's Bay, Wellington and the Hutt Valley. Although no interviews were conducted in the South Island, South Island residents participated in the research. The majority of interviews occurred at participants' request in their domestic residences, providing a parallel of the midwifery practice of providing home visits. Two interviews were conducted in locations that the participants, who both had young children, perceived to be quiet and comfortable places where it was possible to talk without interruption.

### **Informed Consent**

Direct recruitment and potential coercion of participants was avoided, and informed consent from participants was achieved through initiating contact with potential participants through intermediaries. Intermediaries were provided with envelopes containing an interview schedule (Appendix C) and an information letter that introduced myself as researcher and provided an overview of the research (Appendix

D). Individuals were asked in the letter to contact me if they wished to discuss research participation further. Following being contacted by potential participants, I offered the option of an initial meeting to provide more comprehensive explanations of the research and answer any queries. The majority of potential participants chose to express their queries and explore their concerns in telephone conversations. When involvement was agreed upon participants signed a consent form (Appendix E) prior to taking part in a research interview. On completion of interview transcription each participant was sent their transcription for comment. When participants were satisfied that transcripts accurately reflected their interviews, transcript release forms (Appendix F) were signed and returned to me with the amended interview transcripts. Participant (member) checking of and agreement regarding narrative interpretations occurred subsequent to analysis. Respect for participants' voices in relation to ownership, control, analysis and interpretations of interview stories has encompassed participants involvement as autonomous members of the research partnership demonstrating the methodological principle, *mana motuhake*.

#### **Anonymity and Confidentiality**

I facilitated confidentiality through transcribing all interviews and ensuring that completed interview transcripts were securely stored. Although two research supervisors had limited access to sections of each interview transcript, both supervisors were required to sign confidentiality agreements (see Appendices G and H). Access to each completed interview transcripts was restricted to the interviewee and the researcher. There was considerable discussion within the research partnership regarding pseudonyms. Initially three participants desired to be represented in the thesis by their first name. Subsequent to reviewing their transcripts, these participants decided to be identified in the thesis with a pseudonym. Māori participants perceived the research exemplar as being associated with *te whare tangata* (house of the people), and therefore linked with spiritual and cultural power. It was asserted that pseudonyms should be collaboratively selected in order to respect the inherent spirituality of the research and the *tikanga* (cultural traditions) of research participants and myself as researcher. The research partnership agreed that two living elements; *pounamu* (New Zealand jade), and native flora were appropriately representative of participants.

*Pounamu* as already stated within the thesis, is highly valued by Māori. Within the research it operated as a collective pseudonym for participants and constituted a conceptualisation of *Papatuanuku* (the earth mother). Different aspects of *pounamu*

represented whakapapa (genealogical) and/or geographical areas; and therefore had meaningful associations for both myself the researcher and some Māori participants. As within Te Ao Māori, different aspects of pounamu are linked with healing and may be shaped into tools for assisting with childbirth and related rituals, pounamu was deemed a particularly appropriate pseudonym by Māori research participants. Specific examples of native flora were also selected as pseudonyms based on their cultural associations with childbirth, miscarriage and/or related rituals, and tangihanga (burial practices). Participants also chose pseudonyms based on individual or family cultural practices evidenced in Chapters 5 and 8 in which rationales are presented for Matipou's and Pipiwharau's pseudonyms.

### **Potential Harm to Participants**

Within the various fields of research there are various descriptions and/or definitions of the characteristics that constitute vulnerable research. Dickson-Swift, James and Liamputtong (2008b) suggest that vulnerable research projects may range from “the topic of investigation...to...the whole research activity” (p. 1). Therefore viewed through a researcher's lens, women who have experience of miscarriage may potentially be vulnerable research participants. In interviewing vulnerable women and/or potentially women who may have experienced physical and/or psychosocial harm or observed other individuals being harmed, I was required to ensure counselling support was available as required by participants. As I had professional experience as a counsellor, existing collegial networks were drawn on to arrange support for research participants and several counsellors agreed to volunteer their services if required. My background experience also supported an interviewing approach that was guided by sensitivity and informed by disciplinary ethics. Researchers (Corbin & Morse, 2003; Holloway & Wheeler, 2002) suggest that such an approach may have benefits for research participants, and this aspect of research was evidenced during the interviewing process when women (Pipiwharau, Raukaraka, Kahatea, Totoweka, Rewarewa and Tangiwai) acknowledged that it had been really helpful to tell their story to a supportive person. During the research only one participant requested access to a counsellor, and this was promptly arranged. A second person, although offered this option, for cultural reasons preferred three meetings with me to talk through the emotions arising from both the miscarriage and the subsequent research interview.

All participants were encouraged to provide constructive criticism regarding the research design and process. If participants experienced discomfort with any aspects of the research they were invited to provide constructive comments in the first instance to myself or alternatively address their concerns to the research supervisors and/or the Massey University Human Ethics Committee (MUHEC). If they did not address their concerns through in discussion they were aware of their options to decline to participate in the research, and/or withdraw their consent to participate in the research. These ethical tenets ensured the personal *mana motuhake* (autonomy) of each participant in relation to the research process.

From research inception through to completion, I have endeavoured to satisfy the moral and research-related obligations of protecting research participants and advocating on behalf of women for improvements to miscarriage-related care through publications and direct lobbying for improvements to health care. In doing so, I have demonstrated the methodological principle of *whakangungu*; active protection.

#### **The Researcher: Potential Difficulties and/or Harm**

Researching an intimate and sensitive topic requires the development of close rapport with research participants (Stanley & Wise, 1993). Often, as was the case in this research, self disclosure by the researcher provides a tool for *whakawhirinaki* (building trust), particularly in relation to feminist research (Oakley, 1981). However, the intimacy created through sharing stories may facilitate difficulties in the research process in relation to establishing relational boundaries (Dickson-Swift, James, Kippen & Liamputtong, 2006). In addition to having ethical implications, the distressing nature of stories, in this instance miscarriage stories, may have had negative psychosocial and physiological repercussions for a researcher's health and wellbeing. The participants in the research study, through positioning me as a social insider, also enhanced my social vulnerability.

In order to manage potential risks to myself, specific decisions were implemented. My disclosure to participants was limited to information associated with my experiences as a midwife and childbearing woman. Expectations regarding contact with me were negotiated prior to the formal interview, and explanations were offered and revisited in relation to the nature of the interview, interview relationship and research process. A temporal framework for the research project was also discussed and collaboratively agreed with participants so that all members of the research partnership were aware of the temporary and research centred status of the relationships arising from the

research process. The completion of research involvement was marked by the provision of a koha (token of appreciation) to each participant. During the research, koha were offered in the first instance in face to face interactions. However, in some instances at participants' request, koha were enclosed in thank you cards and mailed to them.

During the research process, the distressing stories generally acted to reinforce my commitment to exploring miscarriage in Aotearoa, New Zealand. However, on occasion emotions arose in response to interviews and re-readings of the transcripts. Dickson-Swift, James, Kippen and Liamputtong (2009) suggest that such emotional responses are both a risk associated with conducting sensitive research and a form of embodied and metaphysical emotional work by the researcher. Within this research emotions were managed through physical exercise, meditation, and in two instances talking through distress with whānau kaumatua (family elders). Such debriefing sessions may be valuable in managing research-related stress (Liamputtong, 2007b; Dickson, Swift, James, Kippen & Liamputtong, 2008a). In each of the debriefing cases associated with this research project the focus of the discussion remained the management of feelings arising from listening to particularly distressing stories. Research-related narrative details were omitted from the conversations to ensure confidentiality and protect participants' anonymity.

### **Inconvenience and Hazards**

During the research process participants were inconvenienced through postponing activities associated with their daily lives in order to participate in the research. As previously mentioned, participants were informed regarding a small koha (\$20.00 petrol or grocery voucher) the choice of which was determined by participants. The koha was offered in recognition of the individualised temporal and financial costs that might be incurred by participants due to participation in the research, and as an acknowledgement of their valuable contribution to the research.

It was not an intention of this research to compare care provider and care recipient perspectives regarding a single episode of miscarriage care. However, on several occasions both care recipients and their care providers were interviewed unbeknownst to each other. Although this provided me with the potential to triangulate viewpoints, such occurrences also had the potential to undermine participants' anonymity. I managed these occurrences by separately focusing on each woman's ontological experience when conducting narrative analyses.

## **Participant Recruitment**

As previously stated in the thesis, miscarriage is a sensitive research topic for most women (Abboud & Liamputtong, 2003), and potentially families (Dyregov, 2004). The target population for this research was purposefully selected. Research participants were Māori and/or non-Māori women aged 16 years or older who had experienced first trimester miscarriage and/or had provided midwifery care for women who had experienced first trimester miscarriage. Although English and Te Reo are both official oral languages of Aotearoa, New Zealand, due to the bi-cultural nature of this research project, participants were required to be reasonably fluent in English to ensure a degree of consistency between participants when sharing their stories. Notwithstanding that requirement, it was integral to the research process that participants who identified as tangata whenua were supported to communicate in Te Reo when they deemed it appropriate during the research process.

Following ethics approval and subject to monitoring from representatives from Māori and midwifery communities, recruitment of research participants commenced. Initial consultation and informal discussions regarding potential participation in the research were initiated and conducted as requested with Māori, health service providers, kaumatua, and communities. Representatives from women's health organisations, District Health Boards and midwifery and stakeholder organisations were also consulted regarding the research. Recruitment of women and midwives was conducted predominantly indirectly by word of mouth through discussions with professional peers, friends and family, and snowballing. Direct recruitment did occur in one instance where, at the request of a local kuia (Senior Māori woman), I attended a small hui (meeting) organised by Māori women to answer questions about the proposed research and listen to women's concerns regarding, and requests that they might like addressed during and in completing, the research.

Potential participants received an information letter (Appendix D) that detailed the focus of the study, the purpose for engaging in the research and my contact details. The recruitment criteria for prospective participants were listed and an outline of the proposed interview process was presented. Details regarding how information provided in the interview would be stored, and accessed, and clarification of research participants' rights including withdrawal at any time from the study were also presented in the letter. If prospective participants had any further concerns about the research they were invited to contact the research supervisors and the Massey

University Human Ethics Committee, whose contact information was detailed in the information letter.

In order to facilitate participant recruitment, an advertisement (Appendix I) was also developed. Massey University Human Ethics Committee approved both the advertisement and the posting of the advertisement on the New Zealand Miscarriage Organisation website. Although advertising subsequently proved unnecessary, submission of the advertisement to the New Zealand Miscarriage Organisation for comment prompted potential participants to contact me.

Ultimately, twenty women participated in the research project and of these nine identified as midwives. Twelve women were of non-Māori descent, of these four women were immigrants to Aotearoa, New Zealand. Eight women identified as Māori, of whom four were midwives. Three research participants (Kahurangi, Auhunga and Kahatea) were directly recruited by other participants who reported that they had found the interviews respectively satisfying, helpful and therapeutic.

### **Collection of Narratives**

Semi-structured interviews were conducted and, with the exception of two interviews which were manually transcribed, audio taped for analysis. All interviewees received a copy of the interview schedule (see Appendix C) prior to the interview. The schedule provided a definition of first trimester miscarriage and requested women to share their story about miscarriage. The schedule also listed topics of specific interest and potential themes for discussion that participants might consider before the interview. Examples of the questions that might be asked during the interviews in relation to women's experiences of miscarriage were also provided. The threat of any 'unpleasant' or 'surprise' questions during the interview was minimised by providing the encompassing question and potential topics that could be discussed in the interview, prior to the actual event. Interviewees also had the opportunity to consider the question and topics or themes for an extended period because, as Patton (2002) has suggested, this may facilitate more carefully reasoned responses to questions during the interview. Topics that were subsequently explored in the interview included the context where, and to whom, women had been previously told their story, feelings, communication and family relationships. Interview discussions also encompassed women's experiences of health care providers and their perspectives on the roles of midwives, doctors and hospitals in relation to care provision. Women were asked to evaluate partner's and family member's responses to miscarriage and local and wider

communities' attitudes about, miscarriage. The role of government in relation to developing and/or funding resources for miscarriage-related care was discussed, and women were requested to share any additional comments that they deemed important.

Eighteen interviews were audio-taped, and two interviews were manually documented at the request of participants. I also transcribed the audio-taped interviews as I was the only individual authorised by the participants to have full access to their entire stories. Completed transcripts (audio-taped and manually documented) were returned to each interviewee for review, editing and confirmation to progress the research analysis. Eighteen transcripts were returned for analysis. Follow-up in relation to the two non-returned interview transcripts established that both participants had moved away from their original contact addresses. However, both women forwarded at a later date signed consent forms for their stories to be included in the research.

### **Dialogical Interviewing**

Participant interviews constituted individual conversations between myself and the interviewee. There were only two instances where interviews diverged from this interview format. Two participants requested the presence of support people, and in one interview the supporting individual's commentary was deemed an essential part of the interview dialogue by the research participant.

Dialogical interviewing was adopted during the interviews. The interview method has been characterised as a conversational approach to interviewing that seeks to encourage mutual disclosure and rapport between interviewer and interviewee. Within this research, interviews were conducted as conversations because dialogical interviewing and a dialogical approach to developing knowledge have been perceived as tools for disrupting power differentials between researchers and research participants (Freire, 1967, 2000; Sonn & Green, 2006). Dialogical interviewing may also facilitate a research participant's ability to enquire and/or challenge a researcher's experience, knowledge base, suitability to conduct research and analytical interpretations of research data (Frank, 2005). As Freire (1967, 2000) states:

Since dialogue is the encounter in which the united reflection and action of the dialoguers are addressed to the world which is to be transformed and humanized, this dialogue cannot be reduced to the act of one person's 'depositing' ideas in another; nor can it become a simple exchange of ideas to be 'consumed' by the discussants (p.87).

Lemert (1998) supports this perspective through asserting that individuals are expert theorists in relation to their own lives. Research participants may therefore value dialogical interviewing because it is an interview approach that encourages both co-construction of knowledge and acknowledgement of participants' theories about their ontological experiences. This conceptualisation of dialogical interviewing is evidenced in research participants' comments. Kauri stated 'the interviewing approach has made me think more deeply about my own interpretations of what I have experienced'. Nikau theorised 'I have enjoyed this interview because it has been more of a discussion and you don't feel like you are talking into silence..., it has really made me think about the care I provide'. Karaka agreed with Nikau's remarks and commented 'You know this discussion has been quite useful..., it has made me think not just about how I practice, but why I practice the way I do'. Research participants may also perceive dialogical interviews as allowing participants more control over both interview conversations and/or the introduction of topics of personal importance to the interview (Ochs & Capps, 2001). Dialogical interviewing may therefore be considered a tool for ensuring the methodological principles of both *mana motuhake* (autonomy) and *whakamana* (empowerment).

Critics of this method of interviewing (Kvale, 2006) have suggested that the development of intimacy between researcher and research participants constitutes an overly subjective approach to research that may contribute to researcher bias. Kvale (2006; 2007) has also suggested that a relational approach to interviewing and the research process may be construed by research participants as an obligation to support the researcher's analyses and interpretations of ontological and interview narratives. However, these criticisms may be challenged. Edwards (1993) suggests that "researchers are not just recording instruments... as interviewing is an interactive experience" (p. 185) and infers that interviews may be considered 'co-constructed' (Gubrium & Holstein, 2002, 2003; Patton, 2002). Qualitative research is also not concerned with generalisability but the richness of research participants' experiences and stories. Encouraging relational intimacy between the researcher and participants in interview settings also facilitates the collection of research participants' ontological narratives. Within this thesis, women's ontological narratives and the interview narrative have been co-constructed through the application of a dialogical or conversational approach to relational interactions within interview settings. This research approach draws on Russell Bishop's (1996) conceptualisation of interviews as simultaneously collaborative relationships and stories as well as Elinor Ochs and Lisa Capps (2001) theory that interviews are conversational narratives. Therefore despite

detractors (Kvale, 2006, 2007) relationality and subjectivity are perceived as valuable aspects in conducting qualitative health research.

### **Transcription, Audiotape and Transcript Storage**

As previously mentioned in this thesis, women's stories of miscarriage are deeply personal. In accordance with research participants' requests for restricting access to their recorded interviews and in order to demonstrate interpersonal respect and valuing of participants' stories, I transcribed all research interviews verbatim. Interview transcription is perceived as a time consuming and therefore costly procedure (Miller & Brewer, 2003). However, through transcribing all interviews I became very familiar with interview texts which subsequently facilitated narrative analysis. As recorded cassettes were transcribed within temporal proximity of the interview, my recall of contextual factors that might shape the transcription such as vocal pitch and tone, emotional expression, and physical gestures and postures was also enhanced. Poland (1995) suggests that such measures contribute to facilitating transcription quality and may facilitate rigor in qualitative research.

Final transcriptions included alterations to ensure that personal names, institutions or features that might facilitate identification of individuals, places or specific events were removed. Following transcription, manuscripts were subjected to a final check by prior to forwarding the draft transcripts for member checking. Research participants were provided with prepaid and return addressed envelopes, a copy of their transcribed interview and a transcript release form. All transcripts were returned with completed transcript release forms that authorised me to commence narrative analysis of the interview transcripts. Three participants requested copies of their draft transcripts and these were provided.

Access to recorded audiotapes, and completed transcripts was restricted to the researcher at participants' request. It was agreed within the research partnership that if the doctoral supervisors signed confidentiality agreements (Appendices F & G), the supervisors could view sections of interviews that I proposed to analyse, in order to offer advice. During the research process recorded audiotapes and master transcripts were kept in a locked and fire proof filing cabinet at the university. In case of a natural disaster a second set of transcripts was also kept in a document safe at a confidential location. Upon research completion audiotapes and transcripts have been returned to or destroyed at the request of, research participants in recognition of the participants' ownership of their stories. Although no participants requested to withdraw from the

research project, as participants' stories remained autonomous within the thesis, withdrawal from the research remained a possibility for participants at any stage of the research process until finalisation of the thesis.

### **Choice of Analytical Framework and Analysis of Narratives**

The methodology developed in this thesis Te whakamāramatanga is not tied to a particular method of analysis. A range of qualitative research approaches for analysing texts, for example discourse analysis and feminist post structuralist analysis, could have been applied in order to develop interpretations of women's and midwives' stories during the research process. Narrative analysis was chosen as a contestually relevant method for analysing data arising from research interviews with research participants from strong storytelling cultures. Within the research process narrative analysis provides an exemplar of the principle whakamātautau, in that analysis adopted an abductive and tiered approach to textual exploration that drew on narrative theories, as well as thematic, narrative elements and whole narrative analytical frameworks.

In developing and trialling a research methodology that was embedded in a partnership framework, it became important to maintain congruence between methodology and method. Therefore the disruption of the more commonly held and objectified position of researcher as the 'knower' and that of the participant as 'knowee' was essential; an aspect that participants valued and commented on as characteristic of midwifery practice. In stating: "The midwife takes off her shoes and sits down on the floor with you... You are one of us!" Raukaraka draws attention to my position as equitable to her position within the research partnership.

### **Interpretation Phase**

Narrative research begins with discovering meanings. A researcher moves backwards and forwards between a research text and their perspective. Stories are interwoven constructs which require a multi-theoretical lens when interpreting meaning. Within this thesis the choreography of interpretive analysis has required ongoing consultation, member checking, negotiation and debate with research participants. As narrative structural analyses have a tendency to impose shape and plot on participants' stories (Labov & Waletzky, 1967; Riessman, 2008), a narrative elements approach (Phibbs, 2008; Plummer, 1995) has been adopted to look at stories in their entirety. Meta-narratives such as the stories of Matipou and Pipiwharauoa, and the more discrete nested stories within participants' meta-narratives have been analysed in this manner.

The approach is in keeping with the cultural practices of the midwifery profession and Māori, both of which are imbedded in stories and storytelling traditions. Such an approach has also enabled me to draw on theories from sociology, psychology, linguistics, education and kaupapa Māori theory in order to craft analytical interpretations and theoretical arguments in relation to narrative meanings.

An ethical approach to narrative analysis required the adoption of a relational conceptualisation of textual interpretation that acknowledged participants' storied accounts of miscarriage. Blaikie (2000) suggests that abductive research strategies may offer a relational approach that assists researchers in describing and understanding social life. Particularly, Blaikie (2000) argues through characterising descriptions of social life in terms of "the meanings and interpretations given by social actors to their actions, other people's actions, social situations, and natural and humanly created objects" (p 115). Blaikie (2000) adds that "[T]hese subjective meanings are not private; they are inter-subjective" (p. 115) and therefore may be both collectively constituted, and shared, amongst individuals. Elliott (2005) proposes that the application of such an approach to narrative research analysis requires the incorporation of multiple perspectives and focuses during the interpretive phase, and therefore the "idea that narrative analysis might represent a set of specific procedures becomes problematic" (p. 37). However, in order to demonstrate a degree of analytical integrity, a logical sequence was required to commence initial analyses of participants' stories.

The first step in analysis was transcription. The focus of the research analysis was on both the content of the story and how the story was narrated, this decision was made to minimise cleaning of transcripts to ensure that contextual narrative elements<sup>34</sup> were retained for analysis. Through transcribing all participants' stories, the researcher became very familiar with storied content which facilitated recognition of participants, and as perceived by the participants other actors' cultural values and practices, beliefs, concerns, motives, and behaviours, as evidenced in the research texts.

Subsequent to transcription, the second step of analysis included identification of key topics or meta-classifications. As a precursor to coding the story content, during initial readings of participants' stories, and as recommended by Boyzatis (1998), annotated comments were added to the margins of transcripts regarding potential thematic classifications and theoretical ideas that might be drawn on to discuss specific issues

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<sup>34</sup> Contextual elements included, tears, laughter, long pauses, sighs, and in some cases non linguistic utterances such as um and er.

evidenced in the transcripts. During subsequent re-readings, participants' stories were examined to identify contextually complete blocks of texts. The narrative texts were analysed in paragraph format rather than line by line in order to retain the narrative quality of each participant's story. Formal classifications were allocated for potential topics and illustrated by manually marking the blocks of narrative text with different coloured highlighter pens. Topics or meta-classifications that emerged from the initial coding included; temporality, genealogy, communication and relationships. During discussions within the research partnership and with doctoral supervisors the textual evidence for these topics was evaluated and the interpretive relevance for the research was clarified. A second level analysis of transcripts was conducted. The participants, doctoral supervisors and myself agreed that the cultural aspects of whakapapa (genealogy) would be best addressed through using whole narrative analysis. The meta-themes of time, and silence as a thematic aspect of communication commonly occurred in the research stories, and both thematic elements were perceived by members of the research partnership, as requiring analysis. It was also proposed that participants' storied voices should be explored in order to identify and make public both the individual issues and shared collective concerns of participants.

Differing analytical approaches to narrative interpretation are evidenced in analytical chapters five through to eight to show case the different ways in which participants' stories may be analysed. A macro to micro approach has been adopted in chapters five through to seven in order to demonstrate a tiered narrative elements approach to narrative interpretation. The macro to micro approach has also somewhat serendipitously, developed as a natural consequence of the genre and focuses of participants' stories. Genealogy has been evident in all participants' narratives and drawn attention to the narrative element of corporeal temporality which in turn has shaped aspects of women's voices, particularly silences. Chapter eight shares the nested narratives of research participants which outline what women desire in regards to miscarriage. It was not my intention to convert individualised stories into standard categories that permit the generalisation of collective concerns but to allow for the possibility of shared perspectives to emerge. Participants' stories have been selected for inclusion within the thesis in relation to this perspective. Decisions regarding the inclusion of stories and how those stories have been presented in the thesis have also been negotiated with participants. Matipou requested that her story be presented as a series of discrete accounts. In contrast Pipiwharaua required that her core story of miscarriage be presented as a whole narrative. In some instances and following discussion with a participant I have also chosen to exclude a significant percentage of a

participant's story in order to satisfy ethical requirements arising from the methodological concepts of whakangungu and whakarurutanga.

### **Analytical Processes**

Boyzatis (1998) suggests:

If sensing a pattern or “occurrence” can be called seeing, then the encoding of it can be called seeing as. That is you first make the observation that something important or notable is occurring, and then you classify or describe it... The seeing as provides us with a link between a new or emergent pattern and any and all patterns that we have observed and considered previously (p. 4).

Chapter five presents a narrative analysis of a single participant's research narrative (Matipou's story). Following a careful reading of her story it was determined that whakapapa (genealogy) was both the central theme and analytical tool for interpreting her research narrative, and the underpinning for the key story topics of temporalities, settings, whānau, professionalism, care provision, and culture. Narrative analysis focused on the meanings that Matipou assigned to whakapapa in relation to mediating her life as a Māori woman, family member, health professional and midwifery practitioner. The analysis explores interpretations of whakapapa as a metaphor for narrative, corporeal and discursive positioning tools, metaphysical and material technologies, material and relational setting, and sources of identity capital and knowledge. Narrative interpretation was informed by, and has interwoven, Foucault's (1972, 1976, 1977, 1979, 1988b) ideas of genealogy as the archaeology of situated knowledge, technologies of the self and governmentality. Latour's (1991, 1999) conceptualisation of actor network theory, specifically his thoughts on material and relational technologies are incorporated into the discussion. Davies and Harre's positioning theory and Bourdieu's (Bourdieu & Wacquant, 1992) ideas of capital were also drawn on to examine whakapapa as a resource for the constitution of identities in relation to forms of capital and knowledge.

Temporal fluidity and relational, economic, resourceful and cosmological temporalities pervade Matipou's story. As temporality was also identified as a consistent theme in other women's stories, the thematic analyses in chapter six have focused on temporality. Following initial topic classification, all blocks of relevant narrative text were entered into a computerised index and listed in numerical sequence. Each narrative text was then individually coded regarding content. Following coding, the 153 individual narrative texts relating to time were re-read with a view to developing

sub themes. Four sub-themes were identified: Corporeal temporality, relational temporality, resourceful temporality, and temporal measurement. As a result of the large amount of narrative information that arose from initial coding and analysis, following discussion with supervisors and amongst the research partnership, it was agreed that women's embodied or corporeal temporality was the element of time that was most meaningful for women research participants. The narrative texts associated with the sub theme of corporeal temporality were examined to facilitate the identification of thematic categories. Five categories were identified; corporeal temporalities as measures of health status and health risk, as determinants of humanity and identity, as determinants of women's access to care, particular care providers and specific interventions, and consequently as constituters of corporeal knowledge. Narrative interpretation of these categories has drawn on Bourdieu's (1996) theory and conceptualisation of fields as dynamic networks, Latour's (1999) conceptualisations of actants/actors/actor networks, and positioning theory as developed by Davies and Harre (1990). Somers (1994) ideas about relational narrativity have also been interwoven with Ricouer's (1981, 1984, 1988) perspectives on the interrelationship of narratives and temporalities.

Analysis of corporeal temporalities in chapter six draw attention to how embodied temporalities might silence identities, women's voices and agency. Silence as one aspect of communication was identified as a key sub-theme when the transcripts were originally read. In a similar manner to the time chapter, initial coding involved creating a digitalised and numerically sequenced index of narrative texts which were coded according to narrative content that related to silence. Four sub-themes were deduced from the formal coding of women's stories; self silences, silencing the other, collective silences, and institutional/ regulatory silences. Following discussion with participants a decision was made to focus textual analysis on participants' self silences. Careful attention to narrative texts suggested that women might practice self silencing as a means of empowerment in relation to their lives. The thematic categories arising from formal analysis included self silence as technology, privacy, minimisation, culture, and resistance. Silences were also categorised as temporally mobile actants, both agency and structure, as a form of exiting and/or voicing and as public silences incorporating professionalism and productivity. Theoretical framing for analysis drew on Foucault's (1972) notion that the genealogical construction of knowledge provides an argument for metaphysical technologies intertwined with Latour's (1991, 1999) theory of 'hard' technologies as material processes that enable agency. Bourdieu's (1996) suggestion of discursive 'hiding by showing' was used to explore women's self

silences as a form of resistance. The ideas of Davis (1995, 2003), and Fougere (1990) provided analytical support for theorising silence as enabling and constraining and as a tool for exiting relationships and voicing dissatisfaction.

As a collaborative research project it was essential that the final data chapter, chapter eight, provided an opportunity for women's desire to be voiced in a manner that respected individual variance and presented common concerns. Recognition and relationships were identified as key themes in all participants' stories. Drawing on the aforementioned theorists' and researchers' work, to support narrative interpretations, the importance of these themes for childbearing women, midwives, professional practice and care provision within the field of miscarriage is explored. The discussion in this final narrative analysis chapter also provides a showcase for participants' expertise in theorising their own lives.

### **Trustworthiness and Reliability**

As triangulation may be used as a method to strengthen the trustworthiness and reliability of qualitative research findings (Patton, 2002), this research project has drawn on both investigator and theory triangulation as developed by Denzin (1978). Participants have engaged as research partners through consultation regarding, and approval of, researcher's interpretations of participants' narratives. Cultural understandings and linguistic translations have also been collaboratively agreed upon with participants and, where appropriate, other designated research consultants from midwifery and Māori communities. The consultative approach to the research has facilitated the establishment of trust amongst all members of the research partnership therefore demonstrating the methodological concept of *whakawhirinaki*, the building of trust.

Being variously positioned as a midwife, mother and woman who has experienced early miscarriage has facilitated a conceptualisation of myself as a hybrid actor or actant in the Latourian sense (1999) that shapes narrative analyses through drawing on multiple identities and therefore multiple knowledge bases and theories. However, such an approach may be considered variant to classical theoretical triangulation (Farmer, Robinson, Elliott & Eyles, 2006) which is characterised as the application of "alternative disciplinary or substantive theoretical lenses to view research findings" (p 379). Within this thesis classical theoretical triangulation has also been established through developing theoretical conversations with the ideas of Michel Foucault, Bruno Latour, Pierre Bourdieu, Bronwyn Davies, Rom Harre, Arthur Frank, Margaret Somers

and Kaupapa Māori theoretical concepts. Triangulation has been strengthened through drawing on Western European and Māori epistemologies to explore areas of thematic convergence and dissonance.

Midwifery is a front line profession with a holistic view of health within a field where research is heavily influenced by biomedical and empiricist theories, methodologies and research methods. It may be argued that the midwifery profession's research interests in the human responses to childbearing and related health concerns necessitates methodological overlap with social science disciplines such as sociology, and/or anthropology. Risjord, Moloney and Dunbar (2001) argue that rather than being overlapped, "different research methods, theories and/or methodologies may be integrated into a unified inquiry methodology" (p 41). Within this thesis multiple worldviews and theoretical approaches are interwoven in establishing the trustworthiness and reliability of the research findings.

Additional measures for ensuring the trustworthiness and reliability of transcribed stories, narrative interpretations and thematic identification included reviewing transcripts with thesis supervisors, and research participants. Where ethically appropriate and with research participants' permission other individuals including midwifery peers, Māori, and community representatives, were consulted regarding clarification about emerging research themes.

Taylor, Kermode and Roberts (2006) suggest that the trustworthiness and reliability or rigour of qualitative health research are relationally linked with four key concepts 'credibility', 'fittingness', 'auditability' and 'confirmability'. Credibility refers to the level to which research participants are able to recognise their stories and experiences in the published research findings. Fittingness measures the external relevance of study findings outside the research setting. Auditability encompasses creation of the research decision trail regarding the development and implementation of the research project, and allowing for scrutiny to evaluate the level of research consistency. Through demonstrating credibility, auditability, and fittingness, confirmability of the research project is achieved. In the following section, the relevance of these concepts to the research is discussed.

### **Credibility and Fittingness**

The thesis has required the complex integration of theories and theoretical concepts that are in some instances oppositional perspectives on power relations, social interactions and social organisation. An argument may be made that theoretical framing has drawn on and attempted to integrate ideas arising from poststructuralist, feminist and postcolonial methodologies. Thesis discussions have encompassed technologies, temporalities, narratives, methodologies, voices relationships, and linguistics. The weaving of divergent theories, methodologies and epistemologies has therefore required that the research arguments be extensively scrutinized from both health and social science disciplines in order to ensure auditability. In accordance with this requirement, I presented the thesis arguments and developing methodology for interdisciplinary and indigenous comment at both national (Kenney, 2007, 2008d), and international (Kenney, 2008b, 2008c, 2008d) conferences. All presentations were very favourably received.

The midwifery and miscarriage-related research findings that are reported in the thesis are comparable to and, in some instances directly consistent with findings reported in relevant international research literature. The consistency of findings draws attention to the fittingness of the research. However, the unique context of midwifery practice in Aotearoa, New Zealand also highlighted differences; specifically women's and midwives' wishes in relation to health practices and care provision. Knowledge is invariably both situation and perspective dependent and therefore potentially influenced by disciplinary hegemony. Reflexivity within research draws attention to both the ways in which the research topic may be constituted within the research design and how it is textually represented by the researcher. Through drawing on multiple self identities or positions within the research as mother, Māori, midwife, woman who has miscarried, educator and family member, I have developed a multiple-lensed approach to textual analysis that counters the potentially hegemonic influence of midwifery. Discussions with research participants and supervisors regarding textual interpretations have acted as a form of triangulation. Subject bias has been minimised through collaborative reflection on the analytical process thereby ensuring the transparency of the narrative interpretations provided in the thesis. As participants were involved at all stages of the research process, narrative analyses and interpretations were co-constructed and legitimated by participants as 'our stories'. Moreover, participants also evaluated the contextual relevance, efficacy and therefore credibility of the methodology, as discussed in the next section.

### **Auditability: Participant Feedback on Research Methodology**

During the research process, participants were shown the research methodology model and invited to comment and offer critique. The following narrative excerpts from midwives and women who have experienced and/or provided care for miscarriage are representative of comments from all research participants.

**Matipou:** I love the model! No I love the research model. And it makes me as a Māori midwife look forward to reference it for the future. I love the fact that you have used so much Reo in it, and you haven't compromised. I think you have picked a really good important issue. How many women and whānau are affected by miscarriage... and their silences, for how long have they been carrying that burden of silence.

**Rewarewa:** I think it was really good to share my story, and think about what could be..., a research method, or practice option for midwives for the future. You and I, we've both got knowledge as women and midwives and I think that it's a way we can perhaps pull out something extra... It's good having that dialogue, rather than just one story, just my story, and it prompts more things, it prompts things, which is really important... It's fantastic!

**Kauri:** I like the inter-activeness of this approach to research..., I feel like not just my experiences are taken into account but also my viewpoints... It is very collaborative.

**Kahatea:** I have done research before and this is different. With this I feel like I have had a more active voice in shaping ideas, not just giving you my story, and then you disappear.

The preceding comments by Matipou, Rewarewa, Kauri, Kahatea construct 'Te whakamāramatanga' as a methodology that is collaborative and relational. The women's remarks allude to the ways in which the methodology facilitates mutual respect, trust acknowledgment of diverse knowledges, and encourages interactive negotiation, investigation and advocacy for women's concerns. These positive critiques of the methodology suggest that the theoretical concepts of 'Te whakamāramatanga' are embedded within the research process and support the 'confirmability' of the research findings.

### **Summary**

The chapter discusses issues relating to method to illustrate the processes undertaken to provide a narrative thesis that is both theoretically sound and creative. Methods used to develop the research process were intimately relational and to a degree serendipitous. A detailed discussion of the emerging issues involved in performing the

research for the study is provided. Analytical methods are presented and the interpretive approach discussed. It is asserted that from the overview of the design, implementation procedures, to analytical methods, methodological and theoretical underpinnings have been carefully considered to ensure the consistency and reliability of both the research and the thesis. In addition collaboration and participation by participants in all stages of the research process has ensured that the methodological concepts of 'Te Whakamāramatanga' are encompassed throughout the research process.

# 5

## Theorising Whakapapa

### Genealogies, Nested Narratives and 'Storying' Women's Experiences

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*Kia mau koe ki ngā kupu o ou tupuna. Kia mau ki te tikanga.  
(Hold fast to the words of your ancestors. Hold fast to your culture)*

“Narrative is first and foremost a prodigious variety of genres...Narrative is present in myth, fable, tale, novella, epic, history, tragedy, drama comedy mime, painting... stained glass window, cinema, comics, news item, and conversation. Moreover, under this almost infinite diversity of forms narrative is present in every age, in every place, in every society: it begins with the very history of mankind and there nowhere is nor has been a people without narrative. Narrative is international, transhistorical, transcultural: it is simply there, like life itself” (Barthes, 1977, p. 79).

“Stories have recently moved centre stage in social thought. In anthropology, they are seen as pathways to understanding culture. In psychology they are the bases of identity. In history they provide the tropes for making sense of the past. In psychoanalysis they provide ‘narrative truths’ for analysis. In philosophy they are the basis for new forms of ‘world making’ and the key to creating communities” (Plummer, 1995, p. 18).

#### **Introduction**

In this chapter, it is argued that women’s personal and professional accounts of first trimester miscarriage are characterised by a high degree of narrativity. In accordance with the methodological framework and ethical tenets of the research partnership, outlined in chapters three and four, where possible narratives are represented in their contextual entirety. An attempt is made to represent storytellers’ voices and accounts in

a manner that respects participants' experiences and facilitates reader and/or listener accessibility to, and comprehension of, 'storied meanings'. The terms story and narrative have been used interchangeably, throughout the thesis. However, where it is appropriate in this chapter, the term 'story' has predominantly been applied to women's subjective accounts of miscarriage, and the term narrative has been reserved for, and collectively encompasses public, legislative, disciplinary, and cultural discourses.

In order to explore the storied nature of human identity and conduct in relation to miscarriage, this chapter primarily focuses on the talk of an indigenous midwife Matipou; supported by the voices of additional research participants. Analysis explores the corporeal, social, professional, embodied and metaphysical connections of Matipou's narrative to the multiple and multi-cultural, worldviews, stories, and environments that are found within Aotearoa, New Zealand. In Matipou's narrative whakapapa is represented traditionally, she sets the context for interaction through reference to past, present and future and by positioning herself in relation to her Iwi and the tikanga of her tupuna (ancestors). In doing so, Matipou outlines the way in which stories inform professional practice for Māori. Te whare ngaro (miscarriage is culturally located as both a continuation of, and a threat to whakapapa. The traditional practice of whangai (adoption) is presented as a rongoa (treatment) for miscarriage and/or infertility facilitating and strengthening whakawhanaungatanga (relationship building within families).

The contextual elements of a setting or environment comprehensively shape personal experiences and behaviours within that setting. Within the context of this thesis it is suggested that narratives are metaphysical, corporeal and embodied, entities and environments that may situate and be situated in relation to, and therefore may be considered synonymous with, in the broadest sense, genealogies. Indigenous peoples have traditionally perceived genealogy as a form of embodied and/or corporeal knowledge (Barlow, 1991; Buck, 1949). In the late 20<sup>th</sup> century Michel Foucault (1972) introduced the concept of genealogy as a metaphysical technology to social science. Foucault theorised that genealogy was the ancestral or archaeological framework for the construction of knowledge; which he conceptualised as contingently located in a multiplicity of situations within localised temporal, social and historical settings or fields. More recently, Māori researchers in Aotearoa, New Zealand have characterised whakapapa (genealogy) as a relational way of storying knowledge and experiences (Bishop, 1996; Mead, 1996), and conceptualised

genealogy as an epistemological framework for conducting research (Graham, 2007, 2009; Mead, 1996; Roberts et al., 2004; Royal, 1998; Te Rito; 2007a, 2007b).

Therefore within this chapter it is proposed that narratives and genealogies may be jointly represented by the term ‘whakapapa’ (genealogy). Drawing on kaupapa Māori philosophical theory (Smith, 1997), reframed as research methodology (Bishop, 1996; Mead, 1996) and the social theories of Michel Foucault, Pierre Bourdieu and Bruno Latour, it is argued that whakapapa is a metaphysical, corporeal and embodied metaphor for narrative. An argument is also advanced that whakapapa is a ‘positioning tool’ (Davies & Harre, 1990), which through locating actors in contestable situations facilitates individual and collective constructions of class, subjective habitus and field (Bourdieu, 1977).

Callon (1987) and Latour (1999) theorise technologies as heterogeneous relational and material entities that achieve durability through the linkages created by the actions of actors. Technologies are therefore embedded in actor-networks which are able to transform and redefine the heterogeneous elements that constitute the network (Callon, 1987, p. 93). Drawing on the theoretical perspectives of Callon (1987) and Latour (1999) it is argued that whakapapa may simultaneously be construed as a technological actant<sup>35</sup> and/or hybrid actor and a dynamic, un-finalised actor network (Latour, 1993, 1999). As Foucault (1988b) also conceptualises technologies in their widest sense as relational dynamic, material and/or metaphysical, it is also proposed that whakapapa may contemporaneously function as technologies of the self, production, domination and signification (Foucault, 1972). These theoretical linkages between Foucauldian and Latourian conceptualisations of technologies, using whakapapa as an exemplar, are explored in this chapter.

### **Whakapapa: Theory, Epistemology and Technology**

Various meanings have been assigned to whakapapa. Barlow (1991) states “whakapapa is..., genealogical descent of all things..., a basis for organisation of knowledge in respect to the creation and development of all things” (p. 173). Mead (2003) suggests it may be defined as “the social component of the ira, the genes” (p. 42) and therefore translates as both individual identity (Pere, 1982; Mikaere, 2003)

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<sup>35</sup> The term *actant* and associated meanings are discussed in footnote four on page 11 of this thesis. Latour (1999) uses the term hybrid actor to refer to the interface between actants that encompass hard non sentient material and sentient and/or organic material; human beings. As an example, a car driven on the road constitutes a hybrid actor constructed from both non-sentient technology (the mechanical components that constitute a car) and cognitive corporeality (human actors that ‘drive’ the car).

and relational position within a kinship structure (whakawhanaungatanga) (Bishop, 1996; Mead, 1996). Mead (1996) adds that whakapapa encompasses cultural ways of thinking, learning, and storying knowledge and situates Māori in relation to iwi (tribal affiliations), whenua <sup>36</sup>(landscape) and the creation of the universe (p. 210).

Within academia, whakapapa has emerged as an epistemological concept from kaupapa Māori theory (Smith, 1997); a contemporary philosophical perspective that developed to challenge western theoretical hegemony with the intention of validating and legitimating Māori knowledge. Broadly interpreted, whakapapa has been applied as, incorporated into, and/or provided a framework for, research methodologies (Bishop, 1996; Cram, 2001; Cunningham, 2000; Durie, A., 1998; Graham, 2005, 2009; Mead, 1996; Roberts et al., 2007; Royal, 1998; Te Rito, 2007a, 2007b) health assessment, care/service provision (Boulton, 2005; Durie, M., 1998; Kingi, 2002; Palmer, 2002), policy development and implementation (Ministry of Health 2002; Department of Conservation, 2007), taxonomies (Haami & Roberts, 2002) and organisational development and management (Hook, Waaka & Raumati, 2007).

Connor (2006) suggests that the process of developing research practice for Māori that is exclusively founded on Māori epistemological concepts has been problematic (p. 35) in that research theories, methodologies and methods draw knowledge from other than indigenous epistemologies.<sup>37</sup> In response, Māori academics involved in cross disciplinary and cross paradigmatic health research that incorporates whakapapa, have constructed parallel theoretical framings (Cram, 1997; Cram et al., 2004) to maintain the cultural integrity of particular research projects and the cultural ethics and dispositions of researchers. However, these practices have met with mixed success when crafting theoretical frameworks for research within a bi-cultural setting.

An alternative approach to mediating the bi-cultural interface may be inferred from the work of Sir Apirana Ngata; a Māori leader who was politically and socially active in Aotearoa, New Zealand in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries. Amongst his final

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<sup>36</sup> Whenua translates at the mundane level as landscape and/or geographical land and the placenta that is born during childbirth. The interwoven meanings allude to whenua as the metaphysical representative of Papatuanuku. Papatuanuku the Earth mother is perceived as co-progenitor of Te Ao Mārama (the world of light) and both the metaphysical and corporeal source through Hineahuone (the first woman) of Māori.

<sup>37</sup> The integration of Western European epistemological concepts is evident in the seminal work of senior Kaupapa Maori academics and researchers. For example in *Decolonising methodologies (1999)*, Linda Smith draws from social theory (Foucault), and Russell Bishop incorporates narrative theory (Clandinin and Connelly) into research methodology in *Whakawhanaungatanga: Collaborative Research Stories (1996)*.

works is a whakatauki (proverb) that Ngata wrote for Rangi Bennett, the daughter of Sir John Bennett. Lines two and three state:

*“Ko to ringa ki nga rakau a te Pakeha, hei ara mo te tinana”  
(Your hands to the tools of the pakeha to provide sustenance for your body)*

*“Ko to ngakau, ki nga taonga a o tipuna Māori, hei tikitiki mo to mahuna”  
(Your heart to the treasures of your ancestors as a diadem for your brow)*

Although there is debate about Ngata’s underlying intentions with regard to Māori Pakeha relations (McIntosh, 2001),<sup>38</sup> I propose that the second and third lines of the proverb demonstrate both his lack of ethno-centricity and his cultural pride. The second line of the proverb suggests that Ngata saw value in taking advantage of what was offered by Europeans, to promote maximum personal development in what had become a rapidly changing socio-cultural setting. Within the third line he balanced his recommendation to seize and make use of new cultural resources, with the admonition to remain centred in the cultural foundation of whakapapa, and to display it; wear it proudly at all times.<sup>39</sup>

As mentioned Kaupapa Māori theory has provided an epistemological framework for Māori researchers to conduct research with Māori that draws from Te Ao Māori and the Western European world in order to fulfil Māori aspirations and improve Māori wellbeing. Ngata’s proverb alludes to a way forward for Māori and perhaps in the future non-Māori researchers, working with both Māori and non-Māori research participants that may disrupt the hierarchical positioning and ghettoization of Māori epistemologies within the academy (Smith, 2003). In support of this perspective Weedon (1999) suggests that the concept of cultural hybridity can challenge existing binary oppositions and hierarchies and can have a profoundly empowering effect on women’s lives.

Within this chapter, through drawing on theories and concepts from western and Māori paradigms, whakapapa is conceptualised as a metaphor for narrative. Whakapapa is also perceived as being simultaneously metaphysical, corporeal and

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<sup>38</sup> McIntosh (2001) acknowledges the debate regarding interpretation of Ngata’s whakatauki, and suggests that some interpretations view Ngata’s proverb as signalling his personal support for the assimilation policies promoted by the New Zealand Government.

<sup>39</sup> In relation to the third line of the proverb I interpret the term ‘ngakau’ as meaning separately and collectively, heart, inclination, desire and spirit. ‘Hei tikitiki’ is commonly translated as ‘diadem’ but may also mean ‘topknot’, alluding to the practice of young warriors wearing their hair in ways that would draw positive public regard. I suggest that Ngata intended this line as encouragement to Māori to enthusiastically participate in, and emotionally, socially and spiritually commit to the practice of tikanga (cultural traditions), and the preservation Māori culture.

embodied, located in the past present and future, situated within, and co-constitutive of, whanaungatanga (relationships). The story of a Māori midwife is presented as an exemplar for both the comprehensive analysis of whole narrative and the theoretical examination of whakapapa. Careful attention to Matipou's story and the social relations and processes that it both encompasses and within which it is embedded suggests that whakapapa facilitates the construction of individual (Te Rito, 2007a) and collective (Kelly, 2003) identities. Such identities are contingent and may be locally and/or globally situated; whakapapa may therefore be considered constitutive of, and an epistemological framework for, the 'body politic'. Through locating Matipou and other actors in relation to whānau, communities and the body politic, whakapapa contemporaneously operates as a corporeal and metaphysical positioning tool (Davies & Harre, 1990) or actant (Latour, 1991, 1999), and may constitute and shape local and global settings and multiple temporalities. Therefore for Māori collectively, and at the individual level, whakapapa may be considered as constituting both class and subjective habitus, and a dynamic field (Bourdieu, 1990).

In providing a philosophical underpinning and social framework for Te Ao Māori, whakapapa may also be constructed as a values system. As Frank (2002) states "[T]he local and contingent solutions that people have found are expressed in their stories that recount past attempted solutions to how they should live and are part of their ongoing attempts to seek present ways of living" (p. 110). Drawing on Frank (2002), I suggest that whakapapa as a cultural framework for morality functions as a form of 'trans-temporal governance' (Foucault, 1988a), that through the application of technologies, shapes individual and collective 'selves' and behaviours through enabling and constraining agency within local and global settings.

Māori Marsden and Te Aroha Henare (2003) conceptualise whakapapa as a technique for producing and transmitting situated knowledge within localised settings paralleling Foucault's (1972) archaeological framing of the genealogy or ancestry of knowledge within the western paradigm. However, in contrast to indigenous perspectives Foucault rejects cultural totalisation as essentialist because he views genealogy as discontinuous and comprised of discrete events that are situated and contingent. Within this research women's stories infer that whakapapa in the broadest sense as technology actor network and field may be theorised across temporalities, spaces and cultures and therefore be considered locally and globally as a trans-cultural, trans-historical and trans-national technology. In characterising whakapapa as a technology, an argument

is advanced for a multi element approach to narrative analysis that draws on multi-disciplinary theory and multi-paradigmatic worldviews of genealogy.

Midwives draw on whakapapa or genealogy as a technology to act as, create and locate narratives about clinical practice. For midwifery peers and other health practitioners, their scope of practice and professional conduct are shaped and situated within their professional and social environments through genealogical narratives. Practitioners' clinical competence, self worth, and provision of health care are influenced by carefully crafted genealogies of metaphysical and corporeal knowledge, and commonly also their client's child birthing experiences. "Assisting childbearing women to develop and negotiate 'birth' narratives that can encompass the intense and sometimes difficult experience of birth" (Maher, & Souter, 2002, p. 37) is considered an essential element of care. Midwives commonly retell their client's stories of childbirth to other women (p. 163) in conjunction with sharing their own stories in order to facilitate the client's knowledge base in relation to childbearing and further development of professional practice. Professional and personal stories become intertwined or "nested narratives, narratives nested within other narratives" (Gergen & Gergen, 1988, p. 34) inferring that narrative genealogies are metaphysically multi-layered.

Analysis of Matipou's story incorporates Māori conceptualisations of genealogy or whakapapa, as a contemporaneously, storied corporeal entity (Mead, 1996) and epistemological framework in which perceived patterns and relationships in nature are located (Roberts et al., 2004). Māori concepts are linked with Foucault's (1972) theoretical construction of genealogy as a metaphysical technology of contingent and situated knowledge which in turn is modified by Latour's (1999) conceptualisation of technology as a corporeal and relational entity.

### **The Story of Matipou - 31<sup>st</sup> March, 2007**

Matipou<sup>40</sup> is an experienced registered nurse and midwife. She has provided midwifery services to women, in rural and urban settings, acted as a practice reviewer for the New Zealand College of Midwives and Nga Maia (Māori Midwifery

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<sup>40</sup> The Matipou tree has historically played a significant role within the rituals associated with childbirth. Small branches from this tree were dipped in water and used in cleansing ceremonies such as the tangi (funerals) for chiefs and more particularly for dedication ceremonies for newborns and farewell rituals for miscarried babies. Such childbirth rituals and/or ceremonies were carried out with the intention of preventing the birth of atua kahukahu (spirit demons) that could act in metaphysical or material form. 'Matipou' was selected as a pseudonym in consultation with the research participant because the aforementioned rituals are tikanga (cultural traditions) practiced within her whānau (family) and familial responsibility for performing these rituals has recently devolved to the participant.

Association), provided preceptorship to midwifery students and been an expert witness during disciplinary hearings. At the time of the research interview Matipou was both employed by a District Health Board to provide midwifery services within a tertiary hospital, and self-employed as a lead maternity care provider in independent practice.

I'm feeling very comfortable, and I feel safe, and I feel it's a good time. The timing is right for me to talk about some of the things that have been passed down to me as a Kaiwhakawhānau<sup>41</sup> (midwife) for our whānau... Oh well, he mea tuatahi ka hoki aku whakaaro oku tupuna (firstly are the thoughts of my ancestors). So my story is going to begin with my whakapapa (genealogy) stories that I know from our family. When my grandmother knew that I was interested in becoming a midwife, taking on that way, and, and through my first pregnancy, I just couldn't get enough of the stories, and her sound advice, because my mother, my mother had a different experience in a different time. Nana was..., full of stories and just loved opportunities to tell me about things. And she talked about her own time. The time when she was born; her two brothers were born, and what her mother's experience was and like her (nana) her brothers have very simple names. (Names great uncles) and guess which months of the year they were born in (shared laughter between interviewer and interviewee). I was really interested in their naming of them and she said that she had been told that it was around 1918 they had the epidemic, the flu epidemic, so there was a lot of death and dying and in fact her father died during that time that she was a baby and so she never knew him... Her mother had lots of miscarriages before she was able to conceive and hold on to these precious babies, this precious whakapapa (genealogy), so te whare ngaro (the empty, lost house<sup>42</sup>) ..., te whare ngaro tena (This is the lost house). So she said that she knew that her mother she'd had many pregnancies that hadn't continued past however long I don't know how early they were; but she said that she knew that one of the babies had a name, it was like a tupuna (ancestor) name and then they come down to me and its (names month of the year). And I said 'why was that do you think?' and she said 'Well until me he whare ngaro (lost house). So, in those times they went to the tohunga (priests) for advice on how to conceive and maintain whakapapa (genealogy) so the instructions, one of the instructions was 'These are the names. These will be the names of these babies'... Very simple, nothing on them or you know associated with them. So that was one thing and also strict adherence to..., the principles of te Whare Ringatu (the Ringatu church); so very strict tapu (sacred) law, um..., being careful about what she was permitted to eat; who she was permitted to see, karakia (prayer) and i nga wā kato, morning and night in

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<sup>41</sup> In this thesis, 'Kaiwhakawhānau' is interpreted as the professional designation 'midwife' and encompasses the broader role of nurturer and/or facilitator of the creation of family.

<sup>42</sup> As stated in Chapter 4, the term 'te whare ngaro' is translated primarily as 'the lost house' to incorporate both the concept of infertility represented by the 'empty' te whare tangata (house of the people, barren uterus), and also the corporeal, psycho-social and emotional losses associated with the endings of genealogies, and individual and collective identities.

order for her to conceive.. She only had three, and Nana was the only girl and then two brothers... So that was one thing and another story she told me about was on my grandfather's side of the family and his mother also had had whare ngaro. And so she was actually married to a chief. My great grandfather was paramount chief in the area where I come from and so he was He Pou a te Hahi Ringatu (spiritual leader) and he strictly adhered to, they both did, the instructions of the tohunga (priest) in order for my great gran to conceive and she DID, and she did have a big family in the end. And ah, but apparently with the first born; the first one that she was able to conceive; well she had to live separately in her own house by herself and she just had meals prepared for her, and her alone and karakia (prayer), but once the baby was born the firstborn she was only able to leave the house if the baby gave her permission, so this was like..., if the baby was happy in the company of certain people, that was ok. If the baby started to wander out of the whare (house) in its own time; so right up to that time it was strict isolation. So she could only kind of like follow in his footsteps and if he was going up to so and so then that gave her permission to do that. And it's a really beautiful story that's been handed down about the ability of tamariki (children) to sense and give permission to..., where you could safely go, breaking down a tapu (spiritually related restriction). So those are some of the things that I know.

### **Whakapapa as Whānau Narrative**

Matipou interprets the request for her miscarriage story as an invitation to share whakapapa stories because within Te Ao Māori they are the same story. The narration of whakapapa stories is a responsibility that is delegated to specific family members and stories are usually narrated to only certain individuals within a whānau (Mead, 2003; Mikaere, 2003). Storytelling commonly occurs at particular times and in specific familial, social and geographical settings (Royal, 1998). Knowledge transmission is often intergenerational and the process occurs in accordance with whānau and/or hapū and iwi cultural traditions (Graham, 2009). As whakapapa may create, shape and reproduce knowledge both with, and without intentionality, it may be argued that whakapapa is directly linked with power. Foucault (1976, pp. 92-95, 102) theorises such relational linkage in his concept, power-knowledge. He alludes to power as ephemeral, contingent in that it is “exercised from innumerable points” (p. 94). In relation to whakapapa “the manifold relationships of force that take shape and come into play..., in families ..., are the basis for wide ranging effects of cleavage that run into the social body as a whole”(Foucault, 1976, p. 94).

In commenting ‘I’m feeling very comfortable..., safe’, Matipou alludes to both the cultural value and power of whakapapa knowledge and stories and the importance she

assigns to how, and with whom, such valuable resources are shared. Being safe infers that the cultural criteria associated with the narration of whakapapa have been met. Her remark may also be interpreted as meaning the listener is extra-discursively positioned as an appropriate listener; an individual culturally grounded in their tikanga, who will receive and interpret her story in a culturally respectful way.<sup>43</sup> The rightness of storytelling is reinforced by acknowledgement of the temporal setting where storytelling occurs at a ‘good’ and ‘right’ time. Implicit is the possibility that there may be “wrong” times to tell such stories. It may subsequently be argued that the narrative temporality associated with storytelling accrues moral status, in that cultural traditions appear to have been respected.

The interchangeable use of the pronouns ‘my’ and ‘our’ within the story infer Matipou’s embeddedness within, and ownership of, the whakapapa story. Matipou’s story is that of her predecessors because ‘she’ is the embodiment of ‘they’. Narrative temporality in addition to being characterised as culturally moral, has become fluid. The past is metaphysically present within the story during verbal narration. Through both choosing to ‘voice’ the meta-story and the physical practice of speaking, Matipou provides a corporeal representation of the past and as Matipou manifests the ira tangata (genetic essence) of the tupuna (ancestors), she also constitutes an embodiment of the temporal past. However, in addition to representing the past, stories may always be re-narrated, and so stories or narratives simultaneously represent the past, present, and future.

Matipou acknowledges this connection by stating ‘My story begins with the thoughts of the ancestors’. She narrates a meta-story that commences before she was born and interweaves the ontological stories of four generations of her whānau. The genealogical “nesting of” ontological “narratives” (Gergen & Gergen, 1988, p. 34) establishes the meta-story’s non discrete relationship to Matipou as narrator. Stories are often retold (Bruner, 2002; Hydén & Brockmeier, 2008), and by different storytellers (Brody, 1997) for different reasons, such as highlighting moral considerations or social and temporal contexts (Nelson, 2002, p. 43) and are therefore

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<sup>43</sup> Before agreeing to share her whakapapa story Matipou evaluated the researcher’s cultural competence as both an indigenous woman and health practitioner. The researcher’s whakapapa, knowledge of whānau tikanga (family practices) in relation to birth, embodied experience of miscarriage and professional expertise as a registered midwife were explored during comprehensive discussions. Matipou subsequently positioned the researcher as a cultural insider. As a result of Matipou’s perception that the researcher shared her understanding of cultural values and practices, some cultural elements are not directly explained in the story. Where possible these are interpreted by the researcher to enhance reader understanding. However, the researcher cautions that as cultural practices vary amongst whānau, hapū and Iwi, the reliability of such interpretation is limited.

un-finalised (Frank, 2005). Matipou's grandmother is positioned within the story as the beginning narrator.

Matipou's grandmother commences her story with the history surrounding the birthing of her generation. Birth is temporally situated in the early 20<sup>th</sup> century; a period of frequent death and illness in Aotearoa, New Zealand, and during which a Flu epidemic eroded the population (Rice, 2005).<sup>44</sup> Within Te Ao Māori, forms of social, cultural and economic capital (Bourdieu, 1977) such as familial and community position, education, economic resources, and land ownership derive from whakapapa (Mead, 2003, p. 42). Extended whānau constitute intergenerational fields (Bourdieu, 1996) in which various forms of capital are assumed or assigned based on an individual's mana. Babies are 'precious' in that they demonstrate women's success in carrying out their paramount role as bearers of the future (August, 2004; Mikaere, 2003), and they are the temporally located culmination of preceding generations, embodied whakapapa. The individual and collective beliefs, values and conduct of whānau are therefore shaped by and in relation to whakapapa which may therefore be construed as a form of governmentality<sup>45</sup> (Foucault, 1991). Matipou's grandmother constructs miscarriage as a physiological genealogy that is embedded within, and which poses a threat to whakapapa, the family's metaphysical and corporeal social structure and most valuable resource. The threat requires expert cultural intervention, and usually, as in Matipou's grandmother's story, consultation with a tohunga (priest) related to the whānau by whakapapa.

In the grandmother's nested story, attention is paid to the naming of children in her generation. Assigning babies the names of tupuna (ancestors) draws the mana (prestige) of past genealogy into the present (Mead, 2003). According to Best (1906, p. 13) the power of such names may attract the jealousy of unsettled spirits and result in miscarriage, stillbirth or chronically ill children. Matipou's whānau consulted a tohunga (priest) as expert health practitioner. His rongoa (treatment) requires naming the babies after the months of the year in which they are born. Such names lack history, or prestige, and may reduce the threat of malicious action by spirits and/or jealous tangata whenua. However, in issuing a directive, 'these will be the names', the tohunga demonstrates his social position within the whānau and potentially hapū and

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<sup>44</sup> The 1918 Flu epidemic decimated the populations of island nations in the Pacific. Approximately 5% of the Aotearoa, New Zealand population died (Rice, 2005).

<sup>45</sup> Governmentality is interpreted as the reasoned principles or rationales and social structures that are drawn on by both state and individuals to regulate and police bodies, thoughts, and behaviours, and through which they codetermine each other's existence.

iwi. Historically, tohunga represented the embodiment of disciplinary power (Foucault, 1988b) over bodies and behaviours in social settings. In her nested story, Matipou's grandmother locates the tohunga within a particular narrative temporality, alluding to the contingent nature of his ability to exercise power within social settings. However, she acknowledges that her mother (Matipou's great grandmother) strictly complied with the tohunga's directives regarding nutrition, social conduct, and spiritual practices. Foucault (1988b) refers to this as conducting practises or technologies of the self. For example, technologies of normalisation and self esteem, which he asserts encompass the strategies through which modification of bodies, thoughts, behaviours, and dispositions is accomplished in order for individuals to attain a self perceived state of normality, in relation to the settings in which they are situated (p. 18).

Drawing on Foucault's conceptualisations of disciplinary power (Foucault, 1977, 1979, 1991) and in the absence of any reference to her cultural setting, Matipou's great grandmother could be construed as a "docile body" (Foucault, 1977, p. 138). However, this interpretation would not be accurate. Prior to colonisation, when a pregnancy united two chiefly lines, the childbearing woman who was often a chiefly woman in her own right, was considered to be an individual of great status within the Iwi. Such women received a great deal of respect and often exercised authority. Attention and care was taken in providing spiritual protection and particular types of food to ensure the woman's wellbeing (Makareti, 1986; Pere, 1988).

Te whare ngaro also existed in the whānau of Matipou's grandfather and the tohunga's advice was also requested. In this instance the disciplinary power exercised by the tohunga is augmented by the institutional control exerted over the whānau by the Christianity based Ringatu church. The institutional "gaze" (Foucault, 1976, p. 89) is corporeally represented in the person of Matipou's great grandfather who is positioned by, and within, the whakapapa as contemporaneously paramount chief, and tohunga/spiritual leader for the Ringatu church. Disciplinary power is perpetuated by and within the extended whānau and hapū and internalised by Matipou's great grandmother (Matipou's grandfather's mother) who follows tikanga and resides separately from her family during her pregnancy.

Foucault (1988b) suggests that the interface of technologies of domination, and the 'self', constitutes governmentality. He infers that the relational interactions of temporally and spatially situated individuals and the social structures of power,

(church and state consolidated through embodiment in the form of Matipou's great grandfather) they are subject to, shape contingent and unfinalised realities in which individuals and their bodies are positioned as subject (Foucault, 1977, 1991). In contrast, within a Māori epistemology, the story of Matipou's great grandmother is one of privilege. In being provided with her own house, excused from all daily chores, having all meals prepared for her and receiving regular spiritual support from prayer, she is positioned similarly to her women ancestors, as a rangatira (chief) (Mikaere, 2003) and accorded the requisite authority and respect. An argument is advanced that as both the bearer, and product, of whakapapa she is enabled as a social actor through achieving the identity and status of being 'mother to a rangatira' as well as constrained by tikanga (cultural traditions) in her ability to exercise agency during pregnancy. For example, being physically restricted, separated from her whanau and having her meals selected for her.

Within the story it is evident that disciplinary power is temporally and socially contingent and the ability to exercise power devolves from the tohunga to the newborn child. As the child develops and becomes mobile, Matipou's great grandmother may 'follow in his footsteps', and begin to re-socialise with her family and the wider community. A Western European perspective might view Matipou's great grandmother as constrained in her ability to exercise agency by being situated in a subject position that is in relation to her child. Within a Māori epistemology the long awaited child is the culmination and embodiment of whakapapa. Newborn children are positioned as having the wisdom of the ancestors un-constrained by the imposition of situated social structures. Matipou's great grandmother is both constrained and enabled in her ability to exercise agency by whakapapa. She may choose to walk in her child's footsteps, in acknowledgement of the child's expertise in determining the spiritually 'safe' <sup>46</sup> path and facilitate the successful integration of her new social identity (mother) into her wider social world. Matipou suggests that the story is therefore not about constraint but freedom and healing. She states that the story is retold to reinforce for whānau the value of such children who through the lifting of tapu (spiritual restrictions) are both sources of permission and protection.

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<sup>46</sup> Within a Māori ontology, tapu (spiritual restrictions) are inherent in all aspects of childbearing. Transgressing a tapu is often associated with a negative physical or psychosocial outcome. Very young children are able to identify or draw attention to individuals, practises and geographical areas that are tapu, therefore following "in their footsteps" may provide corporeal and metaphysical protection.

Matipou's interpretation of the request for her miscarriage story as an invitation to share whakapapa stories is not unique to Māori as evidenced in the following excerpts from the stories of Rewarewa and Kawakawa (pakeha participants) that situate their miscarriages within genealogical and relational settings.

**Rewarewa:** I come from a family history of miscarriage... My um paternal grandmother had five miscarriages and my maternal grandmother didn't have any miscarriages but she had a huge postpartum haemorrhage after my mother and wasn't allowed any more babies. My mother had no miscarriages, but my elder sister had a miscarriage, and my sister, younger sister, had a miscarriage, and my brother's wife, whose family had no history of miscarriage, they miscarried. So we've all been there and done that I suppose.

**Kawakawa:** My husband comes from a family of seven so there's like lots of.., lots of cousins and nieces and nephews and stuff and it helped that my mother had had a miscarriage, and all my sisters in law had had it quite hard.., they all had struggled to get pregnant um.., and with keeping their pregnancies.

Rewarewa and Kawakawa construct miscarriage in a similar manner to Matipou's grandmother, as a 'physiological genealogy'. However, as a potential point of difference from their non-Māori perspectives on genealogy, Māori perceive whakapapa knowledge as both socially and spiritually valuable (Bishop, 1996; Graham, 2009; Mead 1996; Royal, 1998; Smith, 1999b; Smith, 1997; Te Rito, 2007a, 2007b).

### **Whangai and Whakapapa**

Within the story, Matipou extends the discussion regarding the importance of children as rongoa (healing) for te whare ngaro (the lost house) to include the practice of whangai (open child adoption within the extended family).

The other tikanga (cultural tradition) in our whānau (family) ..., is whangai (child adoption within the family). Whangai (child adoption within the family) is a rongoa (treatment) for women who are unable to conceive. So one particular kuia (mature woman) got to 37 years old before she was able to finally conceive and that came as the result of one of my grandmothers (beginning narrator) being instructed by her father in law; you know the chief we were talking about, to give one of her babies over to her brother in law and his wife, and she did so but it was painful for her... Mmmm. (1+). But she did it in love as well because she really did love her sister in law. They were close... The baby was a sickly child. She said she still used to have to go

and breast feed him and help her sister in law with him, because he had this bowel obstruction problem... But they just loved him; they just..., really doted on him. And whenever Nana was needed to go and kind of help her, (spoken quietly) he used to have enemas I think to help him be comfortable... So he, as they would say lovingly to each other, that one broke the spell. He was the one who broke whatever it was preventing the kuia, continuing to hold on to her pepe (baby). So um..., he died. But forevermore they would continue to tell anybody and all of us about this gift of, that child, that baby. And he was a special and very cherished child for the short life that he had because he was, he broke the spell as they said and she went on to conceive one, two, three, four children after that you know, until her later thirties. So that was something...

Through presenting whangai (child adoption within the family) as both a rongoa (treatment) for miscarriage and infertility, and as a culturally based alternative to termination, Matipou positions whangai as a cultural tradition that has value within multiple settings. Within the story, attention is drawn to the tension between Māori conceptualisations of childbearing as an embodied narrative of whakapapa (addressed within the text) and Western European perspectives of Māori as irresponsibly fecund<sup>47</sup>(Bassett, 2007) that have an absent presence in the story. New Zealand is a colonised country, social discourses that constitute what is acceptable behaviour or practices are based unquestioningly within a Western paradigm. Māori worldviews that value fecundity are marginalised. Matipou discredits such extra-discursive judgements by strategically framing the practice of whangai as both agency and constraint. The practice of whangai may be construed as choosing to acknowledge the cultural value of a child and therefore enacting agency. Whangai may be characterised as constraint in that the practice provides a means of shaping and/or limiting abortion practices amongst Māori.

Whangai may constitute a familial responsibility and/or a duty that although, as in Matipou's story, it is psychosocially and emotionally challenging for childbearing women, is still required to facilitate the wellbeing of the whānau and the maintenance of whakapapa (Mikaere, 1994). Matipou suggests that whangai, in strengthening whānau structures, facilitates whakawhanaungatanga (the development of relationships) and subsequently enables a reciprocal exchange of support between adoptive couples and biological parent(s). As Whangai is a tikanga that supports and

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<sup>47</sup> Dr Michael Bassett's comments have epitomized this perspective. For example, his remarks that "many of them (Māori) breed fecklessly" and have "opted for breeding as a career", which were made during a speech he delivered at the Institute of Economic Research AGM, 30<sup>th</sup> August, 2007.

shapes social structure and it is instituted within the story by Matipou's great grandfather in his role as paramount chief, it may be inferred that whangai operates as a technology of domination (Foucault, 1977) or social governance in order to facilitate and/or ensure the maintenance of whakapapa and whanaungatanga.

Matipou's grandmother, in complying with the directive to give her child to her sister in law, makes a continuous social commitment to facilitate the welfare of that whānau, through providing ongoing care and support for her biological son. The child is described as seriously ill and requires intensive care from family members. However, he is positioned in the story as dearly loved, more particularly, for enabling his whangai parent to assume the identity of mother and through lifting tapu, facilitating his whangai 'mother' to subsequently conceive. It is therefore argued that in this story whangai may also be characterised as a technology of desire in that it both instils and facilitates the satisfaction of desires <sup>48</sup>(Foucault, 1976). Due to continuous ill health the child dies at an early age. However, as he represents both the embodiment and generative action of whakapapa, his identity as whangai is metaphysically embedded within subsequent narrations of whakapapa within the whānau and becomes temporally continuous.

I am sad that whangai is a tikanga that's not continued, practised regularly today because infertility or whare ngaro, or whatever; for whatever reason some of our women continue not to be able to conceive. It's nothing new; it's something that has been with us all the time in our whakapapa. Whangai...it is not as common... I think its things like DPB that have impacted on our ability to share children. Tamariki are coming into our lives maybe not necessarily for us, we may not be the best person to raise that child and there is always, always someone in the whakapapa who would dearly love to live with that child. So for myself that became a tikanga that I wished to re-establish for my generation, and so with our youngest son who came immediately after the twins. We, I was one of the fortunate fertile women and had in my life not experienced miscarriage but had experienced termination twice... before my twins. I believe that, and in speaking with other Māori women that, we would have had

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<sup>48</sup> Foucault (1976) suggests that "power and desire are joined to one another... where there is desire the power relation is already present" (p. 81). He characterises desire as productive and argues that as a technology of self it works to induce 'desires' in individuals which individuals then work to satisfy. Whangai is a productive technology of self that instils in Matipou's whānau, multiple desires in relation to identities, self esteem, health and wellbeing and social and cultural normality. In relation to the nature of desire, the researcher also acknowledges that philosopher Baruch or Benedictus de Spinoza (1632-1671) initially theorised desire as productive. However in contrast to Spinoza's perspective that all things proceed from necessity and nothing happens by chance or is contingent, within this thesis research analysis focuses on desire as contingent, and the application of desire as an applied technology of the 'self' and/or production. Spinoza, B. (1985). *Ethics. The Collected Writings of Spinoza, Volume 1* (E. Curley, Trans.). Princeton, NJ: Princeton University Press.

rongoa and ways of also being able to control that part of our fertility even though you might have people who disagree... I believe that we women have known in ourselves that the timing wasn't right or the conception wasn't going to be a good one, or being able to have some control over fertility through rongoa... But this knowledge and the decision is something that has been lost, so that it becomes very, you know, sort of a guilt ridden decision... and the Anglican Church sort of coming on top of our tikanga perhaps. That's my own personal belief I don't know whether that's based on fact but that's how I feel about it... Yeh you can send them straight back to you know, where they come from... And say you know the times not right I'm sorry...hoki atu kia ratou ma and come back when I'm able to..., to my mind. But that's one thing.

Matipou's story continues with whangai resituated in the present. Whangai is characterised as a temporally fluid tikanga and act of generosity that is not regularly practiced. Matipou hypothesizes that the Domestic Purposes Benefit<sup>49</sup> has resulted in a reduction in the number of families that support whangai and perhaps indirectly contributed to what is perceived nationally and internationally as a high rate of teenage pregnancy per capita (Lawlor & Shaw, 2004). Her theory is given credit by Lemert (1998) who in stating "social theory is something done necessarily, and often well, by people with no particular professional credential" (p. 1), infers that people, whether lay or professional, are expert theorists in relation to their own lives and cultures.

Matipou re-situates whangai within a contemporary setting as simultaneously a rongoa (healing treatment) for unplanned and unwanted children and practice for building self esteem; as a 'technology of the self' (Foucault, 1988a). Her determination to reintroduce whangai as a practice in her whānau may be construed as attempting to re-establish a culturally safe foundation for the future generations of her whānau. Therefore for Matipou, whangai constitutes agency. However, her ability to enact whangai as agency is challenged by what she perceives as the loss of knowledge in relation to rongoa linked with guilt instilled by Christian values that have been introduced through the process of colonisation. Mikaere (2003) suggests that the notion of Māori women as valued repositories of knowledge challenged the normalisation of hegemonic masculinity as introduced by Europeans (p. 110) and

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<sup>49</sup> The Domestic Purpose's Benefit is a social support payment instituted by the New Zealand government and issued to custodial parents whose annual net income has been subjected to state scrutiny and characterised as inadequate to provide the necessities of life for their children.

resulted in sociocultural suppression through legislation.<sup>50</sup> The suppression of knowledge in relation to childbirth resulted in the loss of birthing experts or midwives for entire families as was the case in Dr Irihapeti Ramsden's<sup>51</sup> family (Macdonald, Penfold, & Williams, 1991, p. 240).

Matipou's personal and cultural experiences and values shape her belief that miscarriages and/or terminations are stories about birth. She situates her two terminations of pregnancy in relation to the birth of her twins. European discourses that assigned guilt or blame to such practices are silenced through presenting cultural stories that situate childbearing women and/ children as unconstrained agents that may both exercise agency in relation to birth. Her story suggests that Māori women may choose to send their babies back to where they have come from<sup>52</sup> without social stigmatization, and/or that Māori babies may decide to 'leave' and potentially be reborn at a later date. The notion that foetal agency may be a cross-cultural belief is also suggested in the following excerpts from Kahatea's and Totara's stories.

**Kahatea:** My husband really reckons that our other little spirits (miscarriages) have actually were actually were just coming testing us out, and that (whispers) she's come back again through our daughter.

**Totara:** I was so cross that this child had rejected me... this little person..., obviously that's all the journey he wanted to make...

In contrast, Matipou's meta-story continues with a discussion of her last pregnancy, in which the relationship of maternal agency to continued childbearing and the practice of whangai is considered.

So, then when that next one came and also at a specific time when I thought I wasn't going to be able to give him..., the welcome to the world that he deserved. Started to think right we'll need that whangai. I am going to... You know I'm going to let my

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<sup>50</sup> Eurocentric control of childbirth began with the Midwives Act of 1904 when it became illegal to practice as a midwife without appropriate certification from a physician. European control was consolidated under the Tohunga Suppression Act (1907). Tohunga found guilty of contravening this legislation were imprisoned, so with the exception of a few isolated communities, the active involvement of Tohunga in childbirth was curtailed within the early part of the 20<sup>th</sup> century.

<sup>51</sup> Dr Irihapeti Ramsden is remembered as a staunch advocate for respecting and valuing cultural difference, and a foundation scholar in the field of cultural safety within health care.

<sup>52</sup> I propose that whakapapa as the relational link between man and creation, locates these unborn children within a metaphysical setting. Māori epistemology locates creation as beginning with Te Kore. Although often translated as meaning nothingness as being "the void" (Buck, 1949, p 434), Marsden (1992) proposes an alternative framing and suggests that as the interface between "non-being and being" where the "seed stuff of the universe and all created things gestate" (p. 134), Te Kore constitutes a space of limitless potential.

daughter know that unplanned pregnancy doesn't have to be a termination you can... Because I LOVE being hapu and I LOVE giving birth, but you know the responsibility of raising another child sometimes, hasn't, isn't with me. And I believe that he came through..., through me to go to the whānau that he is with. So he is growing up there... Yes right from early it was, it was all negotiated beforehand and..., he knows us. Oh yes, open adoption, open whangai, and a homebirth within their home and he was received straight into his whangai papa's arms, and it was an awesome experience and you know there were some in my whānau that didn't wholly agree, that you know that couldn't come to terms with it, but it has been accepted over time. And um yeh, he knows who we are and we know that he knows the circumstances of his birth. He is 10 years old now so..., and he knows all his whakapapa and whangai in his particular family that he is with..., has been intergenerational. His father was bought up by Grandparents; his grandfather was bought up by grandparents so whangai have a really treasured role in that whānau. And all of us are connected by whakapapa... It's not as common but whangai is not going away... But you know there's a lot of infertility amongst our whānau too, and it's heartbreaking... And yeh I know lots of kuia who have raised seven, eight or more tamariki, and they were all whangai. You know you're not sort of seeing that kind of sharing as much so that whakapapa is always welcomed and as it the baby comes into Te Ao Marama, and there is somebody you know... Maybe you don't need to think about a termination because if we continue to welcome them there is always somebody who will be overjoyed...

Matipou's son is positioned prior to birth as a gift to be cherished by the extended whānau. There is no stigmatisation associated with adoptive status because within Te Ao Māori (the Māori world), whangai children have traditionally been considered as particularly fortunate, regarded as special, and cherished (Pere, 1982). Some children are selected as whangai on the basis of their whakapapa or their potentially inherited talents (Stirling & Salmond, 1980). In suggesting that she will show her daughter 'another way' embrace childbearing, Matipou also constitutes whangai as a 'hybrid actor' (Latour, 1993, 1999) that combines time, embodiment and tikanga (cultural traditions) in order to translate whakapapa values to the next generation.

Within Matipou's whānau the process of whangai is carefully orchestrated in accordance with tikanga. Matipou's son is birthed within his future home environment, and immediately embraced by his whangai father as would be the case in a birth where his biological father welcomed him. Matipou's ontological story of whangai, infers that within the extended kinship structure of whakapapa, all Māori children have multiple family homes.

In contrast, Mikaere (1994) suggests that within Aotearoa, New Zealand at the beginning of the 20<sup>th</sup> century, a legislative trend emerged that has subsequently continued; considering children as property for which adoptive parental ownership could be substituted for biological parental ownership. This perspective has been challenged by the continuous perspective of Te Ao Māori that children are not property (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988, p. 23). Matipou supports her son's absolute right to know his whakapapa and comprehensively informs him about his genealogy; acknowledging his autonomy. She signals that the child remains a child of the whānau and that his whangai family with whom he resides have no right of ownership, nor are they a substitute for his actual parents. In locating her son in a family where whangai constitutes the whakapapa, she ensures, despite the absence of intergenerational biological connection, that his identity is 'normalised' rather than 'othered' (Weis, 1995), by and within the whānau setting.

### **Whakapapa: Actant and Technology**

The multiple conceptualisations of whangai as rongoa (healing), whakapapa and technology, suggest that within the story whakapapa may operate within metaphysical, and corporeal settings as a temporally fluid technology. Matipou's discussion of whakapapa as a self healing and self governing entity infers that whakapapa may be characterised as a constructive technology that is involved in a perpetual and intergenerational process of defining, constituting and/or transforming itself; more specifically as a technology of the 'self' (Foucault, 1988b). In that whakapapa is simultaneously conceptualised as a dynamic, and mutually constituted but unfinalised relationship of inherently heterogeneous metaphysical, corporeal and embodied elements, it may also be construed as an actor network<sup>53</sup> (Callon, 1987 [p. 93]; Latour, 1993, 1999). Latour (1999) suggests that actants and/or hybrid actors may be actively engaged with folding<sup>54</sup> time and space. The following narrative excerpt commences with Matipou alluding to whakapapa operating as a narrative actant that translates tikanga, storied by her grandmother as being situated in a past temporal and contextual setting, into the present.

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<sup>53</sup> Callon (1987) defines an actor network as "simultaneously an actor or entity whose activity is networking heterogeneous elements and a network that is able to redefine and transform what it is made of" (p. 93).

<sup>54</sup> Latour's concept of folding may be explained in relation to a map; which is a way of visualizing space, but is also the result of a series of historical settlements regarding the drawing of boundaries and naming of places. For example, a map enables the *folding* of regional spaces onto a single piece of paper that is able to be transported (through time and space) and read.

Yeh..., these are things; tikanga that my grandmother made me aware of. And she um, so she would always say you know ‘Miscarriages, stillbirths and things like that DO happen’, when I was taking up this role as a midwife. ‘That there’s no guarantee of a perfect pregnancy’ And that’s the sort of thing that she would say which has helped me through some difficult times, in some birthing experiences that I’ve had as a midwife. Just helped me to understand. Yeh and to be grateful for some things like you know she would say things like ‘Was that baby born complete you know. (Spoken quietly) It didn’t break into pieces did it?’ and (whispered) some things that I’ve thought of but I hadn’t been able to say aloud to anybody, other things.., yo:::u know!(1+) So that was something to be grateful for. And she would say ‘Oh that’s good, my mother would... tell me.., stories”. (Spoken quietly) I think things were really, really awful for them and you know? The baby came out not complete, and all those sorts of things. And also like with, in recent times she said, there were some of our whānau she told me that wanted full tangihanga for some of these miscarried babies or stillborn, and she didn’t like that idea and in her time it was that the baby would be buried before the sun came up, very quickly!...I don’t know why, but I mean, in those times there were always plenty of live tamariki to be concerned about, to be thinking of and looking after and yeh as sad as it was it was te mate tonu, the old people were always there and would generally..., take care of them, make recommendations. And so to my grandmother it was unusual, it didn’t sit right with her to sort of see these babies have two, three day tangihanga. You know to her that wasn’t something..., that wasn’t tikanga. Although she supported them in the same way, she would sit with them and talk with them at the time... I’ve always taken my kuia’s korero with me throughout my midwifery work and developed it into a birthing wananga(learning forum) that I’ve been able to facilitate at different times, and it is awesome because wananga would ko huri haere te whare (welcome the extended family) and everybody would have the opportunity to share knowledge, experiences, that they’d had, no matter what it was, and often times we would get stories of miscarriage and then there it would become, there would be..., a time to fully express the loss. Sometimes I’d start off... (2+)<sup>55</sup> allow that space that time for that kind of korero to come out. Tears you know... ka heke roimata (crying) and an acknowledgement of every birth, counting as a birth experience, and getting a time to just share it and being surprised that most of the women would have experienced it too, so that there was an opportunity to not be so isolated in their experiences and we at the wananga make um, an ipu whenua yep, and talk about that they were ipu whenua but also that they may be used as vessels for sometimes terminations or miscarriages or you know opportunities to create something, a taonga to, to receive and to return to papatuanuku that which should rightfully go back as acknowledgement.

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<sup>55</sup> (2+) the numerical designation and + sign are conversational annotations that indicate the length of an extended pause in conversation.

Matipou frames her Grandmother's storying of whakapapa as enabling through drawing on the whakapapa stories as both a source of knowledge about childbirth for informing her midwifery practice and as a form of psycho-social and emotional support. Some aspects of whakapapa are acknowledged as disturbing and Matipou is unable to draw on these aspects to further professional development. Within the story Matipou's storied silences (thoughts that may not be said 'aloud'), and corporeal silences, due to physical silencing of tone when narrating the story of her grandmother and great grandmother's experiences draw attention to the constraining of agency. For example, Matipou speaks quietly about babies not being born complete and 'other things..., yo::u know!'<sup>56</sup> Matipou's tonal inflections allude to myself as listener being positioned as knowledgeable about those 'other things' that may not be spoken 'aloud'. It is suggested that due to the contextual and temporal settings within which Matipou's great grandmother and grandmother experienced childbearing, foetal dismemberment during miscarriage, stillbirth and/or obstructed childbirth may not have been accidental (Louden, 1992, p. 130)<sup>57</sup>.

In drawing on her Grandmother's whakapapa story and her embodied whakapapa to constitute her self as a midwifery practitioner and her professional practice, Matipou uses whakapapa as a metaphysical and corporeal technology of the self. Whakapapa also operates as both narrative and corporeal (through embodiment) actant or hybrid actor, shaping Matipou's practice beliefs and professional interactions and situating her as practitioner in relation to other actors, and within various professional, social, temporal and whānau settings. As Matipou's professional identity and midwifery practice are reciprocally shaped by and relationally embedded within diverse settings including genealogy, Matipou may be perceived as simultaneously embodying whakapapa as actor and an actor network<sup>58</sup>.

In remarking on the value of her Grandmother's stories in shaping her professional identity and midwifery practice, Matipou draws attention to how whakapapa enables and constrains professional agency. Matipou's embodied whakapapa gives her cultural

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<sup>56</sup> (::: ) is a lexical convention used in conversational analysis to indicate the tonal lengthening of a word.

<sup>57</sup> Loudon (1992), in his book *Death in Childbirth: An international study of maternal care and maternal mortality: 1800 – 1950*; discusses the common usage, and plethora, of tools that were mentioned in 19<sup>th</sup> century and early 20<sup>th</sup> century surgical texts such as “perforators, craniotomy forceps, cranioclasts, and cephalotribs, and other instruments used to lessen the size of babies”(p 130) and suggests that their utilisation during surgical interventions resulted in unnecessary maternal and foetal deaths.

<sup>58</sup> Matipou simultaneously embodies whakapapa or genealogy as an individual actor and/or relational entity and an actor network in that she is the embodiment of the heterogeneous ira tangata (genetic essence) and therefore collective generations of whānau that have preceded her. In being constituted by and constituting whakapapa, she may be construed as both actor and actor network.

access to, and social authority regarding metaphysical whakapapa in storied form. Transforming metaphysical whakapapa constructed as tikanga into a contextually related wananga or forum for learning, enables Matipou as a practitioner, and potentially her clients and their whānau (families). The wananga is geographically located in order to provide contextually relevant, physical and intimate space for whānau who have experienced miscarriage to meet, acknowledge and share whakapapa as knowledge, express their losses, and provide reciprocal support for each other. Matipou's application of whakapapa as a technology encourages the 'voicing' rather than the silencing of experiences within the wananga. Clients and their families create a genealogy of miscarriage stories that are re-contextualised as birth stories, and therefore re-conceptualised as whakapapa. The characterisation of miscarriage stories as valuable, potentially nullifies social stigmatisation and/or apportioning of blame that may arise due to cultural beliefs about, and the value associated with, fertility.

### **Whakapapa, Tikanga and Change**

Conceptualisations of tikanga compete for validity within Matipou's meta-story. Matipou's grandmother presents tikanga as contextually finalised regardless of temporality. Her story suggests that the tikanga associated with miscarriage is that miscarried babies are to be buried before sunrise. Matipou is unaware of the rationale for the tikanga and speculates that as her grandmother indicated, there were a large number of live children situated within that temporal setting, the children may have required attention during the day. An alternative reading of the rationale for the tikanga takes the temporal and contextual settings in which Matipou's grandmother experienced miscarriage, into account. One possibility is that tikanga was deliberately practised at night as a strategy for keeping both the presence of tohunga and practices hidden in order to protect tohunga who officiated at bereavement rituals and who would have been liable for imprisonment when such professions and practices were made illegal.<sup>59</sup> The legislated suppression of cultural knowledge and practices

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<sup>59</sup> Prior to the 20<sup>th</sup> century, highly skilled tohunga of either gender performed cultural practices including facilitating childbirth. The Midwives Act (1904) made it illegal to practice as a midwife without appropriate certification from a physician. With the passing of the Tohunga Suppression Act (1907), tohunga were outlawed. Practitioners caught contravening the legislation were imprisoned, and with a few exceptions in rural and predominantly Māori communities, the involvement of tohunga in childbirth and birth related rituals was curtailed. The Tohunga Suppression Act (only repealed in 1962) resulted in the radical and permanent loss of mātauranga (knowledge) and tikanga (cultural practices) associated with childbirth.

(Mikaere, 2003; Smith, 1999b) may also explain Matipou's lack of knowledge regarding tikanga.<sup>60</sup>

Matipou's grandmother views contemporary burial practices where families require a three day tangi for miscarried or stillborn babies, as a breach of tikanga. However, it may be argued that colonisation has operated as a technology that has radically altered Te Ao Māori and the contextual situation of Māori. Prior to colonisation a hierarchical class system that was constituted by whakapapa, governed social interaction amongst Māori. Post colonisation the class system has to a degree been displaced or bracketed out by Government sponsored assimilation policies (Mikaere, 2003). More recently, Mason Durie (1998) has suggested that contemporary Māori have progressively and collectively been constructed under the umbrella of a "pan-Māori" (p. 54) identity, which erroneously implies a degree of "homogeneity" (Durie, M., 1998, p. 53). Mead (2003) also argues for valuing and respecting difference, and suggests that "te moenga rangatira"<sup>61</sup> (p. 38) may still have validity in the modern world.

Regardless of debate regarding the constitution of identity and the significance of whakapapa, colonisation has influenced Māori social structures through altering Māori worldviews (Bell, 2004; Jackson 2007; Smith, 1999b) and resulted in the destabilization of the contextual setting in which Māori are embedded. Such changes have subsequently transformed the types of capital, and ways in which various forms of capital may be constituted, assumed by, or assigned to, an individual or whānau (Poata-Smith, 2004). For example, it has been proposed that there is a growing demographic of Māori academic elite (Cunningham, 2008). In that Māori identities, worldviews, and therefore values, beliefs and practices have become fluid, dynamic, debated and unfinished, and the contextual situation has become destabilized, the contemporary world of Māori may constitute what Callon (1998) refers to as a hot situation. Callon (1998) suggests that in "hot situations everything becomes controversial" and that "controversies indicate the absence of a stabilized knowledge base" (p. 260). It may be inferred from Matipou's story that contextual destabilization has resulted in the loss of cultural, professional and whānau knowledge, Māori midwives' inability to provide care and women's inability to express care/care

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<sup>60</sup> There may also be reasons associated with Māori spirituality "that the baby would be buried quickly." However, it would be culturally inappropriate and a breach of tikanga, for the researcher to address these matters further in this thesis.

<sup>61</sup> I translate 'te moenga rangatira' to mean - the chiefly marriage bed and as reference to whakapapa that derives from Māori nobility.

provider preferences. It could therefore be argued that contextual destabilisation is a constraint on agency. Such a loss of both knowledge and personal and professional agency may subsequently disrupt the translation of whakapapa from one temporal and/or spatial setting to another.

Translating whakapapa from one setting to another is influenced by ‘inscriptions’<sup>62</sup>(Akrich, 1992; Akrich & Latour, 1992); artefacts that shape the means by which heterogeneous elements are translated. In Matipou’s story externalities, indirectly introduced through colonisation, have shaped the translation of whakapapa and may be construed as inscriptions. For example, legislation and ultrasound scans influence how whakapapa is translated through time and space. As ultrasound reports story the clinical “gaze” of medicine and subsequently ‘diagnose’ gestation, and facilitate legislation that determines foetal viability these artefacts may constitute both inscriptions and translations. Collectively, such elements facilitate the construction and shaping of human identity. Whakapapa is constructed as contingent and may be silenced. Tikanga derived from whakapapa in addition to being translated from the past to the present, may also have become contemporaneously dynamic and unfinalised; perpetually responsive to the changing contextual situation and translated in new ways. It is possible that in requesting three day tangihanga for miscarried and stillborn babies, whānau are expressing a desire to have whakapapa acknowledged.

Acknowledgment of whakapapa at the individual level is apparent in Matipou’s story. Despite reservations about tikanga, Matipou’s grandmother remarks that in ‘her time’ which may be interpreted as meaning her childbearing years ‘Old people’ are represented as sitting with “them” and ‘talking to them.’ The ‘them’ that are referred to are the deceased babies. The tikanga of being, and communing, with the wairua (soul, spirit) of the deceased may be part of Māori burial rituals (Mead, 2003).<sup>63</sup> Matipou’s grandmother infers that, during her childbearing years, whānau, in enacting this tikanga, acknowledged both whakapapa and the child as a permanent member of the whānau (family). The recognition of miscarried children as continuous family members is also a cross-cultural practise. In Kahatea’s story, her miscarried children

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<sup>62</sup> Inscription may be interpreted as embodying patterns of usage; the way in which "Technical objects..., simultaneously embody and measure a set of relations between heterogeneous elements" (Akrich 1992, p. 205).

<sup>63</sup> For a more in depth exploration of burial rituals, and communicating with the deceased, the researcher refers readers to Mead, H. M. (2003). Chapter 8: tangihanga, Ceremonies of the dead, specifically (pp. 147-148) in *Tikanga Māori Living by Māori Values*.

are buried under a daphne bush, but as her story demonstrates their involvement within the family does not end with burial.

**Kahatea:** When we had our daughter's christening, we had it outside here, and we had the Daphne plant as part of the ceremony, so that our other babies... could be there.

Social acknowledgement of whakapapa in general is important. In the following nested narrative, Matipou is self positioned as both whānaunga (relative) and health professional.

And one of my whānau, I have had some times with... Um, she had had a family..., and then a new relationship after this family that she already had. And she dearly loved this new man, and he had one child but anyway they were keen to have children. And she just had miscarriage after miscarriage after miscarriage and it was devastating and she couldn't understand how or why... And there was no answer to that. So at one time I encouraged her to make an ipu whenua, actually I had an ipu whenua to give to her for the baby that had died and said 'oh well, what is going to happen?' They had agreed for the products of conception to go to the hospital to help them to hopefully find some answers as to why these (miscarriages) kept going on. And I said 'Right did you ask for everything to be returned to you?' and she said 'Yes we did!' And so, they weren't sure what they would receive but they were prepared because she made it perfectly clear to them that she wanted EVERYTHING back, too, you know fluids, whatever. So I said 'OH well this (ipu whenua) is nice and big, and you can line it as I said with moss, or whatever and have this taonga to inter your baby.' And she and her tane went to the hospital together to collect the baby, and were absolutely HORRIFIED when they gave them a laboratory slide..... Just a laboratory slide with..., I don't know pieces of tissue smeared on it I suppose; and that is what they got. And so she came back in tears about that... (2+) that's what they were doing..., but .., that's not so long ago either. So..., she had several experiences like that, and at the time I was also painting these kohatu (shows interviewer a kohatu with a finely painted picture depicting an unborn child with umbilical cord and placenta). I gave them to her so she would have a basket of kohatu. And each one of these miscarriages that she had, she would say I need another kohatu. And she ended up with about seven. She's got seven little children represented.... I think it might even have been more. And they finally did conceive and had a lovely little girl and then more miscarriages after that, and then believe it or not, she got really high blood pressure, dangerously high blood pressure. Non-smoker, healthy and then she conceived triplets! (2+) And she held on to them! YEP! I mean she was into her forties by then... But it was the right time! Right place! Right space! So they, those lost babies all came back Yeh! You know it was a really frightening and difficult time. I mean she had to go into tertiary care up to (Names city), and was on

bed rest but the triplets are about five years old now I believe. So that was one experience... You know she's got different kohatu, and all of them are included. You know you had to include all of the other babies she has had.

In locating her professional care within whānau, Matipou constructs herself as a relational actor embedded within, and co-creator of whakapapa as, an actor network. Her relative's 'devastating' experience of repeated miscarriage is construed as a contemporary example of the whakapapa of miscarriage that is embedded within the whānau. In translating miscarriage from the past to the present, the nested narrative of Matipou's grandmother is resituated in a contemporary world. Matipou is multiply positioned within the translated story; like her grandmother as a culturally situated care provider and mother but also as a contemporary midwife in professional practice.<sup>64</sup> The narrative is presented as multi-layered containing multiple worlds such as Te Ao Māori, contemporary Aotearoa, New Zealand and various professional, social and cultural worldviews. Matipou's story demonstrates that both the meta-story and actors such as Matipou and her grandmother embedded within the story are relationally co-constitutive and situated across multiple temporalities. The various relational interactions of the heterogeneous elements allude to the storying of whakapapa as a trans-temporal, trans-historical, trans-cultural and never finalised actor network.

Within Matipou's story, miscarriage may be constructed as both a moment in the translation, and a heterogeneous element that is co-constitutive, of whakapapa. Finding reasons for such losses is important for whānau. Contextually specific research (Liddell, Pattison & Zanderigo, 1991) infers some miscarriages are unable to be explained. However, public and disciplinary narratives suggest that science should have an all inclusive answer. The lack of rationale for the repeated miscarriages is significant within the Aotearoa, New Zealand context as it may constitute an exemplar of the 'hot' situation. Doctors, whānau members and other care providers are required as "calculative agents" (Callon, 1998, p. 261) to make decisions in relation to a destabilized knowledge base. Medical texts (Beischer, Mackay & Colditz, 1997) characterise miscarriages subjectively with linguistic labels such as "sirenomelus-

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<sup>64</sup> Matipou is a mature Māori woman from a particular whakapapa line, who is both a culturally knowledgeable insider and a mother past her childbearing years. Therefore within Te Ao Māori, she has a whakapapa based obligation to provide culturally based birthing support to younger childbearing women. In contrast, as a registered midwife her obligations as a health practitioner arise solely from the professional and ethical competencies that are the legal requirements associated with midwifery practice in Aotearoa, New Zealand.

mermaid” (Colour plate 8) “hydatiform mole” (p. 192), “blighted ovum” (p. 166), and “products of conception” (p. 179), in order to assign object classification. The use of such terms alludes to diagnosis being based on subjecting reproductive aberrations to the clinical and diagnostic gaze, which Foucault (1963,) describes as “the eye that knows, and decides, the eye that governs” (p. 89).

### **Institutions, Technologies and Risk**

In an attempt to discover the reason for the miscarriages Matipou’s client has allowed the hospital to retain the deceased baby for examination. Matipou uses the terms ‘baby’ and products of conception interchangeably. The deceased child becomes a ‘human’ baby when constructed as whakapapa and situated in relation to family. However, Matipou draws on the linguistic vocabulary of medicine and labels the child as non-human; as “products of conception”, when discursively positioning the baby in relation to the hospital. In construing the child as both subject and object, Matipou demonstrates how family and institutional settings may shape the narrative construction of whakapapa.

The institution’s construction and interpretation of whakapapa within governance policies is evident in the response to the whānau by hospital staff. The whānau request that the entirety of the deceased child is returned to them as is required by tikanga (cultural tradition), but they receive back a single laboratory slide. The laboratory slide acts as both hybrid actor and technological artefact. The slide is a hybrid in that it is constituted from inorganic and organic material. Moreover, the organic elements are conceptualised by the whānau as metaphysically human (a baby) and therefore associated with an identity. The slide therefore constitutes a hybrid actor. The slide also acts as an actor in that it represents medicine’s calculating gaze (Foucault, 1963, p. 89). Through laboratory scrutiny, the slide signifies the deceased baby as objective product and therefore non-human. The slide operates as a technological artefact in that it may be perceived as folding times and spaces. For example, the temporalities of creation (the slide is constructed from mineral deposits that developed when the planet was formed), the manufacturing process to create glass, and years of use in the hospital <sup>65</sup>(Latour, 2002). The temporalities associated with construction and usage of

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<sup>65</sup> Latour (2002) states “The hammer I find on my workbench is not contemporary to my action today: it keeps folded heterogeneous temporalities, one of which has the antiquity of the planet, because of the mineral from which it has been moulded, while another has the age of the oak that provided the handle, while still another has the age of the 10 years since it came out of the German factory which produced it for the market (p. 249). Within this thesis through drawing on Latour’s conceptualisation of a hammer, the laboratory slide is interpreted in an analogous manner.

the slide, are sequentially embedded within the slide and as such act as a material record of movement from one temporality to another.

In the same way, the slide also folds heterogeneous spaces such as the sand dune from which its base elements were collected, the factory where it was manufactured, and the hospital laboratory where it was used on a daily basis. The hybrid nature of the slide also facilitates the folding of bodies and identities through space and time, such as whakapapa and identity. In Matipou's story, as whakapapa and identity are embodied in the deceased child, they are also inscribed on the laboratory slide and therefore successive generations of whakapapa including the baby are made temporally and spatially mobile.

The response of hospital staff members to the family's request is epitomized in the laboratory slide, which is perceived by the family as horrifying, disrespectful, a breach of their trust and as representing the destruction of identity and whakapapa. In addition to being devastating for the whānau, the actions of hospital staff have broader social implications for the local Māori community<sup>66</sup> in which the whānau resides, because as Matipou notes that what has occurred is both a recent, and not an isolated, event.

In contrast to hospital staff's positioning of the baby as non-human, Matipou reinforces her acknowledgement of whakapapa by interweaving her multi-conceptualisations of the baby with a consistent reference to ipu whenua (vessels for containing placentas). Ipu whenua, like the aforementioned laboratory slide, represent what Latour may characterise as a technological artefact that may fold<sup>67</sup> metaphysical elements such as time and space. Ipu whenua are moulded from the earth and may fold temporalities such as the genesis of the planet, time spent in a kiln, and the period since manufacture. Similarly, it may fold spaces such as the clay bank, the kiln, the burial location. However, with reference to Māori cosmology, specifically the genesis

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<sup>66</sup> A Māori ontological perspective may locate an individual's wairua or soul in relation to the integrity of their body. Disruption to a deceased person's body may have spiritual ramifications.

<sup>67</sup> Ipu whenua is located in conventional linear time (the present) and at the same time it enables the folding of time and space through tikanga. Latour's concept of folding is represented by the ipu whenua which acts as an archive for the conservation and representation of whakapapa, that establishes a 'reversible route' (Serres & Latour, 1995) enabling simultaneous movement backwards and forwards through space and time of te ira tangata (original genetic essence) between te kore (the void) and Te Ao Mārama (the world of light). The ipu whenua acts as a bridging device between te kore (the void), Te Ao Mārama, whakapapa, whānau and te pepe mate (the deceased baby). The ipu whenua is an instrument of visualization that enables the translation and combination of elements associated with tikanga. The absence and/or presence of bodies and identities, is possible through these reversible temporal and spatial relationships.

of humanity with *hineahuone*<sup>68</sup> (Marsden, 1992), the multiple meanings associated with ‘whenua’ may present *ipu whenua* as our *whakapapa* link to the earth mother *Papatuanuku*, and therefore *ipu whenua* may fold bodies and identities that are construed as *whakapapa* both metaphysically and corporeally through space and time.

*Matipou* provides her relative with a number of *kōhatu* (stones), one for each miscarried child. In that they are constituted out of earth, *ngā kōhatu* (stones) may also operate as artefacts in a similar manner. Each stone is painted with a depiction of an unborn baby, placenta and umbilical cord. Therefore although debatable, it is possible that the *kōhatu* (stones) viewed through a Māori worldview as constituting *whakapapa* are inscribed in a similar manner to bodies<sup>69</sup> (Groz, 1994). As the visual rendition of the baby may be perceived as both sign and signifier, and as the depiction is painted by the *whānau* midwife it may also be argued that the *kōhatu* (stones) simultaneously constitute inscribed bodies that embody *whakapapa* as well as inscriptions and translations of, *whakapapa*.<sup>70</sup> By suggesting that the stones are collectively placed in a basket, *Matipou* acknowledges that the babies constitute both trans-temporal *whakapapa* and members of the *whānau*. In addition to metaphysically and materially constituting *whakapapa*, *kōhatu* (stones), depending on the space where they are situated and how they are placed, may also have significance as providers of spiritual protection for *whakapapa* (McClintock, 2003). However, within *Matipou*’s story, the location of the basket within the *whānau* home is not stated.

The nested story culminates with the birth of *whakapapa* embedded within and as a response to the temporal and geographical setting. *Matipou* frames the live births particularly of triplets as extraordinary due to risk factors such as maternal age and high blood pressure, which were associated with the pregnancy. Physical separation from *whānau* during pregnancy is constructed as a potential risk to the maintenance of *whakapapa*, because in transferring *Matipou*’s relative to tertiary care, she is removed

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<sup>68</sup> *Hineahuone* the first human was formed out of, and emerged from, the earth, the primary progenitor for Māori. (Marsden, 1992, Marsden & Henare, 2003).

<sup>69</sup> “The body is the inscribed surface of events (traced by language and dissolved by ideas), the locus of a dissociated Self (adopting the illusion of a substantial unity), and a volume in perpetual disintegration. Genealogy, as an analysis of descent, is thus situated within the articulation of the body and history” (Foucault, 1984, p. 82).

<sup>70</sup> Within *Te Ao Māori*, *kōhatu* due to their genealogical relationship to *hineahuone* the first human woman made out of earth, may be interpreted as being both metaphysically and corporeally the genealogical ancestor of all humans, and therefore *kōhatu* may be construed as organic human bodies as well as artefacts which in being painted are acted on or inscribed. Such inscribed stones are often perceived as being vested with the *ahua* (spiritual essence) of spiritually powerful ancestors and therefore the stones may be theorised within *Te Ao Māori* as sources of power and protection in their own right.

from all physical and metaphysical forms of whakapapa such as whānau (family) and turangawaewae (place where the feet may stand, home)<sup>71</sup>. The woman is subsequently positioned as experiencing her pregnancy in a “dangerous and frightening” setting, although her pregnancy culminates with the live birth of her triplets.

In stating that ‘those lost babies all came back’, Matipou like Kahatea’s husband, draws on her metaphysical, corporeal and embodied experiences of whakapapa to construct the newborn babies as the rebirth of whakapapa. In re-conceptualising her relative’s daughter and triplets as the previously miscarried babies, she infers a degree of similarity between her cultural beliefs associated with, and embodied experience of, giving birth to twins. In the story the relative’s children are construed as having resulted from births that occurred in ‘the right time! Right place! Right space!’ Through categorising the temporal, physical and social settings as ‘right’, Matipou draws attention to the moral correctness of the births. Her story suggests that she may also perceive such births as the embodiment of morality and potentially position miscarriages as conceptions that have been situated in the ‘wrong’ temporalities and/or settings.

In the nested story, Matipou’ outlines some genealogical and physiological risk factors that may complicate her relative’s experiences of pregnancy and childbirth. Social risk factors may also impact on the construction of childbearing women’s identity and experiences in relation to pregnancy and childbirth.

Just lately there have been a couple..., of first trimester miscarriages with different women who were high risk. She (the previous actor woman) had her own risk factors but these two that I’m thinking about now were subjected to really severe sexual abuse in their lives and had had more than one miscarriage, and also had been solvent and alcohol abusers and you know other things..., but you know..., they were Hoping! Hoping with each birth being a new beginning, a new beginning and a new promise and an opportunity to change and you know commit to this baby. And it’s been so sad because I’ve noticed this rohe (area, region) where I’m working now it’s like ‘Oh well you need to go to A&E, and they’ll look after you... There is a space there in A&E for midwives to sit and stay with women, and most of us do provide that support but you know generally what women are told by maternity is, to front up to A&E and be admitted, and be seen by Obstetricians... Start some sort of intervention, and maybe things will continue. But usually they’ll start you on misoprostol, (names hospital), and that’s whether the

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<sup>71</sup> In this thesis, turangawaewae is interpreted as meaning the geographical, metaphysical and spiritual space from which, or to which, an individual derives relational connection through whakapapa.

woman wants it or not (1+)... Yes... It's becoming the standard normal practice up here and it's quite shocking, because misoprostol is administered (2+, speaks very quietly), sometimes P.R. (per rectum) and sometimes P.V. (per vagina)... (Still speaking quietly) There is no oral administration where women can..., they could administrate it themselves. (2+) No, not really. (1+) (Whispers) I wish some people were ok with that but..., it's not policy.

The women in Matipou's story share a history of severe sexual abuse, solvent and alcohol abuse and "other things." Although not explicitly stated "other things" in being linked to solvent and alcohol abuse, substances that are toxic, addictive, and which may produce mind altering effects, may infer that the women are also using illicit drugs.

Matipou perceives her relative as *having* "risk factors" that impact on her childbearing experience. However, she constructs the women in this nested story as "high risk". Characterising individuals as 'high risk' may infer that individual's identities, bodies, and behaviours, do not conform to social norms. Positioning individuals as non conformist or socially aberrant within social, familial and health settings infers they may be a threat to social order. Such individuals are often socially marginalised or "othered" (Weis, 1995) or stigmatised (Goffman, 1963). Deliberate marginalisation or othering of women through potentially constructing negative stereotypic identities such as high risk may "dissolve the notion of subject or a concrete individual" (Castel, 1991, p. 281). The deconstruction of identity subsequently impacts on the accessibility of individualised care within health care settings. In prefacing her nested story with the women's social history, Matipou alludes to marginalisation acting as a technology of domination to constrain women's agency in relation to accessing care providers and care interventions.

### **Governmentality and Medicine's Gaze**

In contrast to her positioning of both women as socially aberrant, Matipou perceives the women's desire and attempts to become pregnant, and eventually parents, as 'being normal' within the Māori community and as efforts to change for the 'good'. Foucault characterises technologies of desire <sup>72</sup>(Foucault, 1976) and technologies of normalisation (Foucault, 1988b) as technologies of the 'self' (Foucault, 1988b) that are linked to the creation of productive bodies (Foucault, 1988b; Sawicki, 1991). For the

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<sup>72</sup> With reference to footnote 15, where the researcher comments that drawing on the works of Foucault (1976) and Spinoza (as cited in Feldman, 1982) desire may be conceptualised as productive and contingent and the application of desire as a technology of the 'self' and or production.

women a desire for pregnancy and birth is productive in that it is potentially socially enabling, as evidenced in the recurrent theme of their hope for a ‘new beginning’. Successful childbirth is linked to a change in identity as the women are transformed from being “high risk” individuals to ‘mothers’, and subsequently to their level of mana (social prestige), because within Te Ao Māori, any individual who facilitates the maintenance of whakapapa accrues considerable social status (August, 2004; Mikaere, 2003).

Pregnancy and childbirth transform identities and bodies and require that women behave in new ways. For example, women’s conduct is shaped through their assumption of roles and responsibilities as nurturers, protectors and educators of their children. Matipou suggests that the women are conscious of this because they perceive childbearing as ‘an opportunity to change.’ The change in identities, bodies and behaviours may be construed as the interaction of technologies of desire, normalisation, and production in response to the exercising of disciplinary power in shaping what is perceived as socially normal. The women’s endeavours to create new beginnings may therefore be perceived as an exemplar of governmentality (Sawicki, 1991) through self governance.

In her story, Matipou, through focusing on the experiences of one of these women, provides an exemplar of how marginalised women may experience miscarriage related care in health institutions. She alludes to social and institutional structures, spaces and practices shaping and influencing how particular bodies are situated, and what behaviours are enacted within health settings. Institutional space is allotted for midwives to support women who experience miscarriage, but usage is nullified by the institution’s application of standard protocols; rules, procedures and techniques that are employed to facilitate the admission, assessment and treatment of patients. The use of institutional techniques may constitute the application of a technology of domination<sup>73</sup> (Foucault, 1977), as women are ‘told’ (by hospital staff), not asked or requested to come to A&E, and be admitted. “Domination is a particular type of power relationship that is stable, and hierarchical fixed, and difficult to reverse” (Lemke, 2002, p. 53). Within diverse settings a state of domination may result when power is exerted over individuals through surveillance (Foucault, 1977). Women need to be

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<sup>73</sup> Foucault characterises the term “domination” as referring to “what we ordinarily call power”, more particularly the unbalanced connections of power between individuals who are hierarchically situated in relation to one another and in which the “margin of liberty is extremely limited” for subordinated individuals (Foucault, 1988a, p. 19). As Lemke (2002) remarks “states of domination are the effects of technologies of government” (p. 53).

‘seen by the obstetrician’ or exposed to “the medical gaze..., of a doctor endowed with power of decision and intervention” (Foucault, 1963, p. 89). Within Matipou’s story, the disciplinary power exerted by medicine in addition to governing childbearing women, marginalises midwifery as a discipline and displaces midwives from their professional roles within the health institution.

The story highlights the tension between women seeking to become mothers in order to satisfy social norms of behaviour, and the response of the institution to the women’s desire for ‘normality’. Matipou’s use of qualifying adverbs such as ‘generally’ and ‘usually’ alludes to the commonality of health interactions and interventions received by women who experience miscarriage, regardless of circumstance, within the local health care setting. Characterising health services provision as “normal” suggests that in addition to potentially operating as a technology of domination, health interactions may simultaneously function as a technology of normalisation<sup>74</sup> (Foucault, 1988b) within the work setting.

In acknowledging that there is no choice of medication or route of administering the medication, Matipou infers that outside the localised health setting alternatives such as the administration of medicine by oral route, may be readily available, but does not address the rationale for the absence of local choice. The institution provides care to women in accordance with ‘standard..., practice’. A uniform approach to health care created through institutional hegemony may reflect disciplinary perceptions of women as homogeneous and subsequently facilitate the objectification and subjugation of women (Sawicki, 1991) within the health care setting. Matipou draws attention to how the institutional setting undermines women through subjecting them to invasive procedures that violate intimate parts of their body without consent. Invasive procedures conducted without consent potentially breach rights one to eight, and ten, of the Code of Health and Disability Services Consumers' Rights (Ministry of Health, 1996)<sup>75</sup> and under the Crimes Act (Ministry of Justice, 1961) may constitute physical

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<sup>74</sup> A norm is that which commonly occurs, is personally desirable and socially acceptable. Social norms are often considered the natural state of affairs and the cultural discourses that shape such norms go unquestioned. Those who wish to achieve normality and social acceptance employ technologies of the self to construct and shape their bodies, identities behaviours, and attributes in order to conform with, socially accepted codes of conduct. Foucault (1988b) conceptualises this specific process or technology of the self as normalisation.

<sup>75</sup> Section 2 of the HDC Code of Health and Disability Services Consumer’s Rights Regulation (1996) states that consumers have the following ten rights in relation to receiving health services, 1) Right to be Treated with Respect, 2) Right to Freedom from Discrimination, Coercion ,Harassment, and Exploitation, 3) Right to Dignity and Independence, 4) Right to Services of an Appropriate Standard, 5) Right to Effective Communication, ) Right to be Fully Informed, 7) Right to Make an Informed Choice and Give Informed Consent, 8) Right to Support, 9) Rights in Respect of Teaching or Research, 10) Right to Complain.

assault. Matipou finds the actions of care providers particularly difficult given her clients' histories of sexual abuse.

Matipou finds these practices problematic, as evidenced in her use of extended conversational and tonal silences whilst telling the story. Resistance to the institutional practices is not addressed in the story, suggesting that childbearing women, midwives and/or nurses may not directly challenge these practices. If this is the case it may be argued that women, midwives and nurses are complicit with the practice of institutional violence. Compliance with institutional protocols may demonstrate docility that is the end product of the exertion of disciplinary power (Foucault, 1977).

In stating 'it's not policy' Matipou alludes to policy acting as a form of governmentality. Challenges to the exercising of disciplinary power are not countenanced because hospital employees have become "docile bodies" (Foucault, 1977; Lemke, 2002). Their conduct is measured against institutional norms (Foucault, 1977) where differences are noted and categorised. However, in that power does not operate in a vacuum, Foucault (1976) suggests that "where there is power there is resistance" (p. 95); inferring that power is relationally enabled by resistance. Foucault (1980) therefore argues that "we're never trapped by power: it's always possible to modify its hold in determined conditions and following a precise strategy." (p. 13). As social fields (Bourdieu & Wacquant, 1992), or as in this case, medical arenas are relational, un-finalised and encompass multiple and diverse interactions, they involve the dynamic exchange and/or transfer of power on multiple levels. Therefore they are invariably sites of contention within which "free subjects<sup>76</sup>..., face a field of possibilities" (Sawicki, 1991, p. 25). In whispering her "wish" for change Matipou is aware that she is covertly resisting or challenging policy, and potentially limiting the degree to which she is putting herself at risk of marginalisation for not conforming to institutional norms.

Through sharing the preceding story of her clients' experiences, Matipou demonstrates how individual and collective identities and behaviours are shaped by metaphysical and material structures, spaces and settings and power relations. In the following nested narrative, Matipou draws attention to how this knowledge has informed and

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<sup>76</sup> Bearing in mind the agency/structure debate within the social sciences, and that the concept of 'free' subjects may be considered a contradiction due to the perpetual existence of elements that constrain to some degree, identities, bodies, discourses, and behaviours. Within this thesis, freedom is interpreted as contingent; the degree, to which a subject has the possibility of, and/or ability to resist the imposition of power relations (Foucault, 1982, p. 790).

shaped her midwifery practice in relation to supporting childbearing clients within particular health settings.

In one of the cases I've been thinking of, well the first one, the woman she was really upset, and I hadn't ... Of course you haven't had much chance to meet them either when it happens so early, and so I did go and see her and stayed until she was feeling settled. Until her tane was there; until she had come to an acceptance that she was in the hospital and she was in safe hands. And I had offered them tikanga support; generally women and whānau do like that. At least the Māori families do, and I found that it was one of those cases where my personal support was wanted. The staff on the ward gave me a call in the middle of the night... I was supposed to be off that week, but I knew it was going on and her tane was busy and she hoped that her dad was going to turn up... And I had said 'I'll do what I can to make sure that your dad gets the message, and that he knows that you are in hospital' because she had been trying to find him all day. Any way so the nurse was there on the phone and I said 'Have you heard anything? Has the obstetrician been in at all?' She said 'No, he's just given us some orders (over the phone) and I've never done this before.' And I said 'Well ok, well actually neither have I, but ok I'll come on up.' So I went up and settled with them and made sure that they were ok for that time and said 'Look I'll go back home', because nothing was happening and they were ok, and she was getting comfortable at that time. Then I got a call back to say that 'Hey, she's got bulging membranes there, um... What shall I do?' And I said 'Ok I'm coming up' and I wasn't quite sure what I was coming to because she was too early on for bulging membranes. So I went up to the hospital in the early morning, just before seven in the morning... And I got there and she was lying on the bed and I peeked under the sheet and there sure enough there were bulging membranes there at the introitus. She was reluctant to move or anything else and I said 'Ok, have you tried changing position at all? Have you got any urge to push?' And she goes 'No, not really, and I'm not liking this, I'm not liking this at all.' She could feel it, yeh it was just sitting there. It was just sitting right there. I said to her 'Look um you're not going to .., there is no easy way for this, but maybe if we ...' There was a .., commode in the room and I said 'How about if in the meantime we help you, we'll help you just to sit here, and you can just sit you don't have to push or anything and just sit and I'm sure this is going to help.' We managed to get her up without anything falling out on transferring from the bed to the commode. She sat there and we covered her. Then she said 'Ooooh, It's gone, it's there.' And um... eh so it had come out complete, complete in the bag, nothing had ruptured or anything. She did ask if she could have a look I was interested to have a look too but... Yeh, it was a very tiny, and you could see you know the shape of it. The hospital did provide quite a nice little box that was appropriately decorated. I said 'I need to just check this.' I'm going, saying 'Tane can come with me if he likes.' In the meantime her father arrived which was lovely. So I placed the

foetus into the box, but I didn't disturb it or anything. I wasn't quite sure what to do really, but anyway I put the lid on the box, but it wasn't sealed or anything and then we had a karakia all together. Her dad was wanting to do that (say karakia). And she was wanting him to do that too. And there were some tears and I shared a little bit of karakia and waiata for them too. I think that one of my uncles said 'Jesus when I die don't let me go without a song will you?' (Participant laughs) And I think that it so true, just an acknowledgement, and a song to acknowledge that you've come and been born... And that was quite nice. So I left them and I heard later that the obstetrician had come in to examine the baby and when he saw the lid was on the box he said 'Oh it's already sealed.' He could have examined it they wouldn't have minded but anyway he didn't so he didn't disturb it, and I think that's probably not a bad thing. I mean what, was he going to do? Yeh exactly. What can you do? What could you tell them? But hopefully it was all good, but I don't know, there was a lot, there was a LOT of history in her life you know. And she was quite freely open about it, and she hoped like anything that this was going to be a baby that she could keep because all the rest of her babies had gone to CYFS care with her parents. So there were many, many issues with her particular life story. Like when she went to the hospital she was cramping but not really bleeding. She had actually come to see me a week before and she was still earlier than 12 weeks, and said that she had just felt funny, and I said that 'Well, we can try and listen to the foetal heart., but we don't always hear it now anyway. I will organise a scan though.' And then I got notified while she was at the scan that the baby had, wasn't alive (2+), yeh... Well she wasn't bleeding at all then actually, but she just wanted the baby out, once she knew it was...had died. And I sort of acknowledged to her that 'You knew something had happened earlier eh?' and she said 'Yeh, I did. I had a feeling...Just recently I have been starting to write that for birthing wananga. Talking about first trimester, one of the first things you say 'Congratulations welcome this baby that is coming into your life and that but in the first trimester there are no guarantees so I try and say that, try and make that clear quite early in the piece... listen to your body... So I said to her 'Well let's see what happens and these are the things you can do in the meantime to try and make sure this baby gets past the first trimester anyway but there are no guarantees, you know' and I tried to make that clear... But ..., te whare ngaro.

A Māori worldview invariably construes miscarriage as a whakapapa (genealogy) and relational issue and therefore the responsibility of, and situated within, whānau. Matipou demonstrates her awareness of this perspective in staying with her client until the arrival of the woman's partner, and by attempting to contact her client's father. Matipou also constitutes her attempt to situate the miscarriage experience in a whakapapa setting through facilitating whānau involvement and offering her client karakia (prayer), waiata (hymns, songs) and te reo (language) as a form of cultural

support. However, professional competencies that require midwives to support women's choices and to be culturally respectful in practice have an 'absent presence' (Schilling, 1993) in the story.

In Aotearoa, New Zealand, governance of the Midwifery profession is established through surveillance of individual practitioners. Midwives' compliance with professional competencies is monitored via practice reviews<sup>77</sup> that are authorised by the Midwifery Council of New Zealand and carried out by regionalised committees to which members are appointed by the College of Midwives. In constructing her professional identity and midwifery practice in accordance with professional competencies, Matipou employs technologies of the 'self' (Foucault, 1988b). She specifically applies technologies of normalisation and self esteem to ensure that her professional appearance, persona and conduct within health care settings, comply with disciplinary approval and midwifery practice norms. Although power relations are evidenced in the midwife/midwifery profession interface through the scrutiny of the professional body<sup>78</sup> it may be argued that they are also present within the midwife/woman interchange. For example, women are ideally supported by midwives to make informed choices regarding, and give informed consent to, care interventions. However, women's choices may be influenced by the information midwives provide which in turn may be based on midwives' individualised worldviews and/or previous practice experience. Therefore although midwives may be characterised as women-centred care practitioners, midwives may insidiously limit women's agency in relation to accessing care, choice of care provider and care interventions.

Matipou states that her client chose to manage her miscarriage with medical intervention, inferring that the woman was not coerced to come to hospital. However as previously mentioned, women who had experienced miscarriage, and who were admitted to the institution, received a particular intervention regardless of whether they provided informed consent. If Matipou's client had desired a different form of care, personal agency in relation to that care choice may have been constrained.

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<sup>77</sup> The New Zealand College of Midwives have established Midwifery standards review committees within geographical regions. The committees are composed of consumers and health professionals and conduct biennial reviews of self-employed or lead maternity care providers' and hospital midwives practices and where appropriate, make recommendations for practice development. The reviews are a compulsory practice requirement for midwives who wish to retain annual practising certificates.

<sup>78</sup> The midwife/profession interface may also be extended to include other health disciplines such as medicine and encompass midwifery practitioners' performances of 'midwifery' as both an application of the technology of normalisation and resistance to medical hegemony.

In 'staying' until her client 'accepted' that she was in an institutional setting, and in 'safe hands', Matipou's actions may be construed as perpetuating institutional governance through exercising disciplinary power on behalf of the hospital, and potentially constraining her client's agency in relation to care choices. Therefore her continued physical presence may be constructed as institutional surveillance, reinforced through reassuring her client that care provision was in safe hands. Commenting on 'safe' hands is significant, because Matipou alludes to the possibility of health practitioners with 'unsafe hands' providing care within the health setting, perhaps hands that would inflict intrusive interventions on women without their consent.<sup>79</sup> However, as the factors that determine 'safe' hands are not defined, it would be speculative to hypothesise further.

Matipou is aware that her client is very distressed over the death of her baby. Early gestation is offered as a rationale for her minimal contact with the woman, and the absence of established rapport. Midwifery care is provided within a relational framework and as evidenced in the story, relationships develop between Matipou, her client and her client's family. For example, the woman desires the 'personal presence' of her midwife at the hospital. Despite having scheduled time off Matipou responds to the woman's request for support by agreeing to provide care regardless of the temporal setting. Episodes of care subsequently occur during the night and early morning. Matipou exercises agency in privileging the woman's needs, and potentially enables her professional identity. However, her personal agency is constrained by professional demands, when she is requested by staff at the hospital, in the middle of the night, and she visits the woman.

Despite her efforts to facilitate a whakapapa support for the woman's miscarriage, within the health setting, the woman is separated from whānau as her husband is working, and her father has not been contacted. The availability of 'safe hands' to provide miscarriage related care appears to be a misnomer, as expertise in relation to reproductive aberrations is embodied by the obstetrician, who remains physically absent from the setting. It may be inferred that the physician's actions in choosing not to 'see' the woman and providing orders over the phone reflect an institutional and/or disciplinary view, that both the woman's experience and women in general are homogeneous commonalities. Within institutions, homogenisation is a perspective linked to organisational constructions of risk that are population rather than

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<sup>79</sup> Potentially, the 'hands' of aforementioned care providers who administered misoprostol medication without gaining informed consent from women.

individually based (Lupton, 1999; Peterson, 1997). Therefore within the health setting the physician's actions may suggest, as Castel (1991) states, "to intervene no longer means..., taking as one's target a given individual, in order to correct..., or care for him or her. There is in fact no longer a relation of immediacy with a subject because there is no longer a subject" (p. 288). Castel alludes that in adopting a population based approach, care becomes focused on acknowledging the collective and results in the deconstruction of the individual patient.

The lack of availability, let alone of immediacy, of the obstetrician creates tension for the nurse who has 'never done this (provided miscarriage care) before.' Matipou is equally inexperienced but as an autonomous agent, has committed to supporting her client. Matipou appropriates the "clinical gaze" (Foucault, 1963, p. 98) of medicine and through examining her client determines that, despite her client's experience of cramping, 'nothing' is 'happening', so she leaves the hospital. Matipou's evaluation may draw on the interpretive repertoire of medicine to equate 'nothing' as meaning no visually observable symptoms, or physiological progress, of the miscarriage. An alternative interpretation of Matipou's story is that she is re-narrating an institutional narrative that has been shaped by the disciplinary narratives of medicine which construct miscarriage as a minor medical event.

Matipou attends the woman following a second call from hospital in the early morning. The staff member's diagnosis of bulging membranes is initially disputed because prior to admission the woman received an ultrasound scan that determined foetal development as 12 + weeks gestation.<sup>80</sup> Within the story, the ultrasound scan in acting as a metaphor for the clinical 'gaze' of medicine, operates as an actant and translates pregnancy from a state of invisibility to one of visibility through making corporeal temporality visible and therefore material. Pregnancy gestation is 'diagnosed by the 'technological' gaze. When Matipou goes to the hospital and bulging membranes are confirmed through direct observation it is apparent that in this instance the technological translation and inscription of the corporeal temporality that constitutes pregnancy has become flawed. Put simply, the ultrasound assessment is inaccurate. Matipou's personal "observing gaze" (Foucault, 1963 p. 107) replaces both the technological gaze and the "clinical gaze" that is "calculating" (Foucault, 1963, p. 89).

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<sup>80</sup> A pregnancy of 12 weeks gestation is associated with an early stage of foetal development that occurs before amniotic membranes are formed to the extent that they could be, 'bulging' from the vaginal entrance.

The observational gaze facilitates Matipou's perception that her client is aware of the baby's position within her body, reluctant to move and despite the baby's situation 'at the introitus' (vaginal entrance) has no urge to bear down. Positional changes by women may facilitate birth <sup>81</sup>(Varney, Kriebs & Gregor, 2004). Matipou is focused on supporting her client to give birth with the minimal amount of discomfort. Encouraging her client to move to a chair is rationalised as *helping*, and supporting the woman to *sit* simultaneously respects the woman's positioning of herself as a non-active agent, because she does not have to *do* anything. The woman moves to the nearest chair to the bed (a commode), and by doing so unintentionally positions the birth as a form of defecation and the baby as refuse. Culturally, this may be extremely problematic as giving birth in such a manner may adversely affect the mana of the childbearing woman, the whānau and the whakapapa<sup>82</sup>. The caregiver's attempt to construct physical privacy and demonstrate social respect for the childbearing woman by hiding her corporeality, as the change of maternal position, successfully facilitates the miscarriage.

Matipou and her client wish to 'see the baby'. Desire to visualise the baby on the part of the client may be interpreted as acknowledging the embodiment of whakapapa. Matipou infers that she employs the clinical gaze to examine the baby's entirety and assess if the miscarriage is complete. However, when she examines the baby, she also acknowledges whakapapa through encouraging the baby's father to accompany the baby to the assessment setting.

The deceased baby is treated with respect and put in a box that is 'decorated appropriately'. Appropriate decoration may be interpreted as an attempt by the institution to show cultural respect and suggests that the baby's human identity may be acknowledged. The container is therefore potentially transformed or translated as an ipu whenua. In placing the baby in the box, Matipou makes an effort not to 'disturb it or anything.' 'Not disturbing' means the baby is kept entire in keeping with cultural values that acknowledge the spiritual significance of the baby as embodied whakapapa. The rituals of karakia and waiata, and putting the lid on the box even though the box is not sealed may be considered analogous to closing a coffin and offering the prayers and hymns associated with Christian burial rituals. Whakapapa is also corporeally

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<sup>81</sup> "Positioning that facilitates second stage pushing can be summed up as anything but supine. The supine position is detrimental to uterine perfusion and alignment of the fetal head with the maternal pelvis. Especially facilitative of descent of the fetal presenting part during second stage are the upright positions such as ..., sitting..." (Varney, Kriebs, & Gregor, 2004, p. 832).

<sup>82</sup> As this aspect of the miscarriage is not acknowledged by Matipou or other actors within the story, further discussion is unwarranted.

present and embodied within the whānau through the grandfather and parents, and metaphysically present with the sharing of waiata (songs that flow, sung poems).

### **Cultural Destabilisation: A Way Forward**

Waiata are traditionally purposeful, and there are a variety of waiata<sup>83</sup> which serve different functions including acting as mediums for ensuring the continuity of tribal and familial histories, whakapapa (Mead, 2003). Some waiata may be constructed as epics that have been composed in response to specific temporally and geographically situated experiences, and events. Prior to colonisation such waiata were more commonly composed by socially authorised male and female individuals (Mikaere, 1994). Waiata tangi (laments) are used in relation to miscarriage and burial rituals are generally composed by whānau and friends, and may encompass aspects of the epic waiata. In *Ngā Mōteatea* (Ngata, 2005, 2006a, 2006b, 2007) Sir Apirana Ngata demonstrates that waiata have served, and still have validity, as essential vehicles for preserving both perspectives on, and retention of, tribal knowledge in relation to ancestry, history, and potentially ambitions for the future. Waiata operate as actants or hybrid actors<sup>84</sup> and fold temporalities, events, and settings, through space and time. They also translate selves and therefore genealogy and may affirm the links with tupuna (ancestors) from other generations of the whakapapa. Waiata may therefore provide a rationale for Matipou thinking of the older generations of her family and linking the ritual waiata with whakapapa in the embodied form of her uncle who did not want to ‘go without a song.’ It may also be argued that whakapapa translated as tikanga prompts Matipou to sing a waiata to farewell the baby, and that Matipou stresses the importance of acknowledging waiata as translation of whakapapa, when she states a song acknowledges that ‘you’ (the baby) have come and been born.

Matipou leaves the hospital setting but is informed later that the obstetrician came to ‘see’<sup>85</sup> the baby and observed the lid was on the box, so did not check if the box was sealed, nor did he try and examine the baby. A likely rationale for the obstetrician’s conduct is that the closed box acted as metaphor for the closed coffin and signified the

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<sup>83</sup> Examples of waiata: oriori (lullabies), pao (short ditties or chants with a beat), pātere (performed chants with a rhythm similar to a haka) waiata tangi (laments), and waiata aroha (love songs).

<sup>84</sup> Waiata may be conceptualised as actants or hybrid actors in a manner analogous to narratives in that they are composites of metaphysical elements that may be perceived as human and/or non-human. For example, they encompass specific individuals and identities such as paramount chiefs, lovers, and children and non-sentient artefacts or taonga (treasured possessions) such as a taiaha (weapon staff). Waiata act through influencing human behaviours for example they shape the construction of collective identities such as iwi, support legislative claims and may serve to preserve and facilitate the transmission of whakapapa knowledge.

<sup>85</sup> Seeing the baby may be interpreted as the obstetrician employing the gaze that classifies diagnoses and finalises (Foucault, 1963, pp. 98 - 104).

baby was no longer to be visualised and that burial preparations<sup>86</sup> were finalised. Matipou's asserts that the obstetrician's non-involvement is a good thing as there is little that the physician could say that would explain the loss without subjecting the baby to intrusive examination that may disrupt the integrity of both the baby's body, and the placenta. What goes unsaid is that having been acknowledged by whānau, for cultural reasons, the baby should now remain undisturbed until it is placed in the earth.

The woman's social history in relation to childbearing is characterised as significant. Her children have been removed from her care by CYFS (Child Youth and Family Services) and placed with other members of her whānau, yet this baby was conceptualised by the woman as a means of hope, a new beginning and an opportunity to change. The baby is constituted as a hybrid actor as the baby's presence could both transform the woman's identity from inadequate parent to mother, and potentially her status within her community. Assigning special significance to the unborn baby facilitates the woman's attention to the embodied patterns of childbearing, which are also described as woman's ways of knowing (Belenky, Clinchy, Goldberger & Tarule, 1986; Wickham, 2004a). Matipou's client demonstrates a woman's way of 'knowing' when she acknowledges that she "felt funny" about her pregnancy, prompting the ultrasound scan, and when Matipou re-visits the topic, her client confirms that she knew something was wrong with her baby.

In Matipou's practice, women's knowledge and whakapapa have acted as catalysts for the development of wananga about birth. She constructs and traces the network or genealogy of her client's embodied knowledge to the genesis of their care relationship and the knowledge that she imparts as a health practitioner to her client and other women and whānau with whom she shares birth. However, Matipou's story also outlines the displacement of women's embodied ways of knowing with increasing reliance on medical technology as evidenced by the influence of the 'diagnostic' ultrasound scan. In the final excerpt of her story, she constructs the displacement of women's knowledge base as an ongoing source of professional concern.

You know of the conception where people actually know they are pregnant we lose a quarter of those. For actual conceptions we

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<sup>86</sup> Within Western European funerary traditions such as the Irish 'wake' the closing of the coffin signals an end to personal farewells by family members and friends. In Te Ao Māori, the coffin may not be closed until early in the morning on the last day of the tangi (funeral) and the closing is usually witnessed by whānau and supporters (Mead, 2003).

lose about 50%, so that's a huge amount. I mean that really is huge... I remember reading an article in one of the journals when Joan Donley used to contribute. And it was one particularly about..., what she saw as the modern world and these early testing kits and so forth. Were they creating more problems for us by letting us find out the day after conception, that you were hapu, instead of missing a couple of periods like we did or our mothers did. You know confirming that you were pregnant before you even get a chance to get that feeling 'Oh I've missed a period I wonder if...?' Mmm, I sometimes feel that I do think that can be a disadvantage; just creating a whole expectancy of Oh planning everything... My grandmother used to say too in her time they were never encouraged to get anything ready for the babies before they were born. You know it wasn't a real...baby yet, they weren't allowed to, they didn't start collecting clothes, or anything, or any cots or anything like that... I really don't think that that was a reflection of the fact that they came along at a time when there was puerperal sepsis, so many babies got lost and many women got sick whilst losing their babies... But possibly..., perhaps it depended... Nana had a big family and it wasn't uncommon in (names home town) where I come from, that 18 even 20 children were the norm. It was even in those times, her mum's generation I think we were definitely on the decline then. I mean she came from a family of only three but Nana had ten babies, bouncing back. But even then the old people would say 'We don't get anything ready until before, we don't prepare a name beforehand, all of these things and that the baby was considered still warm until the pito drops off so there was periods of confinement where only mum and, mum and baby could have contact; nobody was permitted to sort of take baby away from you or.. Yeh they took care of you, but you were, you were the only one permitted to hold baby. I think there is a lot of wisdom in that now we are coming to terms with skin to skin, not over holding the baby and the flora from the mother. But usually they were just wrapped swaddled straight away, kept close to the mother, and sort of not all into stretch and grows, and little Adidas booties (shared laughter). She said that there was a purpose to that so she said 'Well babies do die sometimes and there's nothing sadder than seeing all of these things that you've prepared for a baby and having, you know, nobody to wear them and often times everything got buried with the baby, because that was the end of that story. Who wanted them? Who could you pass those things on to? How could you let go of those things even? It was too mai mai! (sad) I think it was to prepare our kuia for "Don't get your hopes up too high! Or, anything can still happen! I don't know, anyway but those are some of the things she used to say me. Not to get everything together beforehand... Yeh and now it's down to me... Yes! And I do think it is part of a midwife's role to be there, even in the hospital..., and the postnatal visits afterwards...

Matipou acknowledges that miscarriage is a commonality, but draws on midwifery disciplinary literature to explore her concerns regarding the application of technologies in the field of human reproduction. Technologies, although a relatively

recent arrival within the field of reproductive health, have proliferated at an exponential rate (Rankin, 2009; Shannon, 2004). Matipou characterises the introduction of technologies as not only influencing childbearing and midwifery but reconstituting the setting within which they are embedded as a ‘modern world.’ Matipou’s ‘modern world’ is a metaphor for a rapidly changing and un-finalised world state that she perceives to be associated with the destabilisation of women’s various forms of embodied and metaphysical knowledge. Tests that detect pregnancy shortly after conception replace women’s embodied awareness of physiological patterns. Matipou suggests that technologies, exemplified in the early testing kits, not only replace women’s ways of knowing, such as missed periods, but in creating awareness of conception, may facilitate the pathologisation of a normal physiological process, early miscarriage. It may be argued that Matipou in tracing the temporal, social, and geographical factors that have contributed to the intergenerational decline in whānau size, demonstrates a genealogy of both the changing world within which her whakapapa is embedded, and whakapapa itself.

In the contemporary world, the application of ‘hard’ or material technologies creates ‘expectations’ and therefore potentially desires not only for children, but for other material elements. Matipou suggests that babies’ booties are no longer generic but must be Adidas, a reference to the way consumerism creates new forms of desire by linking products to upward social mobility as well as maternal and masculine identities.<sup>87</sup> As traditional swaddling has also been replaced by ‘stretch and grows’, perhaps another metaphor for the rapidly changing world in which women and whānau are situated, identities and social process such as consumerism are perceived as relationally linked and embedded within the ‘modern’ world. Therefore it may be argued that metaphysical technologies such as technologies of desire and production (Foucault, 1976) are also active, and that they may facilitate disruption of values and belief systems within the new world state. The meta-story alludes to what Law (1999) conceptualises as relational materiality; shaping the arena of childbirth into a hot situation where heterogeneous elements such as actors, identities, corporeality, practitioners’ and consumers’ agendas, conditions and symptoms, as well as care provision have become contentious issues. Whakapapa is promoted as an alternative that may provide a stable knowledge base for constructing midwifery practice, and

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<sup>87</sup> Adidas is associated with the All Black rugby team. Adidas booties refers to baby sized rugby boots as symbols of upward social mobility, which may be purchased at many sports clothing, souvenir and baby wear shops in Aotearoa, New Zealand. Former All Blacks (New Zealand representative rugby players) Norm Hewitt and Michael Jones have publicly commented that for many Polynesian people in Aotearoa, New Zealand professional rugby is seen as a way out of poverty.

preserving the continuity of women's ways of knowing in relation to pregnancy and birth.

Within Matipou's narrative, time and space are folded and unfolded through tracing the translations of genealogy that link her contemporary embodiment and identity to previous generations, and the network of relational links that translate the corporeal and metaphysical, *whakapapa* and *tikanga*, from the past into the present. A genealogy of knowledge is subsequently constructed. The metaphysical and corporeal value of *whakapapa* as a knowledge base for women's ways of knowing and midwifery practice is established through linking cultural practices with evidence based knowledge and care interventions. For example, Matipou's grandmother relates that the commonality of miscarriage was recognised during her childbearing years, and birth preparations took this commonality into account. Neither material goods, nor meta-physical elements such as a baby's name, were prepared prior to birth, and adherence to *tikanga* was closely monitored within the community. Matipou hypothesizes that such practices were instituted because the baby 'wasn't a real baby'. In doing so, she draws on contemporary public and disciplinary narratives that construct human identity in relation to technological and subsequently legislated determination of foetal viability, in order to construct her worldview. Contemporary narratives of identity appear to displace *whakapapa* knowledge that assigns humanity to an unborn child at an early gestation (Buck, 1949), and suggest that the changing world state may disrupt cultural continuity through altering worldviews.

Matipou's story suggests that *whakapapa* knowledge, although altered through being perceived from a contemporary worldview, is translated rather than entirely displaced. Matipou's grandmother suggests that *tikanga* associated with birth included keeping babies physically close to their mothers and restricting the handling of new babies to ensure that babies remained healthy. New mothers were also cared for to ensure their wellbeing. The aforementioned traditional practices approximate contemporary midwifery knowledge. For example, 45-55% of all conceptions result in miscarriage (Beischer, Mackay & Colditz, 1997, p. 176; Farquharson, 2002), a newborn's immune system is boosted by being colonised with the mother's flora (Stables, 2000, p. 583), and practices such as kangaroo care<sup>88</sup> may facilitate a preterm or fragile baby's

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<sup>88</sup> Beischer, Mackay & Colditz (1997). 'Kangaroo care' refers to the practice of providing warmth to clinically stable infants, through parents cradling their naked babies directly against the parent's skin (p. 653).

wellbeing <sup>89</sup>(McKinney, James, Murray & Ashwill, 2005, p. 737). In tracing the relational links between past and present knowledge and practices, Matipou establishes what Foucault (1984) would refer to as genealogy of contingent knowledge and practices. The temporal fluidity of the various manifestations of whakapapa, enable Matipou to frame whakapapa knowledge and related cultural practices as preparation for childbearing women regardless of their temporal and geographical situation. As Matipou identifies whakapapa as including and being co-constitutive of actors, actants and other heterogeneous elements, she also conceptualises whakapapa as comprising an actor network.

### **Summary**

In beginning her story, Matipou draws on genealogy as metaphysical actant and embodied hybrid actor (Latour, 1993, 1999) to discursively and corporeally construct identities and position (Davies & Harre, 1990) herself in relation to whānau and the wider community. Positioning within the familial and social fields provides her with authority in relation to the social, cultural and symbolic capital (Bourdieu, 1977; Bourdieu & Wacquant, 1992) associated with her whakapapa story. Matipou constructs her miscarriage story as a metaphysical genealogy of stories that simultaneously constitutes a corporeal and embodied epistemology, field (Bourdieu & Wacquant, 1992; Bourdieu 1996) and actor network (Latour, 1993, 1999). Although initially specific to her whānau (family), her story is extended to encompass particular accounts of miscarriage-related events or experiences in which Matipou reflects upon how her own agency and that of her clients, is facilitated or constrained by enacting her professional identity as Lead Maternity Care Provider. The relative success or failure in her ability to provide what she considers as safe care is dependent upon the context in which the miscarriage occurs. The storying of the story is constructed in relation to the primary narrator's position 'within' the story. Matipou is a woman who has successfully undertaken the paramount role of Māori women; (August, 2004, Mikaere, 2003) and aspires to practice as, and in what was (prior to colonisation) the domain of, tohunga. Lemert (1998) theorises that whether lay or professional, we are all expert in relation to our own lives and experiences. Matipou's narrative may be interpreted as theorising whakapapa as multi-layered and simultaneously co-constitutive of 'self', 'other', technologies of power, stories and setting(s); therefore the

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<sup>89</sup> For example, kangaroo care is associated with improved growth and development in the preterm infant (McKinney et al., 2005).

storied relationship between self and whakapapa expressed in Matipou's narrative may be construed as an actor/network.

# 6

## Conceiving Time

### Coporeal temporalities, Contestation and Miscarriage Stories

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*Kua ūta haere, muri tata kino.*

*(To start early is leisurely, but to race against time is desperate).*

“Maybe it is the case that there has been a detectable shift from a time of succession to a time of coexistence, all the times – now in the plural – being simultaneously at work and represented without the past being abolished” (Latour, 2003 p. 44).

“Since there exists in this four dimensional structure [space-time] no longer any sections which represent "now" objectively, the concepts of happening and becoming are indeed not completely suspended, but yet complicated. It appears therefore more natural to think of physical reality as a four dimensional existence, instead of, as hitherto, the evolution of a three dimensional existence..., for us physicists believe the separation between past, present, and future is only an illusion, although a convincing one” (Albert Einstein, 1879-1955).

“What then is time? I know well enough what it is, provided that nobody asks me, but if I am asked what it is I am baffled” (Augustine, 1961, 11(14), p. 17).

#### Introduction

The biomedical perspective on embodied humanity may be considered the most privileged discourse on corporeality within the field of human health care provision

(Foucault, 1980). According to Krieger and Smith (2004) biomedical conceptualisations of embodiment incorporate the temporalities associated with development, growth, presence (in time and space) and evolution that are essentially linear and objective in nature. It is therefore unsurprising that as Adam (1990, 1995) and Baars (1997) suggest, irreversible and therefore finite chronological temporalities dominate in bio-medical studies of human reproduction.

In contrast, within this thesis, narrative analysis of participants' stories suggests that there are multiple and contradictory material temporalities associated with women's reproductive health. Specific embodied temporalities identified and discussed or alluded to by participants include foetal gestational age, personal biological age, menarche, ovulation, menstrual cycles, miscarriage and menopause. These different dimensions of embodied temporality are incorporated into medical, social and institutional discourses. They may be identified in measurements of health status, health risk and moral values, and facilitate the determination of humanity and identity. Through shaping identity, such temporalities have also determined research participants' access to miscarriage-related knowledge, care services, care providers and care interventions. Women's and midwives' embodied and/or material time(s) or temporalities are measured and or evaluated by actors, depending on the context in which miscarriage narratives are disclosed. As narrative constructions of timing(s) and duration(s) are personally, culturally, professionally and/or socially created, such temporalities may be subject to contestation.

In this research it is argued that research participants' narratives about embodied or material temporalities mediate the contradictions of multiple temporalities which are simultaneously tensed, and tenseless, comparative and oppositional, as well as unsynchronized and sequentially ordered, linear and quantifiable. As temporalities may be construed as networks of social relations in which struggle occurs over the appropriation or retaining of certain types of symbolic capital<sup>90</sup> (Bourdieu, 1984, 1990), within the context of this research, they may constitute fields<sup>91</sup> (Bourdieu, 1977, 1996). An argument is advanced that temporalities may also act as positioning tools which situate agents<sup>92</sup> and potentially other temporalities, in hierarchical

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<sup>90</sup> Bourdieu (1984, 1990) assigns the term 'symbolic capital' to resources available to an agent based on social perceptions as to the prestige and recognition that individual has attained within single or multiple field(s).

<sup>91</sup> Bourdieu (1977) suggests that a field constitutes a dynamic arena within which social agents collaborate and compete to attain desirable resources.

<sup>92</sup> Although, the researcher has used the designations 'agent' and 'actor' interchangeably throughout the thesis, where possible the term agent is reserved for social theorists such as Pierre Bourdieu who

relationships within fields, for example, the field of miscarriage, the field of care provision, and or other temporal fields such as relational and institutional temporalities. The notion of positioning as theorised by Davies and Harre (1990), draws attention to what agents (Bourdieu 1977) or actors (Latour, 1999) ‘may’ do as opposed to what they ‘can’ do within a field, which is governed by the ‘rules of behaviour’ of that particular field. Temporalities shape actors’ behaviours in terms of accessing and providing miscarriage related care, it may therefore be argued that temporalities operate as metaphysical and material actants<sup>93</sup> (Latour, 1999). Through shaping behaviours, temporalities also shape and are shaped by ontological, public, conceptual and meta-narratives and facilitate the construction and contestation of un-finalised identities. The co-constitutive and relational interactions of heterogeneous elements such as narratives, bodies, actors, identities and temporalities suggest that temporalities may be classified as actor networks (Callon, 1987; Latour 1993, 1999). Temporalities are also engaged in expertly shaping identities, behaviours, narratives and social networks. Drawing on Foucault’s (1988b) theories about technologies of power interwoven with Latour’s (1993, 1999) conceptualisation of technologies as material it is suggested that temporalities may simultaneously constitute metaphysical and material technologies.

In this chapter, five categories are introduced, which have been identified from evaluation of miscarriage-related embodied temporalities evidenced within participants’ stories. The categories are; corporeal temporalities as measures of cultural and/or moral values; as health status and health risk; as determinants of humanity and identity, and women’s access to care, particular care providers and specific interventions; and as constituters of corporeal knowledge. Narrative analysis of the actions of corporeal temporalities within participants’ stories is informed by theoretical conceptualisations of time(s) and sets of understandings regarding the relational constitution and application of various economic, cosmological, material and metaphysical temporalities in relation to daily life.

### **Thinking Time: Theorising Corporeality and Narrativity**

Time(s) and/or temporalities within the modern western world have largely been constituted in a sequentially ordered format that individuals are socialised into from childhood. The passage of time has historically been reckoned in standard units that

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primarily use the term to designate human individuals. The term *actor* has been applied when drawing on the ideas of theorists such as Bruno Latour and Arthur Frank who commonly use the designation in their work.

<sup>93</sup> The term *actant* is discussed in footnote four page 11 of this thesis.

separately and collectively incorporate elements of clock time, the Gregorian calendar, and the associated Christian era (Greenhouse, 1989, p. 1634) to constitute a “standardised temporal reference framework” (Zerubavel, 1982, p. 3). Individuals function within social contexts and therefore temporal frameworks require social acceptance and application to maintain a degree of social order (Sorokin & Merton, 1937). The provision of health services is structured accordingly (Zerubavel, 1979). At the most elemental level, midwives arrange their appointments with childbearing women based on an assumption that they (midwives) and women relate to each other in accordance with a synchronous temporal framework.

Despite the hegemonic nature of ‘western’ temporality in the ‘present’, the concept of temporality is inherently contradictory. Multiple and fluid temporalities, variously described as cosmological (Pinxten, 1995), economic (Sewell, 2008), chronological (Baars & Visser, 2006), political (Bütthe, 2002), geographical (Massey, 2004), corporeal (Kenney, 2007), spatial (Sassen, 2000), and metaphorical (Assad, 2003) are perceived to exist contemporaneously, and compete for authenticity and priority within various societies, cultures, institutions and environments.

The complexities of constituting and comprehending time are addressed by Augustine (1961). In his ‘Confessions’, Augustine of Hippo identified and examined temporal aporias; the contradiction of linear time as created by God measured sequentially into eternity, with the subjective inner time of the individual, where past, present and future temporalities are re-defined as memory, attention and expectation and reframed as co-existent. Whilst Augustine has identified and examined psychological or personal temporalities which structure and bring meaning to individual realities, the temporal framework that encompasses the purely subjective inner reality of an individual, whilst unique, cannot be separated from the inter-subjectivity of daily life. Events and resultant experiences are sequentially and therefore temporally located in everyday realities and spaces (Goffman, 1974). Time may therefore be viewed as an objective construction that is inherently chronological or linear in nature. Ricouer has suggested that such aporias may be mediated by constituting time within the framework of narrative: “Time becomes human to the extent that it is articulated through a narrative mode, and narrative attains its full meaning when it becomes a condition of temporal existence” (Ricouer, 1984, p. 52). Ricouer appears to suggest, that by relating temporally sequenced events and experiences within narrative frameworks via the application of emplotment, the inherent temporal contradictions are positioned by both narrator and narrative to create a meaningful whole. Accordingly, Ricouer’s proposed

resolution for temporal aporias suggests that narrative may be considered the shaper of time and of temporal existence and that by locating narratives within historical time inherent meanings may be both fully explained and comprehended. Ricoeur (1988) therefore asserts that “narrative is the guardian of time” because “there can be no thought about time without narrated time” (p. 241).

Temporal and/or temporality are terms that encompass the various constructions, perceptions, experiences, and measurements of time. Cunliffe, Luhman and Boje (2004) have proposed the term ‘narrative temporality’ to encompass the idea that time(s) are subjectively experienced and enacted in varied ways, proposing the concept that narratives are acts imbued with meaning, that occur in, and are interwoven through, a multiplicity of temporalities and spaces (pp. 262, 275). Giddens (1984) has proposed that the ‘self’ cannot be understood outside history, and Polkinghorne (1988) adds that the creation of narrative is a temporalising activity of human beings’ lives that “structures and orders time(s) according to hermeneutic principles” thereby facilitating “multiple levels of interpretation” (p. 127). Narrative understanding may therefore be considered a form of historical enquiry.

Within this chapter, an understanding of time within the body or rather embodied time is developed through the analysis of women’s stories about the corporeality of miscarriage. Despite beginning debates by feminist scholars in the social sciences (Butler, 1997; Earle & Letherby, 2007; Weis, 1999)<sup>94</sup> regarding the relational interactions of embodiment, and subjectivity in response to temporal influences, the concept of embodied or corporeal time is largely an under-researched concept within clinical research literature. In this thesis the term ‘corporeal temporality’ is used to incorporate the various temporal aspects associated with women’s embodied experiences of miscarriage. The term is particularly relevant to research which explores and acknowledges differing epistemological conceptualisations of time as in this instance, Western European and Māori world views. The disparate theoretical perspectives of Bourdieu (1990), Latour (1999), Foucault (1988b) and Harre (Davies & Harre, 1990; Harre & van Langenhove, 1999) are integrated in arguing that corporeal temporalities may simultaneously constitute fields, actor networks, technologies and positioning tools. Drawing on the ideas of Ricoeur (1981, 1984, 1988) and Somers (1994) an argument is also presented regarding the co-constitutive

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<sup>94</sup> Butler (1997) and Weis (1999) argue that the subject in the process of becoming does not progress through a linear trajectory to a fixed self but repeatedly moves forwards and backwards through time and space as a never finalised entity.

relationship of corporeal temporalities and ontological, public, conceptual and meta-narratives. The relational interaction is encompassed in the term temporal narrativity. Throughout the chapter analysis of participants' stories provides exemplars of the crafting of identities, bodies, attitudes, values, knowledge health risks and health care through the interweaving of corporeal temporalities and temporal narrativities.

### **Corporeal Temporalities and Values**

Public narratives about temporality are primarily drawn from the western paradigm in Aotearoa. Māori and Pacific cultural values associated with corporeal temporalities are predominantly silenced by colonising discourses (Smith, 1999b). Such narratives divert attention from the social shaping of corporeal temporalities and associated values by appropriating the discursive and cultural spaces of indigenous and/or Polynesian peoples. Marsden (1992) suggests cultures craft differing perspectives of reality and therefore plural and individual worldviews from which stem value systems. It is therefore essential to consider the political work of these dominant western European and institutional representations (Phibbs & Curtis, 2006) of temporal values.

In this chapter it is argued that temporalities measure cultural and moral values. Elder Jr (1994) proposes that public narratives assign temporally related expectations, beliefs and perspectives to social roles and events (p. 6). Baars (1997) suggests that corporeal temporalities in particular may be assigned negative or positive power, and that such assignments encourage the development and maintenance of value laden stereotypes associated with chronological aging. As a result, the temporality of fertility cycles (ovulatory/menstrual and gestation) may be linked to morality, because the timing of pregnancy (age of childbearing woman/time of life) is associated with societal rules or as Somers (1994) proposes public narratives. Such public or social narratives may hypothesize right and wrong times to conceive, as evidenced in the public narrative 'old ladies and young women shouldn't have babies.'

An examination of the following five narratives suggests how corporeal temporalities are a measure of moral and cultural values. Auhunga's story draws attention to the work done by 'age' in shaping what is socially perceived to be morally correct temporalities for childbearing.

**Auhunga:** ...When I had (names son) I was 34 and when I had my first child I was 26, and I was very aware that age possibly

could change ...(1+)<sup>95</sup> I guess I was a little bit more worried because I was older, and may be that had something to do with it. I knew it wasn't, hadn't... But that was I guess I had to think of an excuse, something to blame, (for losing the baby) and in my head my age was one of them.

Auhunga commences her narrative by situating her embodied temporalities of childbearing within a contextual framework that draws on public narratives about age as sequentially linear. She positions herself as a successful child bearer and mother who through conceiving and giving birth at the age of 26 is constructed as experiencing pregnancy at the 'right' time. In describing herself as 'very aware' she discursively positions herself as confidently knowledgeable in regards to her reproductive body and the related embodied temporalities. Auhunga also acknowledges in her story that age may operate as an actant that influences change in birth outcomes. However, her use of an extended pause whilst narrating her story, and non-completion of the sentence in which she links corporeal time (age) to change, infers that the change is problematic. Medical discourses that link age to increased risk of miscarriage have an 'absent presence' (Schilling, 1993) in the story, working to counter Auhunga's initial confidence in her reproductive capacity through the use of qualifying remarks, such as 'possibly' and 'may be' that infer 'age as cause', as a rationale for the loss of her baby.

Public narratives that hypothesize an appropriate corporeal temporality for childbearing, whilst not explicitly mentioned, also have an 'absent presence' (Schilling 1993) in Auhunga's narrative. In stating that she is 'worried' because she is 'older', Auhunga demonstrates awareness of these public narratives and that the pregnancy does not conform to a socially acceptable temporal norm. Through insinuating that her chronological 'age is cause' (of the miscarriage) Auhunga draws upon public narratives that discursively position her body as faulty and apportion blame for her loss. This perspective on age is known as deficit thinking (Reid, Robson & Jones, 2000), and may act, as in this instance, to silence ontological stories and related identities. Davies and Harre (1990) suggest that discursive positioning of selves is commonly based on shared understandings about rights, expectations responsibilities and social structures associated with particular positions. In this instance Auhunga explicitly resists being discursively positioned as too old, suggesting instead that chronological age 'wasn't' and 'hadn't' been responsible for the loss of her baby. However, such loss requires a socially acceptable rationale, and despite an ontological narrative to the

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<sup>95</sup> The (number+) lexical convention is a conversational analysis notation that denotes and measures the duration of a pause. Auhunga's pause measures (1+) seconds.

contrary, she ultimately accepts the assertion that ‘age is cause’ promoted by public narratives of miscarriage. In doing so, she demonstrates complicity in both the silencing of her ontological story and the acceptance of blame for the loss. The complicit nature of the narrative silencing and apportioning of blame may be construed as a classic example of symbolic violence<sup>96</sup> (Bourdieu, 1990, 1996).

In assuming blame Auhunga accepts a new identity, that of reproductive failure and, a marginalised position within the field of childbearing that may be assigned considerable social stigma (Goffman, 1963; Liamputtong 2007a). The negative connotations of failure represent moral judgements suggesting that corporeal temporality may serve as a measure of socially accepted moral values in relation to reproductive temporalities. The discursive construction of reproductive failure in relation to the ‘wrong’ times for childbearing is also evidenced in the following narrative.

**Kahotea:** And I..., when I got to about 42, I thought I’m never going to have a child, because I’m getting too old, and I’m getting past the fertile stage... Well my uterus has ceased functioning!

Kahotea positions herself within a corporeal temporality that is socially inappropriate for childbearing and links the linear chronology of her age to the embodied temporality of reproductive function. Childbearing during the ‘wrong’<sup>97</sup> corporeal temporality results in reproductive failure because the aged body is now faulty. Women’s bodies, through the socially constituted abnormality of their bodily processes, become ‘othered’ (Weis, 1995). Martin (1989) states such an ‘othered’ body is metaphorically perceived as “the disused factory, the failed business, the idle machine” (p. 45) and this metaphorical perspective is evidenced in her story through the use of the term ‘ceased functioning’.

It may be argued that Kahotea’s story also implies that socially wrong behaviour, results in biologically wrong reproductive processes; potentially causing emotional distress. Therefore although not explicitly stated, Kahotea’s narrative infers she may experience her infertility or loss of child as a form of moral justice for transgressing publicly accepted moralities which are relationally linked with corporeal temporalities

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<sup>96</sup> The term symbolic violence refers to those social agents who have attained social capital exercising power over other agents within the field who are perceived as having less, and who in turn perceive their domination/subordination within the field to be in accordance with the natural order of things (Bourdieu, 1996).

<sup>97</sup> Within this context the term ‘wrong’ is a synonym for socially unacceptable and biologically inappropriate and implies a moral judgement.

- such as being childless and trying to have a baby at 42. Kahotea's story may therefore be interpreted as alluding to miscarriage as an embodiment of 'moral' temporality. Conceptualising corporeal temporalities as moral draws attention to socially accepted moral 'norms' in relation to which individual beliefs and behaviours are evaluated and individuals, practice self governance. Foucault (1988) characterises the practice of self governance of behaviours and beliefs in order to conform to socially accepted 'norms' as a technology of the 'self', specifically the technology of normalisation. As evidenced in her miscarriage story, Kahotea does not conform to the moral norm that encourages women to marry and have children at an earlier age and she may therefore experience social and institutional marginalisation in relation to accessing and receiving care.

Moral judgements associated with corporeal temporalities are also expressed by health care providers. In the following narrative extract a midwife interviewed for this research project incorporates the public narrative of age as cause of infertility and miscarriage in her ontological narrative of practice.

**Totara:** Perhaps, because they (the women) do book early, and so we're seeing more miscarriages. However..., I've always had quite a high number (of miscarriages)..., because I think I get the oldies (older women)... And I think that the higher... (2+) Well... Is there a higher miscarriage rate among the more mature women, the 38s to 45s?

Totara discursively assigns identity, and positions her clients within the field of childbirth, solely in relation to their lived corporeal temporality by initially labelling her client's as 'oldies'. In doing so, Totara's narrative simultaneously assigns her clients a new verbal label with negative connotations, and silences their fertility, sex, and individual identities. This discursive silencing is immediately followed by a significant pause suggesting that she considers her uncritical iteration of the public narrative 'age as cause', as potentially problematic. This is confirmed in Totara's next sentence where she re-labels her clients as 'mature women', and in doing so reassigns their gendered identity<sup>98</sup> as 'female' and/or their social identities as adult women. The clients are also re-designated as mature. In contradiction to the negative connotations and lack of value that may be assigned to being 'old', the corporeal temporality 'maturity' has cultural associations with wisdom, and therefore potentially enhanced social value.

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<sup>98</sup> The researcher acknowledges that the term gender although commonly used to refer to biological sex, is applied broadly within the social sciences in relation to a range of socially constructed characteristics that are associated with an individual's social roles and identities. However in relation to Totara's story, the researcher suggests that Totara in re-designating her clients as 'mature women', draws attention to social or public narratives regarding the construction of identity based on age, sex and the gender based 'roles' undertaken by her midwifery clients.

In reframing her discourses about chronological age, Totara appears respectful, and potentially women centred, in her approach to practice. However, the discursive re-positioning of her clients may be construed as a response to the absent presence of midwifery disciplinary narratives.<sup>99</sup> Alternatively, as the midwife is aware that I am a disciplinary colleague and therefore knowledgeable regarding the disciplinary narratives that inform practice, the midwife may be consciously reframing her narrative in order to minimise the possibility of negative judgements about her professional practice by an individual she perceives to be a peer.

The preceding ontological narratives incorporate a public perspective that the embodied temporality of childbearing has a temporal limit that is socially constituted in accordance with, and rationalised by moral judgements and socio-biological arguments in relation to, chronological age. Some women are publicly perceived as 'too old' for childbearing. The two following narratives suggest that moral judgements associated with the corporeal temporalities of miscarriage encompass a temporal range, and that some women may be perceived as 'too young' to conceive.

**Mahoe:** She had a miscarriage and it happened I believe up around (names city) and she said she was made to feel quite bad, whether it was from the nurses, or the medical staff, she was made to feel somehow to blame. She had quite heavy bleeding, she miscarried, and had quite heavy bleeding so obviously had to go into hospital. And she said she was made to feel quite bad about the miscarriage, and that she was to blame or something like that, because she was too young to get pregnant. So when she called me about this miscarriage, she was obviously quite upset about this miscarriage itself, but she talked a lot about that last experience, and how she was made to feel so..., like she was to blame and what have you. Sort of like a young foolish thing who shouldn't have gotten pregnant anyway.

In this first story Mahoe has appropriated aspects of her client's ontological narrative. She reiterates the key elements to construct a counter narrative to public narratives which suggest the embodied temporality of childbearing should be situated within a socially acceptable temporality; the 'right' chronological age range. In stating that her client is 'made to feel', Mahoe is proposing that as a result of her corporeal temporality (pregnancy), the client has been coerced by external sources to accept that she is 'bad', 'to blame', 'too young', and 'foolish'. Mahoe's narrative therefore suggests that her

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<sup>99</sup> In Aotearoa, New Zealand, midwifery disciplinary narratives such as, midwifery is a woman-centred profession and midwives work in partnership with women, encourage midwives' professional respect, and advocacy for women's autonomy and agency. Such narratives foster the development of equitable mutually respectful relationships with women, which may be inferred by the midwife's re-designation of her clients as mature women, a term that denotes respect in contrast to the ageist term 'oldies'.

client's first miscarriage loss was rationalised through the internalisation of moral judgements about her age. In her story there is no evidence of any resistance by her client to being positioned in this manner within the field of childbearing. One interpretation of this absence may be that Mahoe's client is tacitly complicit with the process of apportioning blame for the miscarriage and accepts that she is at fault. However, Foucault (1963) suggests the authoritative gaze of medicine is rarely, and not easily challenged by an individual, because as Foucault (1976) proposes each woman will "under its weight..., end by interiorising" the gaze to the level she is scrutinising and perpetuating social surveillance over, and against herself (p. 155). Consequently within the midwife's ontological narrative the client is discursively positioned as the victim of symbolic violence (Bourdieu, 1996) perpetrated by previous health care providers named as 'nurses' or 'medical staff'. Alternatively, in accepting rather than resisting care providers' rationales for her loss, Mahoe's client may be understood as presenting herself as a 'docile' body and demonstrating social conformity to discourses and practices encountered within health care settings.

Mahoe's ontological narrative exhibits the multiplicity, and nonlinear nature, of corporeal temporalities. Past corporeal temporalities become contemporary, and reconstitute moral and cultural values associated with the client's embodied temporality of miscarriage in the present. The corporeal temporality of the first miscarriage remains un-finalised in that it is revisited by the midwife's client. In revisiting value judgements associated with the previous miscarriage, Mahoe's client may potentially re-designate herself as faulty and to blame for the contemporary miscarriage for which she is receiving midwifery care. Alternatively, Mahoe's client may have accepted the explanation of age as cause for her first miscarriage in the past. Now that she is older, reiterating her story may be construed as seeking reassurance that she is not to blame for the current miscarriage or, potentially the previous miscarriage.

Multiple public narratives about corporeal temporality are also interrelated within Mahoe's ontological narrative. Cultural values such as wisdom are linked with chronological age; more specifically youth as in the case of Mahoe's client, is linked with foolishness and implicitly associated with a lack of wisdom. This linking of the corporeal temporality of youth to a lack of knowledge is also evidenced in the following narrative.

**Kahikatea:** One of my clients, had a miscarriage, and it was a missed miscarriage so she went into hospital for misoprostyl... She was very young, a very young Māori girl, and I was downstairs with someone in labour, and around one o'clock she was convinced the baby was coming and she rang the nurse, who said 'Oh what would you know at your age?' and left. So she miscarried in the dark, in the room by herself and basically caught her own little baby when it was born. And the room, the light, she remembers the fact that the light in the room was not working, only the bedside light, so it was almost in the dark.

Kahikatea's story commences with a contradictory medical event, the death of her client's baby is a miscarriage yet not a miscarriage because it is 'missed'. Her body has retained the dead baby and is therefore presented as faulty and so requires institutional intervention to repair and restore physiological function.

In this narrative corporeal temporalities compete for recognition evidenced by the interchangeable use of the terms miscarriage and baby. Kahikatea initially defines her client's deceased baby as a miscarriage in accordance with medicine's diagnostic parameters and legislation within Aotearoa, New Zealand which designates a foetal death before 20 weeks gestation as a miscarriage (Ministry of Internal Affairs, 1995). The legislative (institutional) narrative of corporeal temporality as gestation reframes the baby as non-human and as a miscarriage, based on the absence of the heart beat. The midwife counters the legislative narrative by reframing the miscarriage as a 'baby' that is 'born'.

In stating the miscarriage occurs in the dark, Kahikatea's ontological narrative alludes to the wider temporal context of the miscarriage and suggests that the miscarriage may have occurred at night. Within a Māori epistemology it is acceptable for death to be associated with the cosmological temporality of te po (the night). However, in Kahikatea's narrative, light is presented as temporally necessary in order for the corporeal temporality of baby loss to be made materially and socially visible.

Although no age is stated, the young Māori client is described as 'very young' and despite her client's childbearing status, Kahikatea appears to discursively assign to her client the identity of girl rather than woman based on her client's age. This suggests that Kahikatea may perceive her client as lacking the social or cultural capital (Bourdieu, 1977) of adulthood. Social or cultural acceptance may be associated with successful fertility and childbearing (Abboud & Liamputtong, 2003), particularly for Māori women (August, 2005; Mikaere, 2003). Binney and Chaplin (1986) suggest the

inability to become hapu (pregnant) and/or safely give birth to the next generation is that which is most feared by Māori women and is associated with a loss of mana (prestige) within Te Ao Mārama (the world of light). Therefore Kahikatea has potentially marginalised her client's position within the field of childbirth and based on her client's corporeal temporality, potentially dismissed the client's cultural prestige attributed to her client as a bearer of the next generation.

The use of corporeal temporality as a basis for devaluing cultural value is more explicitly demonstrated in the reported talk of the health care provider. The nurse reiterates public narratives that link youth to lack of wisdom or knowledge in order to disregard the woman's assertion that the miscarriage is about to occur. In doing so the nurse uses Kahikatea's client's age as an actant to silence the client's ontological narrative and embodied knowledge of miscarriage. The relational interaction through privileging one corporeal temporality (age) over another (embodied temporality of miscarriage) in regards to childbirth, suggests that temporal validation and authority is subject to contestation. Corporeal temporalities associated with age, bodily processes, or foetal gestation, are construed as elements that struggle for position in hierarchical relationships that are also situated within multiple temporalities. For example, cosmological temporalities indicated through reference to the dark, legislative temporalities, and/or chronological times specified in relation to clock or calendar (20 week gestation). It may therefore be argued that in this context temporal narrativities constitute corporeal temporalities as both agents and/or hybrid actants, which simultaneously shape, are shaped by and situated within un-finalised temporal networks (Latour, 1999) or fields (Bourdieu, 1977).

Kahikatea's narrative continues with her client remaining unattended. As the hospital staff do not provide healthcare or support, her client is left solely responsible for her miscarriage. Mikaere (2003) and Palmer (2002) suggest that within Te Ao Māori (the Māori world) due to the spiritual significance of such events the corporeal temporalities of birth (and by default miscarriage) are occasions to be supported and attended by whānau (family) (Palmer, 2002). Mead (2003) and Pere (1982) also assert that such events require the presence of cultural birthing specialists, as well as midwives. The social isolation of Kahikatea's client within the ward and denial of access to whānau demonstrate that the client's cultural and moral values are marginalised within the health care setting. Kahikatea's client is disrespected as the meanings that she assigns to her embodied corporeal temporality are ignored. Such

practices within healthcare settings are discriminatory and a form of temporal marginalisation.

In the preceding narratives, corporeal temporalities operate as actants and technologies in that they assign, measure, marginalise and devalue cultural and moral values. Through doing so corporeal temporalities construct both moral norms and judgments regarding what is 'right'<sup>100</sup>. It is therefore unsurprising that some participants directly associate prompt fertility post miscarriage with 'doing right' as opposed to doing wrong. The significance assigned by some participants to re-conceiving after miscarriage may also suggest that a moral temporality applies and that a 'new' pregnancy can be used to replace the fertility loss associated with the 'old'<sup>101</sup> (previous) miscarriage. A 'new' pregnancy may also transform a woman's identity from that of a reproductive failure to a successful child-bearer and therefore potentially a socially accepted individual, as evidenced in the following narrative.

**Kohuwai:** A friend of mine she had a miscarriage and she didn't do anything. She just let it all come away. But actually there was about... Why I wanted it all done was... I wanted it all done so that I could start again, try again immediately, whereas she bled for about three weeks, and then..., so it was a lot slower and all I wanted to do was get back on that bicycle, and just get..., I just wanted to be pregnant so bad, to be normal..., and I thought right! Well, you know, if I get it, have a D&C<sup>102</sup>...I'm all cleaned out, I'm starting again. That's that. And the fact um..., when I had the second miscarriage I went to (names obstetrician/gynaecologist) and he was great and he checked me, scanned me and said 'No, everything is fine, there's nothing wrong, you're fine, you're already to go type of thing.' So that was really cool.

Kohuwai compares and contrasts ontological narratives about the corporeal temporality of miscarriage in order to rationalise her care preference for exerting external control over her own miscarriage. She suggests that her friend's decision to manage the miscarriage without intervention and 'just let it all come away', denotes an abrogation of self control that results in ill health (bleeding) which extends over a long period (three weeks). Kohuwai presents herself as an active agent choosing to control her miscarriage so that she can 'start again'. 'Starting' is associated with the concept of

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<sup>100</sup> Socially and/or biologically acceptable (correct) actions within a specific context i.e. human reproduction.

<sup>101</sup> This term also has associations with the concepts of 'faulty body' and the pregnancy being located in a 'body' perceived as being past its 'use by date'. (Martin, 1989).

<sup>102</sup> Dilation and curettage is a surgical procedure for removing the products of conception (the deceased baby) from the uterus.

a new reproductive beginning which replaces the previous failure. Kohuwai discursively resituates herself; moving from the contextual temporality of reproductive failure to a temporal state of reproductive potential. The temporal immediacy of this movement from one temporal state to another is metaphorically emphasized with her allusions to getting on a 'bicycle' and in the reported talk of her doctor who states she is 'ready to go'.

The concepts of fertility and pregnancy are connected with the idea of reproductive normality: through employing medical interventions to alter her corporeal temporality Kohuwai is attempting to claim for herself that identity of 'being reproductively normal'. Surgical interventions are justified so that she may be "all cleaned out". This suggests that Kohuwai perceives herself to be unclean or dirty. Public narratives link cleanliness of the body to moral goodness and socially acceptable action (Douglas, 1966; Frost, 2007). The concept of a 'clean slate' is implied, suggesting that the 'dirty business of the past has been appropriately finalised and that a new corporeal temporality has been constructed, a temporality that facilitates a change in the woman's identity from that of unclean fertility failure to clean fertile female. The transformation of identity requires validation from an authoritative source. The woman is evaluated by an obstetrician/gynaecologist. The physician is not a generalist but a specialist, and as an expert in the area of human reproduction he uses technology to assess the women's fertility. The ultrasound scan becomes an actant and is used by the physician to make visible the potentiality of the uterus and therefore the corporeal temporality of fertility is made material. The doctor is able to authenticate Kohuwai's state of health. In explicitly stating there is nothing 'wrong' he implies the biological readiness of her body to bear children. As there is nothing 'wrong', Kohuwai's 'rightness' is also inferred in the narrative and intimates her moral goodness. Kohuwai's talk constructs 'normal' women as women who conceive and have babies. Presenting her desire to conceive may be interpreted as an attempt to establish both her social and reproductive normality. Her attempt at self constituting her identity as a 'normal' woman is aided by the physician, who through confirming that Kohuwai may re-conceive, potentially validates her social normality. However, it is through the doctor's application of ultrasound that Kohuwai's invisible and therefore metaphysical corporeal temporality is made visible. Time is made material and facilitates Kohuwai in crafting a new identity. Within this research corporeal temporalities may therefore act to facilitate the constitution of identities.

### **Corporeal Temporalities and Identity**

In this research study, corporeal time (in the form of foetal gestational age) provides the reference framework for legislating societal recognition of humanity, and therefore shapes a childbearing woman's right to the social identity of motherhood and that of her unborn child to the identity of human being. In Aotearoa, New Zealand the legislated age of viability is twenty weeks (Ministry of Internal Affairs, 1995). Temporal perspectives vary amongst the various health care disciplines regarding the legitimacy of the state legislating foetal corporeal time, and thereby determining 'humanity'. Medical discourses construct miscarriage at an early gestation as a medical event to be managed, or even potentially a non-event, depending on accompanying signs and symptoms (Abboud & Liamputtong, 2003; Atik, 2002; Moulder, 2001). Women comment that physicians' medicalisation of early miscarriage as a corporeal process associated with ill health and waste products, marginalises women's identities as mothers. This has the additional effect of dismissing the embodied corporeal temporalities associated with the reproductive cycle of pregnancy. The legislated non-humanity of their unborn children is reaffirmed by physicians' and other medical health care providers' choice of language and remarks when providing care. Medical discourses shape socially accepted perspectives on health, and therefore sets of understandings (i.e. of work colleagues, women, mothers, and social acquaintances) that perpetuate the marginalisation of women's identities as pregnant mothers and the humanity of their infants.

Alternatively, women and midwives interviewed for this study embrace a mutual recognition of wanted conceptions as life, and the shared perspective that gestational temporality is irrelevant to women's self-identities as mothers. Midwives are specialists in women's health but more particularly their identity is tied to facilitating childbirth. As a result some of the women interviewed for this study, for example Auhunga, Kahatea, Kahotea, Kawakawa and Raukaraka, desired midwives to care for them when they experienced miscarriage. Midwifery care is an affirmation of a woman's embodied temporality (in this case pregnancy) and the resulting transformation in identity to that of 'mother' as well as the humanity of their unborn children regardless of the limited nature of their gestational temporality.

The following three narratives of Mahoe, Kawakawa and Kauri explore how corporeal temporalities determine the identities of women and the assigning of human identity to their unborn children. Mahoe uses references to gestational age in her story, to allude to the differing perceptions of corporeal time.

**Mahoe:** For a lot of women just the fact that they have called me at 7 weeks, and said '(names self) I'm pregnant.' means that this is a baby, this is a baby who is sleeping in a crib, you know? Who is going to be going to school, you know? And they have all that excitement, and anxiety and just the same as they, as any pregnancy... It's thoughts you know for the, for the women, for the mothers that I have been involved with. It's, it's heartbreaking, you know, even if it is 10 weeks that it's happened or 12 weeks or 14 weeks. It's heart breaking, because this was a baby.

Mahoe's story draws attention to the ways in which public, disciplinary and legislative narratives about corporeal temporalities such as 'gestation', that are associated with pregnancy and motherhood, through influencing socially accepted bodies<sup>103</sup> shape socially accepted identities, and potentially marginalise some identities. For example, women's socially appropriate identities as healthy individuals, mothers, and childbearing women, and their babies' identities as 'human beings' and 'children'.

The following extract from Kawakawa's narrative actively challenges public narratives about corporeal temporality that construct early gestation babies as other, as non-human; as merely tissue or products.

**Kawakawa:** But I think maybe that's how some people see it though. It's not really a baby. It's just really a blob of tissue before twelve weeks... It's a more developed baby, the longer it's in your womb, but it's not..., it's still a baby no matter what age it is to me... Yeh it starts to look more like... a, you know, a baby but that doesn't mean it's not a baby. Like... To me um..., if you don't believe it's a life as soon as the egg is fertilized then when does it become a life, when, what, at 10 weeks, or at 20 weeks does it suddenly... PoP! It's alive.

In relation to the preceding narratives, as already stated in this chapter, the legislated age of viability for a foetus in Aotearoa, New Zealand is 20 weeks. Medical, public and legislative narratives of gestation, implicitly frame women's corporeal temporalities as linear and sequential through constructing a hierarchical temporal scale in which a baby may become more of a baby with advancing gestation. Mahoe and Kawakawa resist such narrative constructions of humanity by stating the irrelevance of gestational time as a measure of identity and asserting the babies' human identities and therefore women's identities as mothers. Their stories, through challenging public narratives about early miscarriage, also resist the "sovereignty" of medicine's gaze (Foucault, 1963, p. 89) and the gaze-related exercising of governmentality in health institutions,

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<sup>103</sup> Socially accepted bodies include but are not restricted to women's healthy, fertile' and/or pregnant bodies.

which have an ‘absent presence’ (Schilling, 1993) in such narratives. The sovereignty of medicine’s gaze is explicitly evident and challenged within the following narrative about midwifery and miscarriage care within a tertiary hospital.

**Kauri:** I was working in the neonatal unit as a night staff nurse looking after the neonates and at that stage the antenatal and complicated ward was upstairs..., and during the night, miscarriages would happen over night and you’d have babies being born into bedpans, you know? Steel bed pans! And the women never knew that the babies were actually alive because the..., the midwife would cover them with a cloth and take them to the utility room and then..., and the woman would be told that it was all over and you know sorted out. But the midwife was faced with a squirming ... miscarriage who was still alive in the bedpan, and that she had sitting in a bedpan in the sluice room..., and it was alive! And she would get extremely distressed!

In Kauri’s story, narratives of corporeal time compete for validation. Women are told that the corporeal temporality associated with miscarriage is ‘all over’. The living and breathing babies do not conform to biomedical definitions of what constitutes humanity. They do not exist, so they are not assigned legal or institutional status, and therefore they need not be accounted for to the women who have given birth.

Kauri actively challenges public narratives of corporeal temporality that construct early gestation babies as other, as non-human. Her story also demonstrates her awareness that the hospital context within which she practices as a lead maternity care provider, and associated institutional policies and contractual requirements that govern her practice are defined according to the biomedical perspective. Through using the terms ‘babies’ and ‘miscarriages’ interchangeably as an alternative to terms such as ‘products of conception’ Kauri implies a counter narrative to medicine’s determination of these miscarriages as non-human. She further comments on the babies who are simultaneously squirming miscarriages being born into bedpans and put in the sluice rooms. These live babies are positioned by institutional narratives of corporeal temporality as refuse for disposal. Kauri’s narrative resists this positioning of these babies as unclean, dirty, through both linguistic terminology and acknowledgment of the extreme distress experienced by midwives in response to the use of bed pans and sluice rooms as aspects of care provision. In positioning these babies as unclean and/or dirty, the institutional narratives also draw on public and medical narratives of corporeal temporality and hygiene to imply that these babies are unhealthy, abnormal, and tissue to be disposed of. The narratives therefore suggest that there may be a relationship between corporeal temporalities and health status.

### **Corporeal Temporalities and Health Status**

Medically and socially standardised corporeal cycles are identified as measures of health and wellbeing, and evidence of healing from the experience of miscarriage. Participants have commented that they experienced the re-commencement of the ovulatory/menstrual cycle primarily as physical healing and that for them, the miscarriage process is not finalised until this occurred. However, as the human reproduction cycle is bio-medically defined and socially constructed, within the wider community the temporal change associated with menstruation signifies an ending to the miscarriage process and potentially related risks to women's health status. Participants acknowledge that sets of understandings within society construct this as the boundary for completion of healing and therefore women's experiences of miscarriage may be silenced. Alternatively, some participants report that re-established reproductive cycles provide a source of temporal stability and facilitate psycho-social healing. Hjelmblink and Holmstrom (2006) suggest that this represents women's use of temporal cycles to restore predictability to embodied temporality after the disruption of miscarriage, and to dissolve temporal limits thereby facilitating the potential for 'new beginnings' in terms of reproductive temporalities.

Corporeal processes and/or products may operate as actants. Participants, for example, have identified visible blood as a socially accepted reason for seeking advice and or care from health care providers, but, some women have commented that depending on the volume of blood they perceive is present (i.e. a minimal amount) they may choose not to contact health providers. Blood may clearly be considered a physical actant within this context, however blood is also situated within one, and possibly multiple temporal frameworks. For example, blood is assigned a chronological age (new/fresh/bright as opposed to old/dark/stale blood) and situated within a standardised temporal measurement framework. The temporality of blood loss is established by calculating the volume of blood that is lost and situating that loss in relation to clock time. In this section of the chapter it is argued that it is the temporal situation of blood loss that determines a woman's level of health risk, access to care services, choice of care providers, information provision, consent to, and specific, care interventions for childbearing women. Therefore within this context, it may be argued that corporeal time constitutes a metaphysical actant.

Simmonds (2002) proposes that medicine's obstetrical discourse controls perceptions of normality associated with women's reproductive cycles by constructing a fixed temporal framework that fragments reproductive temporality into standardised

elements “imbued with the potential for danger” (p. 560). This suggests that the discipline of medicine regards women’s embodied temporalities as pathological in the first instance. Medicine’s disciplinary narrative of miscarriage-related risk ensures that regardless of the duration that a deceased baby remains insitu, and research that suggests the contrary (Butler et al., 2005), the mere presence of a deceased baby is automatically identified as a source of health risk by most health care providers. As medicine’s disciplinary narratives shape public narratives about risk, this perspective is also commonly accepted by women. However, there is no evidence-based consensus regarding what constitutes an unsafe duration. As a result, the concerns and beliefs of individual health care practitioners about temporality related health risks, rather than research/evidence-based practices, have shaped miscarriage management, and facilitated significant variance in care practices in institutional settings. Temporalities embedded in standardised constructions of health risk, and local variabilities related to the management of early miscarriage, are also considered in the following section of the chapter.

In an environment where standardised approaches to care provision predominate, women’s needs and care preferences, although usually acknowledged by midwives (Wickham, 2004a, 2005, 2006), are not always considered by health professionals. Acknowledgement of women’s preferences would also appear to be the exception within health institutions, where as Foucault (1963) suggests, the influences of the discipline of medicine predominate, and potentially dictate health care. When women have enhanced cultural and social capital as conceptualised by Bourdieu (1977, 1996), within the field of health, they may challenge the influence of disciplinary and public narratives about corporeal time related to their care, as evidenced in a narrative extract from Rewarewa’s story.

**Rewarewa:** I think it is an area (miscarriage) that I potentially knew a lot about because of my background, practice nursing. The person that I was a practice nurse for did obstetrics so I learned a lot from that I suppose..., as well as from my midwifery training... Anyway when I had the D&C ... Well I had a position there (at the hospital) and I wasn’t just going to stay in the hospital and you know fit in for the sake of risk management protocols...Nobody argued when I said ‘I’m leaving’ (chuckled) and maybe that because people knew me, and would have to face me when I was back in charge (more laughter).

In her story Rewarewa draws attention to the use of her established and extensive knowledge base as a resource for shaping both her behaviour and the actions of health

care professionals within varied temporo-spatial settings.<sup>104</sup> Through linking her knowledge base to her ‘position..., in charge’ within the health care setting, she acknowledges in her narrative the co-constitutional and relational interaction of knowledge and power as conceptualised by Foucault (1976). The narrative habitus of the institution is shaped by medicine’s disciplinary narratives about temporally constructed risks to health. Rewarewa, although a patient in this instance, draws on her identity as a nurse and the social and symbolic capital associated with the ‘position’ of being ‘in charge’ to privilege her personal narrative which minimalises miscarriage-related risk and therefore the need for health care. Foucault (1976) infers that resistance is a precondition of power. In acknowledging and situating her managerial position within a hierarchical and therefore contested network within the institutional field of the hospital Rewarewa also infers the potential for care provider resistance to her care choices.

In contrast to Rewarewa’s story in which the narrative habitus of medicine is disrupted, medicine’s disciplinary narratives about corporeal temporality tend to determine or influence health practitioners’ perceptions of health status within the field of miscarriage. The following midwives’ stories explore how corporeal temporalities measure health status and health risk and demonstrate how corporeal processes and/or products may operate as actants.

**Karaka:** It is just too hard to hang up on these women who are so clearly in need; to say ‘If your bleeding gets to..., oh so many pads per such and such time period, or you need to go to the A&E and be seen by a Doctor...

**Kauri:** Another woman was a (names town) mother. She was bleeding quite heavily... I didn’t feel..., comfortable, it was also one of my first ones, so maybe I was overcautious... ah but she was actually, she was soaking like six pads in an hour. It wasn’t, you know it wasn’t one I felt comfortable sitting on. I felt she needed to be in hospital and she felt the same way so there wasn’t a problem.

In Karaka’s and Kauri’s stories, blood is situated within a temporal framework. It is the measurement of blood loss over time that determines a woman’s health status and/or level of health risk which in turn facilitates or hinders access to care services. It may be argued that within this context blood as material actant, in conjunction with corporeal time as metaphysical actant, produce social consequences. The following narratives of

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<sup>104</sup> For example during her embodied experience of miscarriage; her D&C surgical intervention and temporally sequenced care interactions within the ward setting.

Kawakawa and Kohuwai suggest that blood may also be concurrently situated in multiple temporal frameworks.

**Kawakawa:** I just felt like I'd lost the baby. So then for the next couple of days nothing much happened. But... The baby's going to be OK! And then... A few days later I started to get a little bit of bleeding but..., not much... Just enough ..., just enough to fill say like a liner once a day. So not a lot... Just trickling out slowly.... It (the blood loss) was dark! It was thick and dark so it was old ... And it was, it was, it wasn't very much really. Um... And then it would stop for a day..., maybe three days and I'd have nothing. So it was quite drawn out over time, and sort of... What's, what's happening? Am I having a miscarriage or not?

**Kohuwai:** And at 13 weeks I started bleeding and it was dark brownish and smelly... It was old blood and I, and I thought "Oh here we go". And then I thought "Oh, old blood might not be so bad... but it was like I said, just old, just old dark blood. (Names midwife) was very positive and she sort of said to me "You know, it mightn't be anything." but (names friend) said to me "Well, you know...", which was good because I'm, I, I knew deep down it possibly wasn't going to be very good.

In these narratives, the corporeal temporality of bleeding is constituted as linear, with a beginning and progressing in a chronological sequence to become old and therefore inferentially finite. In addition to measuring blood loss over time, Kawakawa and Kohuwai have discursively constructed the chronological age of blood based on disciplinary and public narratives about the physical characteristics and/or properties of blood such as colour, smell and viscosity. The material character of the blood produces social consequences that are applied as measures of the women's health status and degree of health risk. However, within the context of miscarriage the temporal presence of blood or bleeding is not uniformly considered a determinant of risk, illness or injury as evidenced in the following excerpt from Kawakawa's story.

**Kawakawa:** Because it (post-miscarriage bleeding) was longer than two weeks. They (Radiology practice) actually said "because her bleeding has been longer than two weeks, then it can't be related to her miscarriage"... Well I don't suddenly have my period. This bleeding has like carried on!" Well it made me feel like a freak too because..., um..., I knew that I was, I didn't know why I was still bleeding and I was getting scared by the end of six weeks, because that's quite a long time to bleed.... But to say that because it was beyond two (weeks)... What? "When you miscarry you only bleed for two weeks and that's it?" No, it is too rigid but there's no kind of recognition for that...

Kawakawa's narrative of ongoing bleeding post miscarriage suggests that for her the corporeal temporality of miscarriage is ongoing. According to her health service providers she bleeds for 'too long' and therefore her experience does not fit with biomedicine's definition, and temporal positioning, of miscarriage as a finite temporal event. In determining a specific temporal limit for post miscarriage bleeding<sup>105</sup> (Johnson, Priestnall, Marsay, Ballard & Watters, 1997; Ngai, Chan, Tang & Ho, 2001; Promislow, Baird, Wilcox & Weinburg, 2007), medicine may have constructed an example of what Latour (1999) describes as definitively settling on paper (patient records) that which is not settled in reality (parameters for normal bleeding). Kawakawa is aware of disciplinary narratives that define temporal parameters for 'normal' bleeding. Based on her un-finalised experience of miscarriage she considers herself to be positioned as other and takes on the identity of 'freak' because she perceives herself as not conforming to the medical norm. Foucault (1988b) suggests that individuals who wish to achieve normality shape their bodies and behaviours in order to be socially acceptable. Kawakawa's initial acknowledgement of an abnormal or deviant identity could be considered a form of compliance with accepted social beliefs about health. Her comments also reflect her lack of confidence in her embodied knowledge and the power of disciplinary narratives to marginalise women through subjecting them to symbolic violence. Bourdieu (1996) suggests that the enacting of such violence also involves unconscious complicity on the part of the subjugated. Although Kawakawa's initial acknowledgement of the identity as freak could be construed as complicity, she resists both being discursively positioned as finalised, and the silencing of her miscarriage, by the service provider's restrictive temporal framework. In doing so she draws attention to how narrative and corporeal temporalities shape the co-constitutional interactions of power and resistance.

In contrast to Kawakawa's lack of confidence, Kahurangi discursively constructs herself as knowledgeable regarding temporally-related risks to her health.

**Kahurangi:** I knew by the dates and everything that I was then sort of 12 weeks but the baby was eight weeks (by scan) so I knew that um you know..., physiologically..., there was ..., time was ticking on and things needed to happen progress from a, you know, from an anatomical point of view. Um..., so yeh we had the weekend to think about it and, and there were lots of tears there... But obviously there is a part of the miscarriage that needs addressing, and in some cases urgently depending on how it is

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<sup>105</sup> Research (Johnson et al., 1997; Ngai et al., 2001; Promislow et al., 2007) suggests that the average duration of bleeding post miscarriage is 5-14 days regardless of the care intervention that is used by care providers to clinically manage miscarriage.

presenting itself or like if the baby has been insitu for a long time there is a risk of infection there's a very immediate..., I'm sure there is a percentage of 'Immediate we need to deal with this', but um., I would say that would be a small part of it.

There are competing corporeal temporalities in the preceding narrative, gestation as embodied temporality and temporality made visible. The biomedical technology of ultra-sonography makes corporeal time socially visible. Time is therefore made material because technology is prioritized and represents a classic example of the privileging of "medicine's gaze" (Foucault, 1963, p. 89). Kahurangi links corporeal time to risk of infection or illness based on the conceptual narratives of medicine. The mere presence of a deceased baby in utero is identified as a source of risk to health and wellbeing by most care providers. This perspective may be tacitly accepted by women as evidenced in the following narrative.

**Kahatea:** I said 'Look I really think I'm miscarrying and I just want to see a Doctor...' Because I know there's, it's sort of dangerous if anything is left inside; because it'd been drawn out over a week... They, then they finally took me... (processed through triage in A&E dept).

Disciplinary and public narratives imply that health risks require medical management and/or health care provision. The legislation of age of viability and therefore identity has facilitated the development of a range of temporal measures to control access to choice(s) of care services, care providers, and care interventions. Therefore it may be argued that corporeal time facilitates institutional and disciplinary gate-keeping of time as a commodity; or 'resourceful' time. The relational associations of corporeal temporalities, care accessibility, care providers, and specific care interventions require further examination.

### **Corporeal Temporalities and Care Provision**

Within the field of health care, time is identified as a quantifiable resource that is allocated in relation to accessing care providers, care services and specific care interventions and is therefore a commodity that has inherent financial value. Time as a commodity or resource is controlled by legislation, social rules, disciplinary perspectives, and institutional policies. Medicine as the privileged disciplinary perspective on health, defines miscarriage as a minor medical event. Depending on the corporeal processes associated with miscarriage, such a medical event ideally requires minimal allocation of temporal resources associated with institutional spaces, specialist care providers, clinical services, care interventions and consumables. Minimising

resource allocation is partially accomplished by marginalising, and in some instances the assuming of governance over, women's miscarriage-related temporalities by health institutions.

Lead maternity care providers who are predominantly midwives in Aotearoa, New Zealand, provide maternity services to childbearing women and therefore potentially women experiencing miscarriage, in accordance with section 88 of the New Zealand Public Health and Disability Act 2000 (Ministry of Health, 2000b). Prior to 2007 midwives were able to provide assessment and care for any woman experiencing threatened or confirmed miscarriage. In 2007 section 88 was amended, and service specifications for threatened and confirmed miscarriages previously applicable to all lead maternity care providers were removed and replaced with a tiered specification schedule. The schedule encouraged the accessing of physicians specifically employed by primary health organisations (PHOs) for miscarriage care in the first instance. If this care was not readily available, the legislative changes encouraged women to access general medical care from other local physicians such as those employed by a 24 hour service. The schedule also allowed for midwives to provide a limited degree of care, but only for those women that had already registered as their maternity clients and who were experiencing miscarriages. Although participant interviews for this research project were conducted prior to the introduction of an amendment to section 88, ongoing communication with participants (Kauri, Nikau, Totara, Mahoe & Matipou) after this date, suggested that midwives were continuing to provide care based on women's perceived needs rather than legislated fee schedules. In some instances care is provided with the expectation that, due to the legislative changes, it will not be funded.

The changes to Section 88 of the Public Health and Disability Act (2000b) may have facilitated the medical profession in gaining control of an increased percentage of the services provided in the specialty area of women's health. Consolidating medical control of miscarriage care provision may be construed as the implementation of legislated gate keeping in regards to the provision of health care services. As a result women's choices in relation to care providers may be reduced and women's potential preferences for midwifery care may be marginalised. Women are aware that miscarriages usually occur at an early gestational age within the embodied temporality of pregnancy and that this has implications for temporalities associated with accessing resources such as lead maternity care providers and other care services. In Aotearoa, New Zealand there are few general practitioners and a shortage of midwives who provide full maternity care. Anecdotal evidence from midwifery practice suggests that

women often book care providers from an early gestation to ensure that they receive care from their provider of choice. However, limited public funding for midwives in relation to providing miscarriage care has contributed to the shaping of midwifery care provision and resulted in women not receiving miscarriage-related care as desired, from midwives. Research participants' stories suggest that the limited funding available for miscarriage care and the shortage of midwifery care providers have contributed to unsatisfactory care provision (Inaka, Kahotea) for miscarriage in Aotearoa, New Zealand. Participants who reported experiencing physical and/or symbolic violence from health care practitioners that provided medical care (Kahatea, Kahurangi, Kawakawa, Inaka, Pipiwharau and Tangiwai), have expressed concerns regarding the limiting of women's choices. The participants have also suggested that for those women who have not accessed a midwife's services prior to miscarriage, medicalised care may have potential and ongoing detrimental effects. Issues related to accessing resources, services and care providers are considered in this section of the thesis.

Lead maternity care providers refer women and arrange their admission to hospital in accordance with District Health Board guidelines and hospital protocols. However, institutional protocols for health practitioners who are referring women to secondary or tertiary hospitals may not be established in accordance with research or evidence based guidelines as there is considerable variance amongst hospitals in different District Health Boards with regard to referring criteria. Health disciplines are hierarchically structured and foetal gestation facilitates gate keeping of services by specialist providers. Women are aware that their miscarriage-related care may be marginalised depending on their embodied temporalities. Gestational age and/or duration of a deceased baby in utero may specifically determine a childbearing woman's access to, choice(s) of, and temporalities associated with, care services, care providers, and care interventions. Therefore it may be argued that within this context corporeal temporality has become a direct physical or material actant. The following extracts from the narratives of Totara, Nikau, Kauri and Totoweka suggest how corporeal time or temporalities operate as actants to determine access to care for childbearing women.

**Totara:** I would say most of my clients, under 9 weeks, well under 11, but I think anything over 9 is at risk for retained products and or bleeding or whatever, so anyone under 9 weeks, most of those stay at home.

In the preceding narrative extract Totara suggests that miscarriage of a baby whose gestation is over 9 weeks has an associated increased level of health risk. This is a conceptual narrative of medicine not midwifery, which as Totara's story evidences, shapes her midwifery care. However, Totara also refers to 'her' clients experiencing miscarriage at less than 9 weeks gestation as staying home. In doing so she alludes that her support for clients staying at home is shaped by the disciplinary narratives of midwifery which theorise the 'normality' of miscarriage, as a physiological process that commonly occurs during childbearing. Midwifery disciplinary narratives also advocate respect for women's care choices. Through providing her clients with midwifery care in their own homes, Totara acknowledges women's autonomy as equitable partners in the care relationship in accordance with disciplinary ethics and ensures that her clients are not subjected to unwarranted interventions within health institutions. In protecting her client's corporeal temporalities Totara indirectly reduces usage of institutional resources and subsequently privileges economic temporalities within hospital settings. Totara's narrative therefore draws attention to the co-constitutional, hierarchical, and relational, interactions of temporalities.

The hierarchical positioning or privileging of some temporalities is evident in the following two narratives which describe how corporeal temporalities determine access to specific care providers.

**Nikau:** What intrigues me, is if you've got a woman that is miscarrying you can go directly to the registrar as a midwife, you don't have to go through the consultant, but anything over 12 weeks you have to go through the Consultant.

**Kauri:** For a woman who is under 20 weeks you don't ring the obstetrician, you ring the team and you usually would talk to the Registrar, and you will say to the Registrar 'Ok I've had this woman present to me, she had a so and so, date of birth is so and so, this is her second pregnancy, she... I think she's about 8 weeks (gestation).

In the stories of Nikau and Kauri, obstetricians are only contacted when a baby becomes more of a baby. Increased gestation is also associated with increased health risk. As the corporeal temporalities that are associated with access to obstetricians vary, the narratives that inform hospital protocols are perhaps ontological in nature and/or specific to local culture. If this is the case, women's agency in relation to care may be context contingent. In the following story, Totoweka who was initially congratulated on her pregnancy and baby by her general practitioner is subsequently positioned by

her general practitioner as not pregnant enough to warrant hospital care. Medicine's conceptual narrative, which is embedded in disciplinary and public narratives of gestational temporality, designates Totoweka's first trimester miscarriage as a minor medical event resulting in the dismissal of her pregnancy. Totoweka's identity as mother is silenced through non-acknowledgement and therefore her baby ceases to exist.

**Totoweka:** Well it was, but it was that, it was that number of weeks that um..., you know, when he (the GP) said, 'Oh we only', you know, 'we only put you into hospital if it's after 14 weeks.' And I'm sure he said 14 weeks. I remember thinking at the time, well you know, is it because it's bigger between 11, 12, 13, 14 weeks, the extra 4 weeks made a huge difference. But it was very much a downplaying because it was that first trimester.

Agency may be constrained by the various socio-cultural, institutional, and disciplinary contexts in which an individual is situated. However, the four preceding narratives suggest that corporeal temporality may also facilitate gate keeping of services by health providers. Peterson (1997) suggests that a population based approach to care has been adopted within health institutions in order to facilitate risk management and control consumption of resources. Such an approach promotes the homogenisation of care. Alternatively, midwives may support women in their own homes, and indirectly reduce demand for institutional resources. However, as individual midwives differ in the care they provide to childbearing women (some practitioners may view miscarriage as a minor medical event), and women's needs vary, developing a generic approach to providing miscarriage care is not appropriate. Individualised care interactions are a necessity and they are contextually situated and shaped by women's and midwives' knowledge of miscarriage and the related temporalities.

### **Corporeal Temporalities and Corporeal Knowledge**

Corporeal temporality determines knowledge at the personal level. However, this knowledge must be situated within the inter-subjective reality of everyday life where individual temporality, whilst unique, is subordinately positioned in a hierarchically structured socio-corporeal temporality governed by standardised public narratives, professional discourses and institutional routines. Cultural proverbs contain temporal concepts such as increasing age equating with developing or enhanced wisdom, and youth equating with ignorance. Exemplars include Irish proverbs such as: the

schoolhouse bell sounds bitter in youth and sweet in old age; take the old dog for the hard road and leave the pup on the path, and praise the ripe field not the green corn.

These socially accepted narratives about corporeal temporalities influence the level of credibility or value assigned by care providers to women's embodied experiences of temporality. The beliefs, attitudes, and values inherent in such narratives may also be comparative to cultural and indigenous narratives about time(s) although this is not always the case. Depending on corporeal age, some childbearing women who experience miscarriage may also perceive their care needs to be marginalised by care providers and health care services.

Socio-corporeal temporalities determine beliefs, attitudes and values associated with an individual's knowledge of childbearing, which in Aotearoa, New Zealand is to all intents standardised. For example, public narratives construct the duration of pregnancy as being forty weeks. Temporal knowledge is also assigned value based on socially accepted public narratives that are hierarchically structured according to physicality. For example, 'seeing is better than feeling' and/or 'seeing is believing'. A woman's embodied temporality associated with miscarriage is deeply personal and a potentially hidden corporeality. She is the only individual who experiences the embodied duration of the event. Therefore the personal loss, physical pain and suffering that she experiences as a result of miscarriage cannot be comprehensively shared with or understood by other individuals such as family members and/or health care providers. Research (Hodnett, 2002) suggests that some maternity providers underestimate the level of physical pain experienced by childbearing women during birth, similarly some health providers may not provide adequate care for women experiencing miscarriage or worse, they challenge or dismiss women's experiences of pain and suffering. Vague (2003) proposes that midwives incorporate variant views of temporality into their practice when providing care for women giving birth which by default may include miscarriage. She suggests that in evaluating women's pain through the midwifery perspective of experiential temporality, midwives acknowledge that when in pain childbearing women's perceptions of temporality alter in response to the context or setting in which they are situated. Women's individualised and corporeal temporalities associated with the pain and stress of miscarriage are therefore ultimately hidden and cannot be fully 'known' by care providers.

In contrast the bio-medical technology of ultrasonography makes corporeal temporality socially and materially visible and therefore 'knowable'. The ultrasound scan is a classic technological example of 'the medical gaze' (Foucault, 1963). The scan

symbolises medicine as the dominant discourse in health and employs biological reductionism to define symptoms, identify pathology, and diagnose illness, and as is the case in these stories the completion of miscarriage. The social reification of the medical profession and medicine's perspective on health has established societal acceptance of and preference for, biomedical and technological evaluation of corporeal temporalities (Lupton, 2004). Consequently, participants report that the physical visibility (scan image of gestation), and measurement (physical evaluation of gestation by scan), of corporeal temporality enhances the reality of foetal humanity and the realisation of baby loss. Women comment that, despite in some instances, experiencing tangible physical loss the temporal duration of miscarriage becomes more of a reality on visualisation of the empty uterus.

Goffman (1974) suggests that all temporalities occur in or are associated with spaces. The uterus may therefore be considered as both the 'space' and according to medical discourses about the biochemistry of fertility, the 'source' of corporeal temporality associated with reproductive cycles. This associated temporality is hidden or invisible in what Giddens (1984) defines as the *durée* of women's lives. Within the western paradigm the body has an absent presence (Schilling, 1993) in the sense that it is commonly taken for granted. In contrast, within a cross-cultural paradigm, this hidden nature of corporeal temporality may have spiritual and mythical associations. Gendered and multicultural narratives attest to the sacredness, spirituality, and temporality of such reproductive 'space'. For example, the role of the uterus is 'as grower of babies' in accordance with the 'phases (temporalities) of the moon'. In order to resist the social influence of the medical perspective on pregnancy and childbirth, women and midwives embrace such holistic and spiritual beliefs, attitudes and values regarding the corporeal temporalities associated with pregnancy and childbirth (Davis-Floyd, 2001).

Chapter five explored the way that Māori women value *te whare tangata* as their connection to the creation of the world. The *mana* (prestige) and *tapu* (sacredness) of each individual is sourced through their *whakapapa* (genealogy) links to the Gods of creation, ancestors, descendents, and to humanity in general (August, 2004; Mikaere, 2003). This temporality is acknowledged within traditional (Ngata, 2005, 2006a, 2006b, 2007) and contemporary (Kahukiwa & Potiki, 1999) *waiata* (sung narratives) as evidenced in the verses of the following *oriori* (lullaby) which celebrates childbirth:

*Nau mai rū e te tau e ko koe rū te puū waitanga o ngū moemoeā o  
rūtou mā kua mene atu ki to Pō*  
(Welcome my beloved, you are the blossoming of the dreams of  
those who have gone into the night). (Kaa, cited in Kahukiwa &  
Potiki, 1999, p. 6).

The corporeal temporalities (reproductive cycles) of Māori women may therefore be construed as simultaneously nested within past, present and future temporalities, and are not necessarily discrete to the individual. Simultaneous and non-discrete temporalities are evident in the narratives of some Māori participants. Participants' stories commence with the narratives of tupuna (ancestors), about embodied or corporeal temporalities in the form of whānau stories about infertility. In these stories whakapapa (genealogy) may be extended to encompass multigenerational corporeal temporalities. However, application of the term whakapapa to mean corporeal temporality in a generalised sense is problematic as whakapapa is a whānau specific term. Tikanga (cultural traditions) based perspectives on time including corporeal temporality are also highly regionalised (Byrnes, 2006) and frequently specific to iwi (tribes) and hapu (extended families). Such variance creates potential for differing paradigmatic viewpoints about the corporeal temporalities associated with childbearing to disadvantage cultural interactions amongst indigenous and non-indigenous New Zealanders. Therefore health care providers should consider contextual factors and avoid adopting a homogeneous approach to care provision when managing the corporeal temporalities associated with miscarriage.

Radiographic technology may provide a partial solution for mediating differing perspectives. Ultrasound scans provide visual narratives of corporeal temporalities such as foetal development and whakapapa (genealogy) that are individually embodied, and socially positioned within and in relation to other narratives. In a similar manner to oral or written stories, the sets of understandings developed from various 'readings' of ultrasound narratives are never finalised. The dynamic and un-finalised meanings attributed to such narratives accommodate corporeal temporalities that simultaneously encompass the past, present and future and therefore potentially indigenous perspectives on time. Such visual narratives, as Ricouer (1984, 1988) suggests, may also mediate temporal contradictions.

Scans may also operate as actants influencing actor's agency in relation to choice of care provider and care interventions. For women and their families that experience pregnancies post miscarriage, visualising the temporality of ongoing gestation may

facilitate or restore trust in women's embodied temporalities. The socially accepted medical gaze has diagnosed normality. For example, some research participants reported that during pregnancies that occurred subsequent to miscarriage, accessing recurrent ultrasonography was an important tool for managing associated anxiety as evidenced in the following narrative.

**Kohuwai:** With my second pregnancy... I wanted to go to a doctor (names obstetrician) so I could actually have scans and things like that with every visit... I thought I felt safer with the obstetrician but... I really, I probably only went because of the scanning, the equipment. I know it sounds terrible, but um, (names obstetrician) was great. But the big thing was to be able to see that baby, and see that baby's heart beating, you know and see that baby growing, and think Oh cool, cool... That is really what I wanted; to actually keep seeing it, you know?... So I had (names midwife) with the first one (pregnancy that miscarried), and so when things started happening (beginning of second miscarriage) I... Yeh ... So I rang (names midwife) first because I knew, I think it was about 10 o'clock at night, so I knew I couldn't get hold of (names obstetrician/gynaecologist) anyway, because it was too late at night.... And that's what I did..., and then she organised a scan for me the next day at (named radiology practice) to see whatever it was. (2+) And my baby had died.

Ultrasonography is an expensive assessment tool so within the publicly funded health care system referral specifications are strictly legislated to ensure that national accessibility is financially viable. In the preceding narrative, Kohuwai reports choosing to employ private care from a consultant obstetrician in order to avoid potential gate keeping of publicly funded care services due to legislative constraints. However, as evidenced in Kohuwai's continuing story, corporeal temporalities are situated in a relational hierarchy with various other temporalities such as cosmological (too late at night) and economic temporalities (the private obstetrician, unlike a midwife, does not provide 24 hour coverage of care). Despite exercising agency in an attempt to ensure the visible and therefore continuous health and wellbeing of her unborn child, Kohuwai experiences a miscarriage. She is also confronted with the impositions of cosmological, resourceful and economic temporalities that in displacing the immediacy of her embodied temporality deny her access to the ultrasound scan and therefore constrain her access to the visual narrative of that temporality. The various temporalities therefore constitute metaphysical and material actants which may enable or constrain access to other actants (ultrasound scans) and actors (the doctor and midwife). Kohuwai's story also demonstrates how public temporalities and narratives

interweave to shape sets of understandings about appropriate temporalities for accessing care (seeing her doctor) and care interventions (having an ultrasound scan).

Alternatively, corporeal temporalities, may facilitate access to material actants and potentially constrain an individual's agency in relation to care provider, and care interventions. In the following narrative the importance of gaining knowledge for both care provider and childbearing women through visualising corporeal temporality has determined both choice of care provider and style of care provision.

**Rewarewa:** I had wanted a midwife to look after me..., Yes... (2+) I went in for serial scanning, because they were, they weren't sure about what was happening. And had an initial scan and it was six weeks and they could see a yolk sac but they couldn't see a heart beat. These were all trans-vaginal scans, they couldn't see much. So then I went back two weeks later, which was horrible, because you are sitting at home thinking, that doesn't make sense because I know when they ( the due dates) were put back, and I know what size they should be, and that size on the scan didn't make sense, when they were put back. You know it was all like not right...So I had another scan in two weeks and they said that they still couldn't see a heart beat, but they could see that things had grown, and they weren't convincing. So (names obstetrician/gynaecologist) said 'What do you want to do?' and I said 'We'll leave it for another week.' So we left it for another week and had another scan and there wasn't really anything. We were 10 weeks by then and so I went and had a D&C (dilation and curettage).

Rewarewa stories her experience of a pregnancy that has resulted from fertility treatments. The disciplinary narratives of medicine view such corporeal temporalities as tentative pregnancies that require increased medical scrutiny and management (Katz Rothman, 1993). Rewarewa's story constitutes a field within which temporalities both operate as actants and struggle for legitimacy and authority. In providing visual narratives of the temporality of pregnancy, ultrasound scans are discursively positioned in relational dominance to other corporeal temporalities such as the woman's embodied temporality and the corporeal temporality of gestation. This dominance is based on public and disciplinary narratives that perceive ultrasound scans as authoritative sources of knowledge; posited on the premise that 'seeing is believing'.

Rewarewa is constrained in her ability to exercise agency in relation to her pregnancy care by medicine's technological gaze; the visual narrative of temporality. She depersonalises her medical caregivers as 'they', who based on that which is visually

present ‘a yolk sac’ and that which is visually absent ‘they couldn’t see a heartbeat’, finalise her identity as non-pregnant and that of her unborn child as not human. She resists this visual interpretation by challenging both the scan’s accuracy, and positions the provider of authoritative knowledge, with her statement ‘they couldn’t see much.’ Despite social legitimacy, the research literature suggests that the accuracy and therefore authority of ultrasonography is questionable. The visual narrative of a trans-vaginal ultrasound scan is affected by factors such as the sonographer’s expertise, the position of the patient, anatomical configuration and the angle(s) of scan<sup>106</sup>(Merz, 1999; Rotten & Levailant, 2004).

Initially, Rewarewa’s strategy of resistance to the scan’s position as provider of authoritative knowledge is unsuccessful, but she continues to contest the scan’s legitimacy by drawing on medicine’s disciplinary narrative of gestation. Like temporalities, such narratives also function as actants and influence actors’ behaviours. In this instance the obstetrician acknowledges the woman’s concerns as valid by encouraging her to exercise agency and through seeking her advice about a potential course of action she is ultimately able to determine her care.

## **Summary**

Within the field of health and in relation to the human body, medicine has accrued the most dominant position in terms of social, economic and cultural capital. As Foucault (1963) suggests, it is medicine’s “eye that knows and decides; that governs” (p. 89) all things pertaining to health. Women and midwives may, or may not, challenge this view. However, within the preceding narratives there is evidence of participants’ resistance to being categorised and finalised, as well as challenges to medicine’s exercising of power and position within the field of health. In this chapter it is argued that as corporeal temporalities are networks of social relations in which struggle occurs over the appropriation or retaining of certain types of symbolic capital (Bourdieu, 1977, 1990, 1996), that within the context of this research, they constitute fields (Bourdieu, 1977, 1990). Analysis of participants’ stories suggests that corporeal temporalities associated with age, bodily processes and foetal gestation simultaneously and hierarchically position (Davies & Harre, 1990), actors within the various fields that are associated with miscarriage. This chapter has suggested that women who miscarry may be simultaneously positioned within the field of miscarriage, the field of

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<sup>106</sup> Although two dimensional trans-vaginal scans have been routinely used to diagnose foetal abnormalities at an early gestation, three dimensional trans-vaginal scans are currently recommended for precise delineation of defects.

care provision, and or other relational or temporal fields such as those associated with cosmology, institutions, economics, medicine and/or legislation. In hierarchically positioning women within a range of fields, temporalities operate as metaphysical and material actants (Latour, 1993, 1999) which shape agents' behaviours in terms of accessing and providing miscarriage related care. Through shaping agents' behaviours temporalities also influence the actions of other material actants such as drugs, surgical technologies, and hospital resources as well as metaphysical actants (public narratives, women's stories, silences). Through influencing agent's behaviours and beliefs, corporeal temporalities may also be construed as technologies which both shape ontological, public, conceptual and meta-narratives and facilitate the construction of actors' un-finalised and contestable identities. The various relational interactions of heterogeneous temporalities that are related to diverse bodies, narratives and identities may therefore be construed as actor networks (Latour, 1993, 1999). Power and resistance are simultaneously exercised and contested within actor networks and/or fields through the application of temporalities as metaphysical and corporeal technologies.

# 7

## Reading Between the Lines Stories, Silences and Silenced Stories

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*Ka ngaro te reo tangata, kiki o manu.*  
(Human voices are silent except, the twittering of birds).

“Our lives begin to end the day we become silent about things that matter!” Martin Luther King (1929-1968).

“Silence is one of the great arts of conversation.” Marcus Tullius Cicero (106 BC - 43 BC).

“Silence is a source of great strength” Lao Tzu (600 BC - 531 BC).

“There is not one but many silences, and they are an integral part of the strategies that underlie and permeate discourses” (Foucault, 1976, p. 27).

### Introduction

Literature drawn from the disciplines of sociology, psychology, nursing, social work and anthropology suggests that miscarriage has become sexualised (Oakley et al., 1984) and is constructed as physically, emotionally and sexually messy women’s business (Abboud & Liamputtong, 2003; Cecil, 1996; Moulder, 2001). This conceptualisation is perpetuated in the media as miscarriage is frequently portrayed in televised dramas<sup>107</sup> as visually bloody, physically painful and emotionally traumatic

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<sup>107</sup> Grey’s anatomy, season 2, episode 3, first aired 10/9/2005 in the United States of America and on TVNZ Channel 2, 9.30pm 20/02/06; Brothers and Sisters; Brothers and Sisters season 2, episode 6 first aired 11/4/2007 in the United States of America.

tragedy.<sup>108</sup> Morris (1991) proposes that the notion of miscarriage as an abject narrative is rejected within western cultures. Such rejection may position women's losses at the margins of what is socio-culturally deemed normal within the Western (European) paradigm (St John, Cooke, & Goopy, 2006) and constitute miscarriage as a "taboo topic" (Hazen, 2003, p. 148). Within the wider community, public, cultural and disciplinary narratives present unwritten rules about what may be considered discursive taboos (Charmaz, 2002). Various narratives may impose silence on women and their families and perpetuate the social silencing of miscarriage as a discursive topic. Foucault's (1976) linkage of taboos and silences as key aspects of what he describes as the "modern puritanism" (pp. 4-5) within western society, suggests that discourses and/or narratives about miscarriage may be shaped by, and contain, multiple silences.

Most of the women interviewed for the research, narrated stories and experiences that were consistent with prior research findings regarding miscarriage-related silences. Specifically, the social silences in relation to miscarriage (Frost, Bradley, Levitas, Smith, & Garcia, 2007; Layne, 1997; Moulder, 2001; Renner, Verdekal, Brier & Fallucca, 2000; St John et al., 2006; Van, 2001), and the silencing of miscarriage experiences, care choices, and access to care provision, by health service providers (Cecil, 1994; Friedman, 1989; Wong et al., 2003) and health institutions (Adolfsson et al., 2004; Bansen & Stevens, 1992; Cornell, 1992; Harvey et al., 2001; Simmons, Singh, Maconochie, Doyle & Green, 2006; Tsartsara & Johnson, 2002). Participants' stories also presented experiences that were comparable with previous research findings which suggested medical and masculine hegemonies may, in some instances, facilitate the silencing of women and their families (Brost & Kenney, 1992; Davis-Floyd & Sargent, 1997; Letherby, 1993; Malacrida, 1999; McCreight, 2008).

Attention to the interwoven silences and voices in participants' ontological stories of miscarriage has suggested that women are knowledgeable about the various actions of silences and have developed expertise in the crafting and strategic operation of silences within social interactions and activities. In this chapter women's and midwives' strategic applications of internalised silences and externalised silencing practices within ontological narratives are considered. Foucault (1988b) suggests that immaterial elements, simultaneously classified as tools, techniques, systems, and/or organisational structures that are used to strategically shape, and are potentially

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<sup>108</sup> In this thesis the term 'tragedy' refers to an event that results in; great loss, misfortune and personal distress.

embedded within and shaped by social processes may be broadly characterised as technologies. Rose (1999) proposes that “technologies imbued with aspirations for the shaping of conduct in the hope of producing certain desired effects and averting certain undesired ones” (p. 52) operate as technologies of power. Within the context of this research the silences and silencing practices employed by participants, in shaping, narrating and relating to ontological, public, conceptual and meta-narratives about miscarriage are arguably operating as technologies of power.

Similarly to chapter six of this thesis, where it was argued that corporeal temporalities simultaneously constitute metaphysical and material actants and actor networks it is suggested that silence(s) may operate as technological actants. Silence is conceptualised in this chapter as being simultaneously a hybrid actor/actant, relational entity and a situated but dynamic and therefore never finalised network of heterogeneous elements/actants and/or actors that are reciprocally co-constitutive. Drawing on Latour (1991, 1993, 1999) and Callon’s (1987) relational conceptualisations of technology, actants, hybrid actors and networks and Michel Foucault’s (1988b) theorising of technologies of the self, desire, signification and production, silence is conceptualised as both a technology of power and actor network. It is also suggested that silence through strategically shaping and structuring social dynamics, terms of social existence and social organisational patterns, may be construed as agency, the product of agency and structure.

The term techno-silence<sup>109</sup> has been used in the chapter to accommodate the multiple and multi-layered silences that are deliberately constituted or used by research participants. The actions of techno-silences within miscarriage narratives are explored in relation to participants’ construction and maintenance of various ontological selves,<sup>110</sup> agency, social conformity, resistance to hegemony, professionalism, and culture. Participants’ narratives, in addition to presenting ontological silences, story the silences, and silencing practices, of health professionals, family members, friends and the wider community. The actions of techno-silences within peer, professional, health related, familial and community relationships are also examined. It is argued that within the context of this research, women strategically employ technologies of silence

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<sup>109</sup> Techno-silences are conceptualised as separately and collectively constituted, deliberately voiced and/or unvoiced, and characterised individually and/or contemporaneously as personal, cultural, embodied or corporeal, communicative, relational, economic and productive.

<sup>110</sup> The term ‘ontological selves’ is used as a synonym for the personal, social, relational, corporeal, cultural, productive and/or professional identities/roles that are evidenced within research participants’ narratives.

to govern or manage multiple risks<sup>111</sup> to their ontological selves' within private and public settings.

### **Silence as Technology: Actants, Actor Networks and Bio-Power**

The techno-silences associated with miscarriage are deliberately constructed tools and/or processes that shape, are shaped by, and embedded within, ontological, public, conceptual and meta-narratives. Within narratives, conceptualised in this thesis as dynamic, relational and un-finalised social networks (Latour, 1999) and/or social fields with porous boundaries (Bourdieu, 1977), silences may operate as technologies of power (Foucault, 1982, 1988). Latour (1993, 2000) suggests that technology and society are relationally embedded and mutually constitutive, in that technologies operate as dynamic processes that shape social interactions and structures. Narrative silences, through constituting and maintaining identities and operating as a form of psychosocial governance (Foucault, 1977) by providing storytellers with temporal, spatial and social distance from the miscarriage experience, may constitute technologies of the 'self' (Foucault, 1988b). Davis (1995) argues that women's bodies may be commodities able to "be endlessly manipulated, reshaped, restyled and reconstructed to meet prevailing fashions and cultural values" (p. 17) in order to maintain social marketability (Foucault, 1988; Lupton, 1995). Drawing on Davis (1995) it may be theorised that the various narrative silences and forms of silencing associated with women's reproductive bodies, may be situated in relation to technologies of desire<sup>112</sup> and therefore function simultaneously as Foucauldian (1988b) technologies of production.

Technologies of power as theorised by Foucault (1988b) shape human bodies, behaviours and therefore agency. Agency<sup>113</sup> viewed through the lens of Actor Network Theory may be characterised as a "regulatory fiction"<sup>114</sup> (Haraway, 1991, p. 135); something you 'do' rather than 'have' (Haraway, 2000). In constructing agency as stripped of intentionality<sup>115</sup>, Haraway (1991, 1997) draws attention to Latour's (2005) alternative perspective that "objects too have agency" (p. 63). Latour's (1999, 2005)

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<sup>111</sup> In this thesis, risks to the self are categorised as physical, embodied, emotional, psychological, social, economic, professional and reproductive.

<sup>112</sup> Attached to identities such as the healthy individual, fertile woman, successful childbearer, mother.

<sup>113</sup> Agency is a concept used in philosophy and the social sciences that refers to an agent's (Bourdieu, 1990) or actor's (Latour, 1999) ability to act in the social world. Within neo-liberal discourses, agency is commonly understood as the provenance of humanity in that it encompasses an individual's ability to make independent choices and be unconstrained in enacting (socially sanctioned) chosen behaviours.

<sup>114</sup> In which free will is reified over social and economic constraints on individual choices.

<sup>115</sup> Haraway (1997) argues that agency as a set of disciplinary practices and as a form of valorisation is both embodied and incorporated into networks such as exchange relationships through which everything else (people, objects, economic subsystems, ideologies) are transformed.

attribution of agency to non-living objects reconstructs objects as actants which though unable to make sentient choices normally considered a requirement of agency, influence human behaviour. Latour (1999) mediates potential theoretical critique<sup>116</sup>, through defining technological actants as hybrid entities or actors, constituted by 'hard' material and by the social universe in which they operate and which, as suggested by Callon (1987), they also help create. Michel Callon (1987) adds that an assemblage of actants, hybrid entities and other diverse elements is "simultaneously an actor or entity whose activity is networking heterogeneous elements and a network that is able to redefine and transform what it is made of" (p. 93). Latour (1999, 2005) and Callon (1987) suggest that objects are not passive vehicles for human interests but actors within their own right and they present material technological actants as relational entities. As previously suggested in chapters five and six of this thesis, Foucault's (1988) conceptualisations of technologies of power mediate Latour's (1993, 1999) focus on hard technological actants and the materiality of technology. In this chapter Foucault's (1988b) and Latour's (1993, 1999) conceptualisations of technologies are interwoven to facilitate the theorising of silence(s) as simultaneously metaphysical and material technologies which enable agency.

Narrative silences are individually and socially constructed through the exercising of agency. Participants deliberate application of silences for the strategic manipulation of actors, and actants within narratives suggests that in addition to being 'the product' of agency, silence may be construed 'as agency', particularly in situations where silence functions as a form of resistance to hegemonies such as the power exerted by biomedicine within the field of health. The silences within and of miscarriage narratives may be considered as resources that are generative and/or co-constitutive of social action within particular settings. Giddens (1984) proposes that "the rules and resources drawn on in the production and reproduction of social action are at the same time the means of system reproduction - the duality of structure" (p. 19). In contemporaneously operating as personal and moral agency and constituting structural hegemony, silences may operate as technologies (Foucault, 1982, 1988b;

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<sup>116</sup> The notion of autonomous human agency is critiqued within the social sciences, because individuals are perceived as being situated within social milieu and therefore influenced by social structures. Structuralists perceive individuals as socialised into, embedded within and therefore products of social structures. Individualists locate human agents at the centre of social worlds and view social structures as creations that arise from the relational interactions amongst individuals. Some theorists (Bourdieu, 1990; Giddens 1984) have attempted to mediate the agency/structure theoretical divide through focusing on the co-constitutive nature of the agency/structure relationship. Structuration theory is an exemplar (Giddens, 1984). However, Latour's (1993, 1999) theoretical attribution of agency to objects disrupts distinctions between objects, agents, structures and social worlds through drawing attention to the relational network within which hybrid actors are embedded, and collaborate to create.

Latour, 1993, 2000) that mediate the relationship between agency and structure and represent an exemplar of Giddens' (1984) structuration theory.

Narrative silences may therefore constitute metaphysical actants which shape the behaviour of and discursively position the narrator and other actors and/or actants within narratives. In doing so, narrative silences influence the assignment of, and struggle over various forms<sup>117</sup> of capital. Within the context of this research, it is suggested that participants construct and apply silences within miscarriage narratives to discursively create and maintain self identities. Actors within participants' stories are hierarchically and relationally positioned (Davies & Harre, 1990; Harre & Van Langenhove, 1999) by various silences, and are in turn perceived by participants as using silences and or silencing strategies to reflexively position other participants and actors within the field of miscarriage.

Within stories, silences are frequently characterised as absences of sound (Charmaz, 2002), primarily of voice. Denzin (1997) suggests defining "voice is a complex matter. It refers to many things at the same time...; the quality of being voiced or voiceless – having no voice; and silence" (p. 40). DeVault (1990) argues that silence may be understood both literally and metaphorically .... "Silence means not speaking, not writing, not being present, not being heard or listened to, and being ignored, censorship, marginalisation, trivialisation, exclusion, ghettoization and other forms of discounting" (p. 77). If as Denzin (1997) and DeVault (1990) suggest, voice and silence are complex, intertwined phenomena, then when a narrator is saying one thing within a narrative space, they are not saying another.<sup>118</sup> Bourdieu (1996), in his discussion of how representations in the media privilege one perspective on an issue over another, describes this activity as "hiding by showing" (p. 19). He defines this activity as hegemonic in nature. The problematization of silence(s) within, and by, western discourses may be considered cultural hegemony (Poland & Pederson, 1998). In contrast Mazzei (2003) characterises silences as inhabited and meaningful. For example, within Te Ao Māori (the Māori world) communicative and/or linguistic silences within stories are culturally enabling. Such silences open up social space for reflection, enlightenment and comprehension as well as suggested by Holmes (2003),

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<sup>117</sup> Within the chapter Bourdieu's (1984) conceptualisations of symbolic, social, cultural and economic capital are extended to include embodied forms of capital.

<sup>118</sup> The research acknowledges that arguably the intertwined phenomena of voice(s) and silence(s) within narrative spaces may facilitate individuals in simultaneously communicating more than one element at a time. However, with regards to the agency exercised in 'saying', individuals, elect to 'speak' particular words in preference to others.

facilitating social connection through reciprocal communication of knowledge and shared cultural understandings.

Although linguistic silences have been extensively discussed within the social science literature (Charmaz, 2002; Jaworski, 1997, 2005; Kurson, 1998; Poland & Pederson, 1998), silence may be more than an antonym for sound and constituent of 'voice'. If, as Latour (2004) suggests, "[t]he body is engaged in accounts about what it does" (p. 206), then the body potentially communicates silence physiologically through miscarriage. For example, through miscarriage states of being (pregnancy), and/or identities (mother and/or child), are subject to embodied silencing. Miscarriage is also constructed by public and disciplinary narratives as corporeal or embodied silence and linked with the biomedical model's mechanical metaphors of infertility; the broken body, the faulty factory, and the "idle machine" (Lupton, 1999; Martin, 1989, p. 45). Implicit within these constructions of embodied silence is the disruption of technologies of (re) production and challenge to the discourses and practices of biopower. Douglas (1966) states "[T]he body is a model which can stand for any bounded system" (p. 115), suggesting that the structures and processes of the body may mimic those of "the body politic"<sup>119</sup> (Lupton, 1999, p. 40).

### **Silence, Privacy and the 'Private Self'**

The simultaneous action and interaction of technologies of power (Foucault, 1963, 1977, 1988b) in order to shape identities, bodies, and behaviours, that occur in private settings, is demonstrated in the following narrative. Inaka's story presents her miscarriage as a deeply personal and private experience.

**Inaka:** And I actually went to the hairdressers this day and um..., I thought I was going to treat myself. I got the solution put into my hair and it was really, really strong, and I was thinking 'Geez and I wonder if that could do anything?' Well I think it did, because I'd no sooner come home you know and all of a sudden I started going into um..., like labour pains. And you're thinking to yourself all the time 'Is this a miscarriage?' And you don't want to tell anybody so you don't. I didn't.... But..., 'Is this what a miscarriage is?' And 'No, it's just your period coming. You were just late', you know it has finally come, that's how I felt. But I would probably say I would have been 8 weeks (infers gestation) ..., just a little while to grow (infers baby)... (2+) (speaks quietly) Yeh it was barely there really. (1+) But it was the pain

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<sup>119</sup> Within this thesis the term 'Body politic' refers to a politically organised, spatially situated and constrained body of people that are uniformly subject to regulatory and disciplinary power. Gatens (1996) links the body politic to the imaginary body that is embedded within civic discourses. She identifies this body as white, male, middle class, heterosexual and able-bodied.

that I felt, I just knew that this is not your normal monthly period, and I went to the toilet, and it (bleeding) just kept (1+)(speaks more quietly) kept going. And you're sort of sitting there, and you go into your own space and think (whispers) 'I think I've just had a miscarriage what do I do now? Do I need to go to the doctor?' I didn't do any of that stuff... I didn't want to tell my family... Every time I told my mother that I was pregnant or something, it was 'Oh you're not! Oh NOT again!'. So I hadn't told anybody except for my best friend ... So I waited a while until it ..., slowed down and after a while I had a shower and I washed myself... And I thought 'I didn't really want to be pregnant in the start so... I didn't have any sad loss about it but... But it's not until you come to it later... You think about it... And he would be 21 now.

In Inaka's story, her pregnancy has an absent presence<sup>120</sup> (Schilling, 1993) in her initial conceptualisation of the hairdressing experience as a source of health risk. Silence is strategically used to govern the potential risk of self blame. Personal agency in relation to salon services is masked through attributing blame to the hair solution which, drawing on Latour (1999) may be characterised as a potentially dangerous actant. Inaka repeatedly self questions her physiological symptoms, and provides alternative rationalisations for her physical experience to silence the personal reality of miscarriage. In doing so she deliberately avoids pain and grief and creates an illusion of wholeness and health. Applying silence as a technology of the self ultimately proves ineffective for Inaka to maintain her self identity as non-pregnant. She re-conceptualises self silencing of her miscarriage as a personal choice. In stating 'You don't want to tell anybody so you don't' she constructs silence as agency in order to manage risks to social and relational 'selves'.

Inaka uses the personal pronoun 'I' when she states 'I would have been 8 weeks', to both acknowledge the physiological experience of pregnancy and appropriate her unborn baby's narrative of identity (gestation). Silencing her baby's claim to a narrative identity enables Inaka to depersonalise the baby as "it" and position the miscarriage as bodily waste or refuse to be disposed of in a toilet. Within this narrative, lexical and non-lexical silences and physical silencing of voice, minimise and/or metaphorically silence the corporeal silence of miscarriage. However, Inaka also acknowledges these silences in her story with conversational and tonal silences. Such pauses or silences are commonly applied in social interactions and potentially indicate that what is being stated is contentious. It may therefore be inferred that although

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<sup>120</sup> 'Absent presence' is a term developed by Chris Schilling (1993) which acknowledges the body as an active agent, and the ways in which it shapes individual's behaviour and therefore indirectly the social world, are commonly rendered invisible within narratives and other discourses.

Inaka has deliberately silenced her miscarriage experience, it is problematic or difficult for her to do so, and her actions may be shaped by social narratives that determine what stories may be publicly re-produced.

Miscarriage occurs in secrecy hidden from view because cultural rejection of the notion of tragedy may limit societal tolerance of grief (Moules, 1998). Silences may also represent what cannot and/or should not be said. Charmaz (2002) suggests that stories are context specific with their “own standards of acceptability and adequacy” (pp. 316-317). Public narratives govern which ontological narratives are selected to be socially re-produced. Stories perceived to be dangerous are characterised as liminal stories and are socially silenced. As miscarriage stories are stories about deep plight, have cultural associations with narrative conceptualisations of body fluids as pollution and the transgression of boundaries (Douglas, 1966), they may not be publicly acceptable and/or able to be socially reproduced.

In cleansing the traces of the miscarriage from her external body it could be argued that Inaka has personal knowledge of public narratives that associate menstrual and miscarriage related body fluids and tissue with pollution (Douglas, 1966). Showering may represent ritual silencing of the state or identity of failed mother and movement to a new, healthy and fecund state. Inaka uses silence to manage psychosocial and emotional risks through detaching from her emotions, and denying her desire for a baby. In stating ‘you go into your own space and think... What do I do now?’ she suggests that spatial distancing and temporal silences have also facilitated coping with the loss. Her competent management of her miscarriage experience is evident in her final comment. Silences are no longer applied as measures for protecting the self, and in contrast to preceding narrative silences, she constructs her child as a temporally relational actor through the assignation of gender, age and human identity.

Inaka’s comment ‘you go into your own space’ may also be construed as deliberate self-silencing, which enables her, through facilitating the creation of a form of privacy, to gain psychological distance from the miscarriage event. Swanson, Chen, Graham, Wojnar and Petras (2009) suggest that psychosocial distance may provide women with partial emotional protection from experiencing the grief associated with child loss. For example, distancing may act as a form of protection through preventing women from developing awareness and comprehension of what might occur and/or might have occurred, in terms of the physical event, health care interventions and institutional practices. Alternatively, Inaka’s crafting of spatial silence may be understood as

providing her with a temporalised spatiality in which she may focus on the ontological meaning of miscarriage. In both cases silence provides a mechanism for protecting the ‘self’ and managing the miscarriage and associated experiences of loss and grief. Intellectual space is privately owned and removed from the corporeal reality of miscarriage, allowing self-acknowledgement of the miscarriage, whilst maintaining a social silence. In discussing her ongoing silence regarding the pregnancy and subsequently the miscarriage in relation to family members, Inaka states she ‘didn’t want to tell’ due to her fear of receiving a dis-preferred response from her mother and being criticized and/or marginalised by her whānau. Her silence has become a technique for maintaining a moral relational status. ‘Not doing’ operates as silence in action to govern potential risks to personal, social and relational selves.

Women who have experienced miscarriage also manage the risk of social rejection through deliberately and strategically employing self silences in order to maintain various selves and/or identities within multiple settings. The application of moral, personal and social silences in order to conform with social ‘norms’ and minimise potential risks to the ‘self’, are also evident in Totara’s story.

**Totara:** I realised that I was pregnant at that stage (after ending relationship)... And of course it wasn’t the done thing! You know nice girls didn’t... I didn’t say anything and worked out that I could be a solo mother... I miscarried... That was so sad because I was so cross that this child had rejected me, that was my first thought, that he chose not to stay with me... And then... rationalized that it was perhaps a good thing..., that boyfriend and I were not..., compatible, and ... Then the midwife says ‘Well maybe it wasn’t a good one’ and there are all those sorts of things with which you rationalise that loss... I never told the baby’s father, oh I’d see him occasionally, and we’d meet at the pub for a drink and that sort of thing, because we’re good mates and I still ..., see him occasionally... Anyway..., so I um..., I didn’t tell my flatmates that I had been pregnant either..., because I didn’t think... It wasn’t something that I thought they would have empathy with you know... And I’m tough and strong anyway. (2+) (Speaks quietly) Yeep. But I was really bereft; I was really sad that that had..., had happened to me. That, that this little person..., obviously that’s all the journey he wanted to make.... (Whispering) Um..., I called him (names baby) because that’s what I was going to call him if he was a boy, um ..., (long pause) um..., and he was..., (names baby) was born complete with., um..., (whispered) in the..., in the amniotic sac..., and (2+). I went to my GP afterwards and said ‘This is what’s happened.’ And so she prodded my stomach and said ‘Right you know what to do.’ So she listened and gave me some..., support and said ‘Are you Ok?’ and... and she said ‘What have you done with it?’ And I said ‘Buried it in the garden under a tree.’... One

of the women I was flattening with owned the house, and a number of years later, she said 'you know that tree in the corner of the garden, I'm cutting it down; it never really was a good one.' 'OH NO! DON'T CUT DOWN MY TREE!'

Temporally contingent public narratives such as 'nice girls' do not have sex, or conceive and have babies out of wedlock' shape Totara's story and embodied experiences of pregnancy and miscarriage. Totara constructs herself as not a 'nice' girl because she is sexually active outside marriage and therefore transgresses social 'rules'. Her subsequent pregnancy is also constructed as problematic because it is contravenes social norms. Drawing on her midwife's labelling of the baby as 'not a good one' (defective baby), she rationalises her miscarriage as the moral result of non-compliance with social 'norms'. Corporeal silencing of life is inferred as a 'punishment' for enacting embodied agency that is socially constructed as immoral.

Totara also constructs her unborn child as a gendered agent who initiates the miscarriage as an expression of his embodied agency. She alludes that he rejects her and chooses 'not to stay' as a result of her self determined personal, social and moral inadequacy. Perceiving herself as inadequate creates and shapes risks to the 'self'. Totara attempts to manage such risks by using silence.

Women who have experienced miscarriage may self silence due to the perception that in voicing their stories they transgress the social rules regarding the narration of liminal tales (Zeidenstein, 1995) and because no one 'wants' to hear their story (Charmaz, 2002). Totara 'hides' her vulnerable identity and shows a 'tough and strong' persona. She also lexically, non-lexically, and tonally silences her pregnancy and miscarriage related experiences within public and private settings. Her risk management strategies are subsequently unsuccessful<sup>121</sup> Despite Totara's desire to share her miscarriage experience within the interview, she has great difficulty telling her story due to the distressing memories it revisits. Non-lexical silences disrupt narration suggesting that personal agency in relation to 'voicing' her experiences has become psychosocially and emotionally constrained in relational interactions.

The health services provider (general practitioner), through labelling Totara's miscarried baby as an 'it', dismisses the baby's identity as human, and potentially Totara's identity as mother. However, Totara perceives her care provider as supportive and she discusses her miscarriage experience, including her ritual care of her

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<sup>121</sup> After audio-taping of the interview was concluded, Totara reported that she grieved for many years over the loss of her child.

miscarried baby (burial under a tree), with the care provider. Totara's outspoken ownership of the tree suggests that the tree has become a silent metaphor for her child. Although never explicitly stated in her narrative, having buried her unborn child at the base of the tree, she infers that the baby has been reborn and continues to live and grow by becoming part of the tree. She may consider her former flatmate's devaluing of the tree as repetition of the devaluation of the baby expressed in the midwife's reported talk at the time of the miscarriage. The destruction of the tree may represent a final and externally controlled silencing of her pregnancy, miscarriage, unborn child and private identity as mother. Her story continues with her commentary on the personal and professional repercussions of self-silencing in regards to her miscarriage.

**Totara:** Not telling anyone really, apart from the GP..., not a good thing when I think about it now, and that's why I'm very insistent to my clients to encourage them to at least tell another supportive friend. They can tell their partner but I want them to tell another woman as well, so that they have actually got someone on that empathy level to talk about the experience of miscarriage with... My personal experience has certainly helped me, um... (sighed) emphasize to women having miscarriage, to look at it as a person that has been lost to you and to grieve, to acknowledge that they were a person to start with and to grieve it, but to keep talking about it.

Practising self silence in response to miscarriage may subsequently contribute to women experiencing a sense of isolation that is potentially heightened because the disciplinary narratives of medicine have "...emphasised women's biological unreliability as reproducers" (O'Malley, 2005, p. 52). Totara's experience is that self-silencing of personal narratives is ineffective for resolving pain and/or grief, and this perception of self-silencing has shaped her midwifery practice. She describes her miscarriage experience as a professional asset that gives her an advantage when supporting women having similar experiences to her own. Contrary to the self-silencing of her miscarriage narrative, she promotes the narration of woman's stories and encourages her clients to share their experiences and feelings about miscarriage. Sharing is encouraged in order for women to avoid social isolation, to establish supportive networks with close family and friends and receive reassurance that they are not faulty or inadequate. Her clients are encouraged to have what she now perceives as key elements of miscarriage care.

Totara initially constructed silences around the miscarriage experience as providing her with privacy, as well as protection from social scrutiny and potential judgement.

Distal to the miscarriage, these silences continue to shape her ongoing practice and enable her professional development. In influencing this midwife's practice and potentially her client's behaviour, these silences become temporally mobile and, drawing on Latour's (1993, 1999) theorising, operate as multifunctional actants which fold the past experience of miscarriage into the present practice context.

### **Silences: Temporally Mobile Actants**

Temporally mobile silences in which the past manifests itself in the present are also evident within the narratives of women who experience pregnancy and childbirth subsequent to miscarriage. Such silences may contribute to the development of, and/or exacerbate, women's anxieties about childbearing as evidenced in the following stories of Totoweka and Kohuwai.

**Totoweka:** I was so uptight..., worrying about miscarriage in that pregnancy every blimen step of the way! So, very, very, anxious... I just told people I was worrying because I was older... So I lied, basically. But it was because of the miscarriage! And there was no one! (2+) I mean it was something you just shut up about. You know? I never, I mean you know, I never spoke about it.

In Totoweka's story the past (miscarriage) becomes the present. Her previous experience of miscarriage produces anxieties and fear of reoccurrence in her current pregnancy. She manages these anxieties through the application of silences. Drawing on Bourdieu's (1996) conceptualisations of media practices which privilege particular versions of events in relation to others, Totoweka's behaviour may be characterised as 'hiding (one reality) by showing (another)' In stating that she lies to 'hide' her internal state, she effectively conceals her miscarriage-related anxieties by 'showing' or acknowledging anxieties drawn from public and disciplinary narratives that conceptualise reproductive risk based on chronological age. In contrast, Kohuwai characterises her narrative silences as exaggerations of the truth.

**Kohuwai:** And then when I got pregnant with (named second daughter) I thought 'Here we go again, I'm going to have another miscarriage'... And you don't talk about it but..., I did anything I could to get scans because then I could see for myself that the baby was okay... You know, like I had morning sickness for a long time and sometimes after sex there was a bit of bleeding, but I'd exaggerate when I was at the doctors... (laughed) I suppose it was a bit naughty... But it was the same with the other children when I had them... I felt really stressed through those

pregnancies. Oh I was so::<sup>122</sup>, I was really nervous but I never told my doctor. He just wouldn't have understood.

Kohuwai acknowledges the influence of public narratives that constitute miscarriage as an unacceptable topic for social conversation by remarking 'You don't talk about it (miscarriage).' However, she alludes to the social silencing of miscarriage as problematic because socially silenced anxieties related to her past miscarriage are revisited in the 'new' pregnancy and she has become 'stressed', 'really nervous', and requires ongoing reassurance. Potential risks to psychosocial wellbeing are managed by 'hiding' pregnancy-related anxieties because the 'doctor... wouldn't have understood', and 'showing' the doctor deliberately problematised physical signs which Kohuwai infers, would enable her to access ultrasound technology. Disciplinary narratives of medicine are drawn upon to foreground her gravid state, in conjunction with current uterine bleeding, in order to facilitate the corporeal silencing of miscarriage. Kohuwai, through implying the presence of corporeal or embodied silences, is enabled to manage potential risks to her various 'selves'. She strategically uses her body and body silences to gain access to ultrasonography technologies which she perceives as a means of personal reassurance.

The strategic application of silences in Totoweka's and Kohuwai's stories result in the social perception that both women are fertile and healthy. Silences may therefore be considered as enabling, and simultaneously constituting and/or operating as actants, technologies and agency.

### **Agency/Structure: Embodied and Embodying Silences**

Women may use embodied or corporeal silences to enable self management of potential risks to the 'self' within private settings. The following narrative suggests that such silences may enable or constrain (Davis, 1995) women's agency in relation to governing potential risks to the 'self'.

**Kakotea:** People don't need to know every single detail. I'll tell the details to who I tell, and leave it at that anyway so I suppose um... think at that point it (the miscarriage) was very private, and new territory and I think I was working out how I was going to deal with it, and how it was going to hit me, and all that kind of thing you see? I felt really vulnerable... But I couldn't let go and just felt so bad and had this funny lump in my throat, um, that you know... I, I swallowed, and I could never quite swallow properly and I felt there was something there and so I thought I

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<sup>122</sup> ::: Lexical convention used in conversational analysis to indicate an extended vowel sound in speech.

should be, you know responsible and get it checked out. And ah..., the GP couldn't find anything, but she could see that I was worried about it and so she said 'Well if you like I can make an appointment for you to go and get it checked by a specialist...' So I did that and he found nothing... And then eventually..., it um..., it just went away, months later, and I read coincidentally in a book that apparently a sign of unresolved grieving is to have a lump in the throat that you can't... get rid of, so I believe that's what it was...

Kakotea presents her miscarriage as a 'very private' and therefore self-silenced experience. She initially positions herself as an autonomous agent in relation to verbally 'voicing' her story, and rationalises decisions to selectively voice or not-voice her story within social contexts. Miscarriage is perceived as an aberrant event that is situated outside her lived context. Saville-Troike (1985) suggests that embodied silence may include non-action, which may be applied according to McKeever and Miller (2004), for purposes of strategic manipulation. Deliberate non-action is a form of action and may constitute agency. Self-silencing of embodied 'doing' may constitute a strategic response to oppressive and controlling practices (Houston & Kramae, 1991) by health care providers and/or institutions. Embodied resistance to voluntary self-silencing practices may also be enacted through forms of physiological silencing. An example of this physiological silencing is an unexplainable lump in the throat that may constrain speech, and which occurs contemporaneously with the intentional self-silencing of the miscarriage. In situating and silencing herself, within 'new' and unfamiliar 'territory', Kahotea exercises agency in order to construct spatial and embodied silences for managing perceived risks to her wellbeing. Over time, Kahotea notices a 'lump' in her 'throat' that constrains her ability to swallow. Attempts to identify the source of her physical discomfort are not successful and she eventually self diagnoses her 'funny lump' as unresolved grief. In this story, embodied silences that were initially and strategically constructed as actants (Latour, 1993) to facilitate self protection have become entrenched corporeal silences that are experienced as psychosocially constraining and physiologically disabling.

Miscarriage related, embodied or corporeal silences may directly and indirectly constrain women's agency, in relation to performing activities or roles associated with personal and/or social identities (Davis, 1995), as evidenced in Totoweka's narrative.

**Totoweka:** Self blame is one of the reasons you keep it (miscarriage) quiet... It's I've done something wrong ... and that's made me miscarry... as in my case, I mowed the lawns! Yes. I mean it's really bizarre... I certainly didn't expect it to be

some sort of, you know, odd twinge when I was doing household chores ..., mowing the lawn. (1+) And now..., I don't mow lawns. (exclamation) You know, isn't that pathetic! (said angrily). (2+) (speaking quietly). Because I had a miscarriage when I mowed the lawns 12 years ago (started to cry)... Isn't that dopey? I'm just very aware that I've only mowed this lawn once and we have been living here 12 years, and that I was mowing the lawn when my miscarriage started... Isn't that, I mean that's crazy. (sobs) God!

Totoweka perceives mowing the lawns as the genesis of her miscarriage. She infers that mowing is a household chore and a home owner's responsibility. Having chosen to undertake this activity, an activity that subsequent to the miscarriage she views as unsafe, she ultimately positions herself as liable for the loss. In doing so she draws on public narratives about the constitution of risk, as well as social and disciplinary narratives that apportion blame for reproductive failure on a gendered basis. Self blame becomes the rationale for remaining conversationally silent about the miscarriage within social and familial interactions. Totoweka links the embodied action of mowing the lawn with the corporeal silence of miscarriage thus facilitating verbal silences within interpersonal interactions and culminating in the ongoing constraint of agency in relation to performing the household activity, mowing the lawns. Verbal and physiological silences conjointly generate and are relationally embedded with embodied silences, presented in the narrative as a form of deliberate action through non action or not-doing, suggesting that embodied silences may operate as both constraint and agency.

The employment of embodied silence as agency in response to medical hegemony is also evidenced in Totoweka's narrative. In the following excerpt various techno-silences are employed by both the health care provider and Totoweka.

**Totoweka:** Went in (to the doctor's office) and said..., I have been bleeding, have I had a miscarriage? And he said 'Oh, they usually fax me if there's something wrong. I don't think so. I'll, let's have another look. Blah, blah' so he went out of the room, and he obviously rang the um..., radiographer and came back and said 'Yes, yes, yes you've had a miscarriage, 25% of women have miscarriages, um... And I said 'Well you know what, is there a process or anything?' And he said, I still remember very clearly!, he said that 'There are some brochures in the waiting room that might be some help, um but if you really don't feel much good come back'... This is the doctor! (1+) This is the GP (general practitioner), the visit the next morning (after the ultrasound scan). So I went out and I couldn't see... It was a room full of people. (2+) (speaking loudly with emphasis) Well! I wasn't going to go and find..., a brochure from I don't know where in

the waiting room! (1+) So I went home... And that was my experience of miscarriage... I am still frustrated when I think about what happened that day..., but it was mainly the lack of..., him (the doctor) providing..., any information. It was very much, oh get... (Angry tone) It was glossed over! It was got over! You know, then 'Go out! Go on out, and pick up something on the way out!' (angry tone)... Oh, just that it was a total non event. It was like I'd gone in for a cold! (angry tone)... I have never brought it up with him. Never! Never! Never! (1+) (speaking more quietly) No, it's never been referred to on any of my um..., you know, I presume it's on my medical file. I'm sure it's on my medical file. I must check now actually.

In this narrative the doctor initially challenges Totoweka's story of miscarriage because he has not been informed by an authoritative source (ultrasound report) which suggests to Totoweka that her embodied knowledge is not valued and therefore the miscarriage could not have occurred. When the doctor receives a diagnostic report from a radiologist, a potentially reliable and authoritative source of knowledge, Totoweka's miscarriage is acknowledged. However, the general practitioner's acknowledgement of Totoweka is limited as he situates her loss within the context of miscarriage as a commonality and therefore continues to marginalise and silence her experience. The general practitioner provides Totoweka with minimal information and ends their conversation, thereby preventing any further opportunities for discussing miscarriage related concerns, by re-directing her to explore the brochures in the 'waiting' room. He both verbally silences, with his lack of communication, and physically silences, through ending the patient consultation, Totoweka's miscarriage. Such silencing may be interpreted as the general practitioner not being prepared to give 'time' and 'space' to a woman because miscarriage is deemed to be of little medical significance, whereas disciplinary and public narratives assign significant value to a physician's time. This lack of value is reinforced by the general practitioner in relegating Totoweka to the 'waiting' room, which she perceives as indicating that neither her miscarriage nor her health status is a priority. The general practitioner has in effect socially silenced the personal significance of her miscarriage. Such social devaluing is disempowering for an individual and it is not surprising that Totoweka was not prepared to search the waiting room in front of other patients for any information that might relate to her miscarriage.

Non reproductive women are socio-culturally positioned as aberrant. Public narratives within the western paradigm promote the notion of the good woman as a mother and reproductive success suggesting that there is no clear place in society to be a mother without a child (Harvey et al., 2001). Miscarriage is an embodied silencing of life that

alludes to potential infertility. Public, cultural and disciplinary narratives assign stigma to infertility (Liamputtong, 2007a; Whiteford & Gonzalez, 1995) and may therefore facilitate the social stigmatization of women who miscarry.

Goffman's (1963) typology suggests that stigma may arise through "physical deformities, individual character deformities or through deviation from the group identity" (p. 12, p. 19). Therefore women who miscarry may be triply stigmatized through having flawed bodies, being morally inadequate and/or not conforming to social and cultural norms associated with childbearing. For example, reproductive difficulties are primarily attributed to women by public and disciplinary narratives which classify women's bodies as inherently faulty (Martin, 1989; O'Malley, 2005), and leaky (Douglas, 1966; Frost, 2007). Such narratives also assign moral agency to childbearing women. Women who miscarry do not enact the socially accepted states of being, and/or identities, associated with pregnancy and motherhood (Harvey et al., 2001). Infertile women, through non-conformance with accepted social and cultural behaviours may risk being labelled as physically and morally flawed (Bellieni, 2005) or physically inadequate (Liamputtong, 2007a). Social structures are reproduced in small in the human body (Douglas, 1966). The social construction of miscarriage as other, and public marginalisation of this event, foreshadows the way in which individual women who miscarry may become 'othered' (Weis, 1995) as a result of their bodies (anatomy) and bodily processes (physiology) being socially constructed as abnormal. 'Othering' of non-reproductive women as aberrant leads to marginalisation of women by and within wider communities. Such marginalisation is potentially more problematic in countries where pro-natalist discourses are dominant (Israel), and within some indigenous cultures (Māori) where the social role of childbearer is assigned considerable social prestige (August, 2005; Mikaere, 2000, 2003). Marginalisation or 'othering' of women who miscarry within the field of health care may also facilitate individual resistance to the imposition of power, as evidenced within Totoweka's story.

Although not communicated to her general practitioner, Totoweka deliberately states in her narrative that she 'wasn't going to go and find a brochure' in the waiting room. Her verbal silence in not challenging the physician's advice and embodied silence (non action within the waiting room) may be interpreted as constructing silences to operate as forms of resistance to the practice of domination exerted by the physician within the consultation. Silence and self esteem are relational processes. Foucault (1988b) describes self esteem as a technology of the self concerned with the constitution and

management of an individual's identity and/or soul. Totoweka strategically employs silences that enable her to maintain a level of autonomy in regards to accessing care and support information, indirectly facilitating the maintenance of her self esteem.

In this narrative, silences operate as processes for self management and may be defined as a technology of power in the Foucauldian sense. Totoweka's deliberate and strategic employment of verbal and embodied silences within the social and temporal context of the visit to the general practitioner provides an exemplar of silence as collectively social, personal and embodied agency and a technology of signification in response to hegemony.

### **Silence as Exiting and/or, Voicing**

In exercising silent agency, Totoweka may also be subtly enabled to manage her frustration with the health care interaction, without resorting to what Hirschman (1970) characterises as "exit" and "voice" (p. 6); actions commonly employed by individuals when dissatisfied with service provision. Fougere (1990) states "[E]xit involves switching to a competing product" (p. 158). Within the context of miscarriage care, exiting may mean substituting one health practitioner's care provision for another practitioner's services. In contrast, voice involves "any attempt to change rather than escape from an objectionable state of affairs" (Hirschman, 1970, p. 6). Women who miscarry may voice their dissatisfaction with care by saying no to particular care interventions and/or health provider's actions. The following four narratives of Kahurangi, Auhunga, Kauri and Matipou demonstrate how women may use verbal and embodied silences as voice, exit or in combination as a response to unsatisfactory health care interactions.

**Kahurangi:** My back got up pretty much straight away because I was in there and she (house surgeon) sort of came in holding the clip-board and not even sitting down and making eye contact with me..., and then proceeded to sit up on the clinical bench and talk down to me (gestures to indicate subordinated position)...to tell me my two options. She then said 'What would you like to do?'...But I felt I need time to process things, and I felt a bit rattled ..., so I said to her 'Oh, so, do I need to make this decision now?' And she said 'Well, yes!' And I said um..., 'Can I have some time to think about it?' and she said 'Oh, Well... I suppose I can go away and see someone else?' And I said 'That would be good!' And you know, deep down I was digging my heels in thinking... Hang on! But of course I didn't say this to her. I said 'I've made the decision to have the D&C' even though I wasn't convinced at that point that was what I was going to choose. 'I'll take the papers and sign the consent form' and she

said ‘Well, they really need to be in by 12 o’clock for theatre, to sort the, the timetable for tomorrow’...And I said ‘Oh, well, I can always ring up and revoke my consent anyway’ And when I left that room I was not happy and had every intention, after coming home, that I would be ringing up at 5 and saying ‘Sorry, I’ve revoked my consent’.

Kahurangi’s story commences with her silent embodied resistance (her ‘back’ is ‘up’), to being marginally positioned by the house surgeon in relation to decision making about health care provision. The physician’s request for an immediate consent to intervention is initially deflected through the verbal negotiation of ‘time to think’ about choices. Alternatively, by ‘digging in her heels’ in silence Kahurangi suggests that she may refuse to consent to health care and exit the care relationship. It may also be argued that Kahurangi resists institutional hegemony by ‘voicing’ but not acting on, the implied possibility of ‘exiting’ care. However, in relating the story, Kahurangi translates the possibility of ‘exiting’ care into a probability. She also draws attention to additional factors, including public narratives such as ‘the doctor knows best’, which may constrain agency through influencing her ability to challenge hegemonic structures.

In contrast the following story suggests that although an individual’s agency may be constrained by institutional structures, a woman who receives miscarriage-related health care may both ‘voice’ her discontent with care provision to health care providers and ‘exit’ care services.

**Auhunga:** I felt like I was part of a machine in the hospital... And I didn’t really know what my rights were. No one in A&E (Accident & Emergency Dept) explained anything! And I did actually ring (names midwife) at one point and say ‘Am I allowed to refuse a test?’ And of course I am! And I did! In the end I thought stuff it, and just packed up and came home... But it’s a fine line, I mean they (the doctors) are the experts, and you’ve got to back your judgement against that lot.

Auhunga enacts silence as embodied agency through exiting the accident and emergency department and in verbally refusing care. However, in her story she also acknowledges that challenging the dominance of medicine within the health arena is difficult and associated with personal risk. In stating there ‘is a fine line ... they are the experts, and you have to back your judgement against that lot’ she draws attention to the power of the medical profession thus her comments might also be interpreted as questioning her original decision to resist medical interventions. Women may be constrained regarding the voicing of their dissatisfaction with the level of care they

have received from immediate health care providers, and subsequently relate concerns and frustrations to external health care providers as evidenced in the following narrative.

**Kauri:** There was one particular instance, I remember where a woman in (names town) at 2 o'clock in the morning was bleeding very heavily, called her GP that she had had all her life and had great faith in and he said 'wait till morning'. She called me, and if, her husband hadn't called the ambulance before I got there she probably would have died... He (general practitioner) didn't come and see her even though she was just down the road, an old patient, you know... She was just so angry that he should do that, and because he didn't listen to what she was saying... And she said 'I was nearly fainting when I was calling him and I begged him to come, and he didn't...He said No, no you'll be fine just wait till the morning.' And she said she didn't say anything to him (general practitioner) but she wasn't going to wait for the morning and her husband called the ambulance...I looked after her next pregnancy. She didn't go to the GP for pregnancy tests. She just called me direct and said "I won't go back to him for anything!"

Within Kauri's narrative of midwifery practice her client exercises agency by resisting the general practitioner's directive to 'wait till morning' for care provision. The client's resistance in acting to call the ambulance is embodied but not voiced as she remains silent and does not disclose her intention to seek immediate help to the general practitioner. Contacting Kauri as a substitute provider in the emergency situation signals her intention to exit from the relationship with her general practitioner. When she voices her anger and frustration to Kauri regarding what she perceives as provision of substandard care, it is based on the premise that Kauri is now confirmed in her new relational role as permanent care provider as evidenced in her client's statement 'I won't go back to him for anything.' Kauri is subsequently positioned as the first contact for all her client's childbirth-related health concerns and, although not within the scope of midwifery practice, as frequently the first contact for family health matters<sup>123</sup>. Narrating her story allows her to share her pleasure that she is perceived by her client to be reliable, trustworthy and competent, and therefore an appropriate person with whom to vent distress.

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<sup>123</sup> In Aotearoa, New Zealand the midwives scope of practice is restricted to providing care for women during pregnancy and the 6 weeks immediately after giving birth. Kauri is not legally able to provide general health care for the woman and her family members and would not do so. However it is not uncommon for women to discuss concerns that are not pregnancy related with midwives prior to contacting health professionals that are appropriately qualified to provide general health care.

The stories of Kahurangi, Auhunga and Kauri's clients suggest that women who miscarry may consistently be able to use elements of voice within various settings to challenge what they perceive to be problematic health care. In participants' stories, self silences have operated as technologies of risk governance and resistance. Verbal (lexical and non-lexical) and embodied silences are deliberately enacted as resistance to the exercising of power by other actors. However, women's use of voice and/or exit within relationships with health care providers may not be restricted to interactions perceived to be a source of dissatisfaction. Some women who experience miscarriage may exit relationships with health care providers without voicing concerns to the primary health care provider, or individuals within the wider community, as evidenced in Matipou's story of midwifery practice.

**Matipou:** The interesting thing is I never saw her again. I tried, I tried to get in touch with her but she just kind of... She kept a few phone calls, and we'd make plans but..., she was just a bit distant. And then we just couldn't..., you know she never kept the meeting times that we arranged. I'd go around and try and find her, and if I did it was never quite the right time for her to sit down and kōrero... She never said anything but..., I think I just reminded her you know of what had happened so she didn't want to talk, yeh and wouldn't meet with me, but she never said...

Matipou is aware that her midwifery client has exited the relationship. However, in her story she positions herself as having a positive relationship with the client and the client's whānau. The client is presented as using multiple embodied silences such as not talking, not meeting and on occasions when social connection has occurred deliberately withdrawing from social interaction, to silence the client/midwife relationship. Matipou infers from her clients' behaviour that her services are not wanted. She draws on narratives of midwifery practice that suggest women may desire psychosocial distance from any actors or elements associated with miscarriage in order to resolve grief and loss. Matipou's rationale is supported by midwifery research conducted in Aotearoa, New Zealand (Kenney, 2003). The research results suggest that deliberate psychosocial withdrawal or exiting by women from health care relationships may ensure there are no visual reminders of the miscarriage and facilitate resolution of grief.

### **Silence, Resistance and 'Hiding by Showing'**

Psychosocial exiting from a health care provider relationship may not require physical exiting from and silencing of the relationship with a provider. Psycho-social silences

and relational exiting may be accomplished through “hiding by showing” (Bourdieu, 1996, p. 19) as evidenced in Kahatea’s story.

**Kahatea:** The doctor who came in..., and just explained everything he was going to do. That he was going to do an internal; and he did an internal and by this stage I’m kind of having to squeeze (names husband) hand because every time I got a contraction wave it was really, really painful. And he put in one of those kind of things that they use when you are having a smear, you know, a speculum, yeh... And he put this little one, (laughed) and he couldn’t see, and then he got (laughing) this wide huge one and I couldn’t believe it was actually going to go in, but I behaved and didn’t say anything... And it was not like at the family planning centre where they run it under warm water and make it nice. It was bloody cold, and he sticks it in and he could see that there was um, a bit caught on my cervix and he wanted to try and get it out himself with his fingers, you know, like just reach in, and so he reached in and he was having real difficulty getting it. (burst out laughing) And um, (names husband) and I laughed about it afterwards because he must have had the (more laughter) stubbiest little fingers we’d ever seen (still laughing). The fact is that he had to actually get a bigger clamp thing to reach up and get it, because he said ‘Your cervix is odd it is at a funny angle, and it faces the wrong way’; a certain way or something like that. So he said it was actually quite hard to reach... It wasn’t the most comfortable experience, no, but it was quite funny, but because we noticed both (names husband) and I noticed that his fingers were I don’t know how to describe it but really stubby at the ends, really like they were meant to be a little bit longer but they stopped short of growing, poor man. (still laughing)...When he said ‘Oooh I’m having trouble reaching it’, we both had the thought like ‘I’m not surprised’, but of course we didn’t say anything at the time.

In Kahatea’s narrative silences operate as agency in response to symbolic and physical violence (Bourdieu, 1977, 1996). She presents the doctor as rationalising his inability to perform a physical assessment through finding fault with her body, which is constructed in his ontological narrative as having ‘funny’ and ‘wrong’ anatomy. Medically constructed narratives about the faultiness of the female body (Martin, 1989) have evolved into public narratives that facilitate socially accepted stereotyping of gender and identity. The doctor’s personal narrative, in conjunction with the unspoken but inherent public narrative, apportion blame to the woman for potentially more than just the difficulty of performing the physical assessment. Such narratives do not directly suggest the miscarriage has occurred due to female faultiness. However, the influence of these narratives is such that Kahatea and her partner may be silenced from challenging the doctor’s professional expertise. Such silence may be construed by the doctor as complicit with his construction of her body as faulty, as well as the

marginalisation of her identity and her experience of miscarriage. In her story Kahatea chooses to resist this positioning through the subtle and strategic use of topic silencing, and by doing so manages risks to her various 'selves' and/or identities as woman, mother and patient within the institutional setting. The doctor's critique is disempowered through non-acknowledgement. In addition to silencing through not addressing any of his blame-apportioning remarks, Kahatea chooses to 'hide' her disagreement by drawing on extreme case formulation to reciprocally position or 'show' the doctor as physically aberrant. She states 'he must have had the stubbiest little fingers we'd ever seen' and theorises that his fingers 'stopped short of growing.' She infers that such an individual should be pitied 'poor man' and not socially embarrassed through drawing attention to his unusual anatomy. 'When he said... I'm having trouble.., we... thought... I'm not surprised, but of course we didn't say anything at the time.'

In addition to practising silence in the form of hiding by showing in order to resist hegemony within health care interactions, women may also silence through hiding by showing when performing and maintaining identities. Within health care settings the substitution of professional identities for personal identities may be enabling for health care providers who experience ill health. In the following narrative, Rewarewa a midwife applies silence as a technology of production to hide one identity by showing or producing another, with the intention of enabling personal, corporeal social and temporal agency in relation to decision making regarding, accessing and receiving health care.

**Rewarewa:** I was with (names obstetrician/gynaecologist), working in delivery suite at the time and I didn't feel very well. So I left and went to a friend and that was the date for me (tearful laugh). And I'm still upset about it... I had just started spotting that day, but I went home from work and felt emotionally unstable I suppose, you know vulnerable... Um... And then when they scanned me they found it had actually died three weeks before. (2+) So um..., that's why after two more days I decided I couldn't stand it, and I had a D&C (dilation and curettage). But I was a typical midwife..., like I was nil by mouth. I went in at 11 am, and had the procedure with (names same obstetrician/gynaecologist) at 11.30am and this was public not private, at half past 11 (laughed). And as soon as I got back to the ward I took my drip out, went to the loo (toilet), had something to eat and told them I was going home... So it was all very matter of fact... (started laughing) Yep, yep. So at the end of the day you put the brave face on. Yeh..., and sometimes I think that it is because we feel that people (society) expect us (health

professionals) to cope better. Mmm. I think so..., but I didn't feel like that inside.

Rewarewa's narrative is the story of a health services manager experiencing care within her familiar daily work-space, and this is where her miscarriage experience begins. She acknowledges feeling 'emotionally unstable' and 'vulnerable' privately. However, in order to favourably position herself in relation to accessing care services within what she perceives as the 'public' and institutional setting of the hospital, she deliberately silences through privatising her personal identity. Within her miscarriage story, silence has become, as Goffman (1959) proposes, 'performative' acted within a particular context for a specific community.

Maintaining her public identity or 'face' becomes too difficult, and she exits the hospital and goes home to grieve in private. Public and private identities require the enactment of different relational selves. When she returns to the hospital the personal identities of mother and grieving woman are 'hidden' by 'showing' the public professional identity of a senior health professional. Rewarewa's professional identity is relationally embedded within the health care setting, and she draws on institutional discourses which grant this identity, powers of governance in order to facilitate personal agency and decision making in relation to care provision. Disciplinary narratives, that characterise the 'typical midwife' as 'matter of fact' and therefore pragmatic act as resources for constructing the substituted identity. Institutional discourses enable her to control decision making evidenced in her remark about her manner when talking to staff, 'I told them.'

Performance of identity may also be constrained by public narratives that suggest there are social expectations regarding how health professionals cope with grief, loss and ill health. Rewarewa's perception is that she should 'put on a brave face'. Performing 'bravery' reflects European cultural narratives about what is considered 'good' and therefore moral behaviour. Rewarewa silences her competing personal identities (grieving woman and patient) in order to be socially and morally acceptable, and maintain a professional position within the institutional setting. She acknowledges that her 'hidden' identities contradict her public persona, but justifies continued self silence as a means of ensuring personal agency. Rewarewa uses silence as a tool, or as Cotterill (2005) suggests adopts silence as a 'right' for maintaining an individual's status quo in private and public settings. Potential personal narratives about factors such as identity and baby loss, and reproductive failure, are subsequently silenced. Rewarewa presents

her application of silence as hiding by showing as an example of personal, corporeal and social agency. However, she also acknowledges in her story that the enactment of silences and management of identities in the face of tragedy is personally challenging.

Silences are not always enabling as evidenced within the following narrative in which Kohuwai positions herself as a senior health care professional within a health care setting in which she both receives miscarriage care and is employed.

**Kohuwai:** I was actually working in the gynae ward at the time. I ended up having to go up there (gynaecology ward) and wait, and on the ward, the job I was doing at the time was quite senior, in pre-assessment... And I'm standing there in my hospital gown in the office waiting to go to theatre for a D&C, and I'm thinking 'Oh my God I've got to sort out all the notes for tomorrow.' So there I was in my hospital gown in the office (laughing), fiddling around... And they (ward staff) were like 'What are you doing?' And I said (still laughing) 'I've got to get the notes sorted. Yeh!' (laughing) And the staff said 'Forget it. Don't worry about it. Get the other nurse in.' But, the other nurse I was job sharing with..., had hyperemesis and was having a terrible time, and she'd spent every 10 seconds saying 'Oooh, I feel so sick, I wish I wasn't pregnant... Raadie rah.' And all I wanted was the opposite... So she was off work (1+) ...There was no one to sort things... I was left in charge really... So that was a bit tricky, but you just get on with it... I got through it.

Kohuwai experiences a loss of agency in relation to health care provision. Her care intervention is determined by the physician, she is required to attend the gynaecology ward within which she must 'wait' for care. The loss of social position within the health care setting prompts Kohuwai to physically resist the subject positioning of herself as a patient through situating herself within the ward office, the locus of ward control. In interactions with staff members she attempts to substitute her professional identity for the assigned identity of patient. Her attempt to 'hide' by 'showing' is unsuccessful. In acknowledging that she is wearing a 'hospital gown' and is 'waiting to go to theatre' she is perceived by staff to be attempting to perform both personal (patient) and public (staff member) identities. Her health care providers, although they are also professional colleagues, consistently position her as a patient. Kohuwai silences health care providers' suggestions to 'forget' and not 'worry' about work by resisting the assigned identity of patient with rationalisations for her adoption of the identity 'health professional'. Despite asserting her identity as a health professional on the ward, Kohuwai expresses a desire to assume a colleague's embodied experience of pregnancy-related hyperemesis, because being sick is preferred to having a miscarriage. The pregnant colleague is granted sick leave, which results in Kohuwai

being 'left in charge'. She perceives herself as having a duty to 'sort things' because there is 'no one' to manage. An argument could be advanced that the colleague's pregnancy is privileged within the institutional setting over Kohuwai's miscarriage. However, Kohuwai constructs her professional identity as a position characterised by responsibilities that are undertaken by, and expected of, a senior staff member. Identity performance is characterised as an exercise in subjectivity due to her perception that institutional constraints suggest she is the only individual who may manage particular work (sorting notes). In the absence of her colleague, Kohuwai's agency is constrained as she perceives that she 'must' act and does so by attempting to perform professionalism. Evaluation of the strategic effects of 'hiding by showing' in Rewarewa's and Kohuwai's narratives suggests that performing alternate identities may both facilitate and/or constrain a patient's ability to self position within health care settings for the purpose of exercising agency.

Midwives perform multiple roles or identities when providing care for women and their families (New Zealand College of Midwives, 2009). They also self position within health care settings by 'hiding' non-professional identities in order to carry out professional roles and/or facilitate professional practice. However, the practise of identity substitution may constrain practice at the individual level as evidenced in the following narrative, and may subsequently contribute to public and disciplinary silencing of the midwifery profession at the macro-social level.

**Mahoe:** When I talked to one client she said the GP had done a vaginal exam, and I thought (chuckled) I never said anything to her. You know, I would never ever denigrate another practitioner. And I thought now why would they do that? It's sort of like GPs who do vaginal exams postnatally. You know, maybe they're just checking to make sure the cervix was still there. Well I suppose the GP was checking to see if the cervix was closed or you know; whatever. But I just found it really invasive and unnecessary... And the woman didn't know why (it was done) so the GP didn't actually offer informed choice... She did a swab! The GP did a swab! (burst out laughing) She did a swab to rule out listeria! But she wouldn't get listeria on a swab! (laughed)... I never said anything to the woman though (chuckled). Um with this miscarriage, she had a tummy bug..., for a few days, like when she phoned she said '(names self) I've had a tummy bug for a few days and then this has happened.' And we talked about..., the miscarriage and ..., you know, listeria.

Mahoe stories her client's narrative about miscarriage-related care provision by the general practitioner, and suggests that such care is not evidence-based practice. She positions her client in the narrative as lacking in knowledge and suggests that the

general practitioner's care interventions were provided without consent. In Aotearoa New Zealand, health care without informed consent breaches legislation (Ministry of Health, 1996). Rather than contesting the care provision directly with the woman or by communicating with the physician, Mahoe selectively self silences her concerns within the healthcare interaction. She performs the disciplinary identity of 'educator' in advising her client about listeria, but is specifically silent regarding the care that her client had received from the general practitioner. Her silence regarding what might be considered non-evidence-based, unnecessarily intrusive, or even physically abusive, care is rationalised as enacting professional etiquette. She draws on cross disciplinary narratives about professional morality and the maintenance of courtesy amongst actors within the field of health care provision, to construct and perform the identity of a professionally moral health practitioner. In enacting this cross disciplinary identity she constrains her disciplinary identity as a 'woman centred' midwife.

Midwives have ethical responsibilities to fully inform, and advocate on behalf of women. Mahoe's self-silences privilege the physician's position in relation to that of her client within the field of health care. Her actions may be perceived as complicity with what she identifies as the absence of informed consent to, an 'invasive and unnecessary', intervention. Despite privately challenging the physician's actions and knowledge base, seen through the disciplinary lens of midwifery, Mahoe's narrative silence regarding the doctor/client interaction could be interpreted as complicity. Such complicity perpetuates what Bourdieu and Wacquant (1992) term symbolic violence and may be deemed unethical professional behaviour. Constraints imposed by professional etiquette at the micro-level of midwifery practice are problematic as they may have wider disciplinary repercussions. Foucault (1977) suggests power is exercised and embedded within social relations. Therefore "mechanisms of power at the micro-level of society become part of the dominant network of power relations (Sawicki, 1991, p. 24). Mahoe's silence may also be interpreted as mirroring the social privileging of medicine's habitus within the fields of health and may facilitate the silencing of midwifery as a discipline. In addition to potentially constraining health care practice, silences within cross disciplinary interactions may also enable health care practice.

**Kauri:** When I worked in (names hospital)... Miscarriages would happen over night... Mmm (2+) The night supervisor used to actually wrap them up in cotton, in cloth, and bring them down to me (from the complicated ward). I would put them in an incubator for the rest of the night until they died, and then she'd pick them up and take them back (chuckled) because (speaks

quietly) none of us could bear the idea that this little thing was in the..., (whispered) cold bed pan... So we put them in the incubator, which sometimes caused concern. I remember one night, one of the paediatric registrars coming in to resuscitate..., to do something during the night, and um, looking at this thing in the (chuckled) incubator and saying 'What's this BABY doing here? I haven't been told about this Baby!' And I said 'Um (1+) but he persisted and I went... 'No, no, you DON'T want to know!' (laughs) This isn't for you! THIS is NOTHING to do with you!'(1+) And he went (slowly enunciated) 'I don't want to know!' (laughing) and then he took off.

In her narrative Kauri disputes the institutional positioning of miscarriage as refuse through situating it in a 'cold bed pan.' In contrast, she constructs the miscarriage as a baby that you 'wrap..., up' and place 'in an incubator' until it has 'died'. However, legislative narratives shape cross-disciplinary understandings as to what constitutes human identity within health care settings. Drawing on these narratives, Kauri uses depersonalisation and minimisation to silence the baby's human identity through positioning the baby as a 'little thing' in her reported conversation with the physician, and negating the baby's existence as 'nothing'. Kauri uses lexical and non-lexical silences to facilitate cross disciplinary understandings about the status of the baby within her interaction with the registrar. The narrated conversation contains no explanation regarding the baby in the incubator, but Kauri's repeated verbal negation of the baby's identity facilitates the doctor's comprehension that this 'living' being is not 'living' and is therefore not a patient. The doctor demonstrates his complicity by reiterating Kauri's lexical silencing statement, and corporeally silencing the interaction by exiting the ward. In collectively silencing the baby's human identity Kauri and the physician collaborate to facilitate efficient health care provision within the institutional setting.

### **Miscarriages, Silences and Minimisation**

Health care providers, women and/or their families may collectively or individually enact silence by minimising miscarriage and may subsequently constrain women's agency in relation to accessing miscarriage-related care. Care providers may use minimisation to silence miscarriage in order to manage psychosocial and emotional risks to the 'self' within public and private settings. The following narrative suggests that cross-disciplinary and disciplinary narratives minimise miscarriage by characterising it as an unavoidable commonality for the purpose of governing risks to care providers.

**Mahoe:** Miscarriage... Well it's always sort of passed off as you know, 'You can always have more babies'... You know it's not a pregnancy... I don't know, it's just a general feeling I get from just out there, in the wider professional community... But I suppose..., I don't know... It's sort of something that you can't do anything about you know, physically... It's going to happen. We (midwives) use the term inevitable. So..., as a way of dealing with it I suppose, some people just..., maybe health practitioners just see it as ..., well... Women get pregnant again, and it's too hard to deal with all that other stuff that goes with it. If you think of all the emotional stuff that goes with it..., it can be upsetting..., and probably for most health practitioners... There are even midwives out there who don't. You know, they don't have that background knowledge. There are midwives out there who may never ever have dealt with a woman having a miscarriage um..., and may choose never ever to in their whole career... I see somebody who you are accepting responsibility for as lead maternity carer that is suddenly having a miscarriage. You don't pass them over. You don't fob them off to the GP 'Oh sorry, I can't deal with doing your blood tests', or 'I can't deal with talking to the consultant about your scan' because you're having a miscarriage', - I'm not interested.

Mahoe suggests that due to a lack of interest and/or clinical knowledge, and for psychosocial self protection, some midwives or midwifery practices will not provide care for women who experience miscarriages. The disciplinary narratives of biomedicine that shape cross-disciplinary and public perceptions of miscarriage define miscarriage as a medical event that may require 'medical' treatment. The pathologisation of miscarriage facilitates the potential exclusion of miscarriage care from the midwifery scope of practice, which focuses on pregnancy and birth related processes as normal life events. Mahoe suggests that some midwives may rationalise this perspective into their professional practice philosophies.

Midwifery (verbal) discourses promote the perspective that midwives provide women centred care (Green, Renfrew & Curtis, 2000; Fairman & Donnellan-Fernandez, 2006; Stewart, 2004). However, midwives' (non-verbal) body language may suggest that they are too busy to listen (Stapleton et al., 2002a) and potentially facilitate women's self-silencing practices. Alternatively in some consultations midwives may silence women's voices by not allowing women time to narrate pregnancy and/or childbirth related concerns (Stapleton, Kirkham, Curtis & Thomas, 2002b). Such practices may also infer that issues of professional productivity are privileged over women's care needs. An alternative interpretation of such practice might be that midwives are uncomfortable managing the psychosocial aspects of miscarriage-related care.

Public and disciplinary narratives characterise midwives as health care providers who facilitate women's reproductive health through helping other women to have babies. Mahoe perceives enacting of embodied silence through 'not doing' as collective abrogation of midwifery professional and ethical responsibilities and corporeal silencing of women's agency in relation to miscarriage-related care. Her narrative also argues that collective silencing of miscarriage and related care provision by some midwives is not in keeping with the accepted 'habitus'<sup>124</sup> (Bourdieu, 1977) of midwifery practice. Implicit within Mahoe's narrative is the suggestion that care is either provided or collectively silenced. However, midwifery care practices may be situated along a continuum of involvement that is shaped in part by service funding. Legislation constitutes payment for miscarriage-related services (Ministry of Health, 2000b) as a component of a midwife's entitlement for providing full maternity care to pregnant women who have registered as her clients. In conjunction with cross-disciplinary narratives such as 'minor event, minimal service' legislative structures may shape midwives' agency in relation to providing miscarriage-related care as evidenced in the following narrative.

**Karaka:** I do remember caring for one of my partner's clients who had an early miscarriage. It was my partner's weekend off, and so she (the client) rang me. She was very distressed on the phone and bleeding. I went around to see her because I always found it difficult not to go, and feel that in my practice that my colleagues thought that I..., I tended to do too much... And this was a bit problematic... It wasn't blatantly said, but there was an awareness that you were thought badly of if you spent too much time with the woman. You knew there was a right way to do it (provide care) because..., because there really isn't any, isn't much payment for it... I never got a lot of support... And maybe that's because it isn't really considered a pregnancy yet. Although I don't know when it really counts. When does a baby...? Does a baby become more of a baby? (2+) I don't think so. It is ALWAYS a baby!

Although she acknowledges the economic constraints of professional practice Karaka suggests that her professional philosophy conflicts with the philosophy of the midwifery practice to which she belongs. She resists what she perceives to be a practice philosophy that, in response to social and legislative processes, collectively silences women's agency in relation to health care by minimising miscarriage and limiting service provision. However, Karaka's ability to exercise professional agency is

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<sup>124</sup> Bourdieu (1977) suggests that structures, for example class specific material conditions which may include disciplinary narratives, produce *habitus* which Bourdieu defines as "systems of durable, transposable *dispositions*" (p. 72), or in other words habitual, or a predisposition to particular, ways of being.

embedded within and therefore influenced by multiple relationships (Granovetter, 1985, p. 487; Somers, 1994, p. 629). For example, her relationships with local health institutions shape the temporalities and settings in which she may admit her clients for hospital-based care. Her relationships within other practitioners within her midwifery practice also influence the degree of practice support she may receive. Although not explicitly stated, she alludes to being personally marginalised and unsupported within the practice as a result of her non-compliance with the collective's practice narrative. Karaka suggests that her colleagues may draw on public and cross-disciplinary narratives that characterise midwifery services as care provided to healthy women, who experience normal physiological and live births, as a dismissal of Karaka's practice philosophy. Through dismissing her practice philosophy her care practices are also effectively dismissed, facilitating her assignation to a subordinate professional and social position within the practice. Despite perceiving herself as professionally marginalised by her peers Karaka questions the professional minimisation of miscarriage and miscarriage-related care, drawing attention to the social and political work that such minimisation achieves, the silencing of human life as evidenced in the following narrative excerpt.

**Kohuwai:** When you've got a gynae patient having something like this, it's like a light patient that you've got. It is nothing really because there's nothing much you have to do. You get them back from theatre, you do a couple of obs (observations), you do, check their pad (sanitary napkin), you know, you feed them, make sure they've had a pee. They're out of here.

In her miscarriage narrative Kohuwai commented on experiencing grief in relation to the loss of her unborn child. She stated 'having the miscarriage is the worse thing in the world' and 'I was just sad all the time.' However, multi-disciplinary and public narratives shape personal, social and professional behaviour and facilitate how institutional settings do their work (Linde, 2001). Kohuwai draws on institutional and nursing narratives to construct miscarriage within the hospital setting as a minor and solely physical event. Linde (2001) states "[A]n important part of the work of the institutional representative is to use his or her control to fit the client into organisational ways of thinking about a problem" (p. 520). Kohuwai silences women's embodied identities as mothers and pregnant women by positioning them as 'light' patients, who having experienced 'nothing', require minimal care. 'Light' patients draw on less economic resources and are therefore cost effective. The narratives of other research participants also demonstrate awareness of the institutional practices of minimising miscarriage, and contemporaneously silencing associated identities, as

evidenced in the following narrative excerpts from the stories of Kahotea, Auhunga and Totoweka:

**Kahotea:** In the hospital I heard one story in particular that made me very grateful for the fact that mine had been ultimately so simple, just nothing really. You know, and just, if you like, a standard miscarriage (laughed). Well what I mean is I'm normal compared with... There are people that have had five miscarriages and still haven't conceived a baby.

**Auhunga:** It's quite interesting in the hospital you are not sort of..., abnormal, because you haven't had three miscarriages... It made me feel a bit minimised, like my miscarriage was nothing really... Like you've experienced something that happens all the time, it's nothing out of the ordinary... You're normal so you just keep quiet and get on with it.

**Totoweka:** I mean mine's nothing compared to what you know, some women go through with miscarriages. They have two or three miscarriages. You know? I'd had three healthy children. So I was, I was lucky.

The stories of Kahotea, Auhunga and Totoweka suggest that women respond to institutional minimisation of their miscarriage, silencing of their identities and the identities of their unborn children, by accepting such positioning as a form of normalisation. Rose (1999) characterises a norm as that “which is socially worthy, statistically average, scientifically healthy and personally desirable” (p. 76). In order to achieve the ‘norm’ of being normal, individuals employ various strategies, including downward comparisons, in constituting identities and shaping behaviours. The process of ‘normalisation’ operates as a technology of power, through invoking specific technologies of the ‘self’ (Foucault, 1988b). In the aforementioned stories, normalisation is achieved through the use of lexical silences by classifying the miscarriage as ‘nothing’, and non-lexical silencing such as ‘hiding’ the identity of ill women ‘by showing’ the identities of ‘normal’ women, or as in Totoweka’s narrative, the identity of a ‘childbearing woman.’ The women’s narratives of normality may also draw on ideas of self responsibility. Responsibilisation may operate as a technology of the ‘self’ (Foucault, 1988b) in that the women are aware of the social risks of being perceived as ill and/or faulty and instead work to construct their individual situations as problems for self management (Lemke, 2001). As Auhunga states, ‘[Y]ou just keep quiet, and get on with it’. However, the participants have also hierarchically positioned their miscarriage experiences both within their ontological narratives, and the

discursive field of prenatal loss, as subordinate to other women's experiences. In doing so they have reduced the element of social danger associated with miscarriage as a liminal event, and the potential risk of social rejection. Minimisation of miscarriage may therefore constitute a silence that operates as agency and a source of constraint.

### **Public Silences: Professionalism and Productivity**

Foucault (1988b) suggests that technologies of biopower facilitate the co-constitution of embodied and social productivity. Public narratives about productivity, normality and morality covertly exercise disciplinary power. Such narratives both shape individual perceptions of what constitutes a satisfactory worker, and create "docile bodies" and "subjects" (Foucault, 1977, p. 138 - 139) whose conduct will conform to institutionally derived norms (Sawicki, 1991). Drawing on Foucault (1977), Sawicki (1991) suggests that disciplinary practices secure subject compliance by establishing social norms against which individuals, bodies, behaviours and conduct, are evaluated (p. 68). She proposes that women internalise and practice self governance (Foucault, 1977, p. 201) in accordance with such 'norms.' In work-related settings, women who experience miscarriage may self silence as a technology of the 'self' or form of self governance in order to maintain or perform a stable social identity, that of the healthy productive worker. Self-silencing may therefore constitute performing professionally, facilitate the maintenance of 'normal' identities, and act as resistance to being positioned as a potential source of employment-related risk and/or as an unsatisfactory employee.

The workplace is governed by public and conceptual narratives about productivity which construct workers as functional economic units separated from their emotions, attitudes and beliefs. In the hierarchically structured employment sector, disciplinary power is linked to resource control, and therefore employers' demands are publicly and professionally privileged. The subject positioning of individuals as employees facilitates employers' social influence and/or control over workers' bodies, and activities in order to minimise risks to productivity through the influence of non-work related or personal factors. Participants, through representing their miscarriages as 'normal' and as commonalities, position their miscarriages as insignificant and potentially undeserving of attention and care within health, social and/or professional settings. Such perspectives may silence women within the wider public sphere and contribute to the social performance of 'normal' and therefore 'healthy' public and/or professional personas. Mahoe's narrative presents her client as an employee who is

aware of, and complicit with, the social rules or expectations incorporated into employment/productivity-related public narratives.

**Mahoe:** With (names client) who just had a miscarriage in the last 2 months I think it was..., she needed a health certificate for work, but she didn't want me to write the health certificate, because then they would have known she was pregnant, so she went to her GP. So she didn't want work to know that she'd been pregnant and had a miscarriage, but she wanted to take some time off work. So..., so I said 'You know, I can write you a note?' But she said 'If you write the note, then they'll know that I was, that I had a miscarriage. I'd rather they just think it is a normal flu bug.'

Mahoe's client refuses her offer of writing a health certificate. Although her client perceives miscarriage as a personal issue to be disclosed and retained only within a private setting, her actions are also constrained by public and employment-related narratives of productivity. Such narratives facilitate the potential exercising of disciplinary power (Foucault, 1988b) in relation to the reasons for her absence from work. She protects her employed 'self' by drawing on institutional narratives that authorise temporal space for productivity loss (sick days) in order to ensure that her miscarriage is silenced within the public arena. The client's personal experience of miscarriage is 'hidden' by 'showing' herself as a 'normal' worker with a 'normal' illness. Foucault (1988b) characterises such practices as exercising a technology of normalisation. Mahoe's client draws on technologies of normalisation associated with common illness requiring sickness certificates combined with performing a public identity, that of the 'average' worker to maintain the status quo within her employment environment. Through using normalisation to self position as a normal 'healthy' worker within the public workplace she also draws attention to her subject position in relation to market and institutional structures.

Auhunga also situates her miscarriage within the private sphere whilst on annual leave, and copes with the loss of her baby within the intimacy of her home, and therefore during authorised non-productivity related time.

**Auhunga:** I happened to be on annual leave, because I had taken annual leave I was fortunate enough..., I thought at the time... So I had a week at home, um... And so I didn't have to go to the office every day. So I didn't have to function normally and pretend that everything was OK... It's hard to lose something that potentially you feel you're the only person that knows about it. So I hadn't shared any of that with my work colleagues because I had felt that it was too early to tell work about the

pregnancy, so apart from a close friend at work, I never told anybody because I was on this leave. And it wasn't until a year or two later. I'm not even sure how the topic came up when a boss said to me 'I didn't know you had a miscarriage. When did you have a miscarriage? You must have been working here? How would I not know?' And he felt quite hurt that he wouldn't have known that I might have been going through something like that; that would have affected work, not affected work, but that might have affected ME at work... And I thought that was quite interesting because at the time I would definitely not have said anything anyway, not to my boss.

Auhunga draws on public narratives to craft and narrate her story. In doing so she provides an exemplar of how social and cultural narratives constitute what are acceptable behaviours and relatable stories in private and public settings (Charmaz, 2002). She presents her workplace silence as an autonomous right. However, in situating the performance of 'normality' within the professional arena, she unintentionally alludes to functioning 'normally' as a work-related requirement that is governed by institutional and/or disciplinary power. Drawing on Foucault (1977), Sawicki (1991) states "...disciplinary power is a knowledge of, and power over, the individual body; its capacities, gestures, movement, location and behaviours" (p. 67). Therefore within the workplace it may be argued that certain types of 'bodies' and 'subjects' are produced by disciplinary power (Foucault, 1977, pp. 138-139). Sawicki (1991) describes "disciplinary practices" as conceptualising "the body as a machine, with the intention of making individuals "productive, useful and docile..., at the micro-level of society, in the everyday activities" (p. 67). Auhunga's narrative alludes to her subject positioning within the employment arena, but is silent regarding disciplinary practices that govern her conduct. Sawicki (1991) suggests that is because disciplinary practices go unnoticed and secure subject compliance by creating desires and establishing norms against which workers, and workers' behaviours and conduct are judged (p. 68) and in accordance with which, workers may internalise and practice self governance (Foucault, 1977, p. 201). As work productivity and practices may be classified as cultural practices it may be argued that disciplinary power and practices shape cultural practices and within the context of this chapter, cultural silences.

### **Cultural Silences and Silencing Culture**

**Kawakawa:** I told, I chose to tell some of my friends later what had happened, but not at the time... It's kind of a hard thing to bring up with people, like you don't really just go 'Oh. Guess what? I've just had a miscarriage.' You know? It's quite hard...

Like I can bring it up now if I know someone who has..., if I've got a friend that has had a miscarriage or ..., something. But it's not something that you can really bring up with people when it happens... I think that's a cultural thing too. I think in New Zealand we're quite sort of ..., reserved in talking about that sort of thing. It's not..., not so acceptable. Like we have this sort of thing where you know, you don't tell people that your'e pregnant until you hit the 12<sup>th</sup> week for the safety thing. So I guess..., we don't really talk..., sometimes we keep things a bit buttoned up a bit too much... It is that old English tradition I reckon! Our English ancestors..., just..., too proper... Sometimes we don't recognise when we need to talk about something, because it's not the right thing to do. We just keep silent.

Kawakawa suggests that personal and social agency in relation to voicing her pregnancy and miscarriage experiences, are temporally and socially constrained by cultural 'norms' which have been crafted by regulatory and disciplinary practices. Regulatory power is exercised through legislation. Disciplinary power is enacted through public narratives that constitute what is and is not acceptable conduct, for example, what stories may and may not be told. In her narrative, Kawakawa draws on cultural narratives from a Western European paradigm to determine what stories and/or experiences may or may not be voiced within social settings. Kawakawa characterises Aotearoa New Zealand's culture as uniformly 'reserved' and 'a bit buttoned up' as a result of what she perceives as Aotearoa New Zealand's cultural foundation; the 'old English tradition'.

Miscarriage is considered a liminal event that may result in social stigmatisation and therefore is a suppressed topic in social interactions. Kawakawa silences her ontological narrative of miscarriage within social and public settings accordingly. However, Aotearoa New Zealand is officially a bi-cultural environment and influenced by cultural traditions from western European, Polynesian and Māori paradigms. Non-acknowledgment of other cultural perspectives may be construed as using cultural silences to silence culture (Minh Ha, 1988). Kawakawa potentially enacts colonial hegemony by positioning 'Western Europeanism' as the sole habitus (Bourdieu, 1977) of New Zealanders. Within a European paradigm silences in general are associated with problematic issues (Poland & Pederson, 1998), and in relation to miscarriage silences are constructed to suppress that which is perceived as negative and presented as the cultural 'norm'. As a result silence constituted as a western European cultural

‘norm’ also operates as a technology of oppression that constrains agency<sup>125</sup> within private and public settings.

In contrast to Kawakawa’ story paradigmatic, contextual and ethno-cultural differences shape the constitution of, and meanings attributed to, silences within Raukaraka’s narrative which draws on understandings of miscarriage and the associated silences that arise from Te Ao Māori.

**Raukaraka:** There is a silence..., but, it’s ..., the silence is not always because you feel whakama (embarrassed). (2+) When you first came out to see (names support person) about the research we all got talking you know about your mahi with the local kui<sup>126</sup>... And although it’s not something that’s talked about, that we talk about..., some of us are not whakama to talk about it. And the kui said we should talk to you, but that it is not something you tell the whole world. It’s a taonga, and you talk about it better with Māori women who have already experienced it who understand, because not everything needs to be said out loud, you know... It is a taonga, an important taonga in a way because it’s all part of our history with te whare tangata, but also in terms of our whakapapa and the whakapapa of miscarriage itself... (spoken quietly) You know the children that are given back to the tupuna... (continues to speak quietly). But I never really talked about it until... (1+) I think things changed because last year my 19 year old had a miscarriage... The next generation...you know whakapapa..., and so we talked, I talked a lot then to support her, you know.

Within Te Ao Māori (the Māori world) communicative silences within stories are culturally enabling; they open up social space for reflection, enlightenment and comprehension as well as facilitating social connection through reciprocal communication of knowledge and shared cultural understandings (Holmes, 2003). In narrating her story Raukaraka draws on what she perceives to be cultural understandings and the relational connection that she has with the researcher. She positions me as a knowledgeable and respectful Māori woman who understands the reason why, ‘... not everything needs to be said out loud.’ Although not stated, Raukaraka assumes I will assign cultural value to Te Whare Tangata (the house of the people) which August (2004) and Mikaere (2003) assert, refers to Māori women’s paramount social role as bearers of the next generation.

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<sup>125</sup> Agency is understood as being personal, professional, corporeal, social, relational and temporally fluid.

<sup>126</sup> ‘kui’ is an abbreviation of ‘kuia’ and refers to a female kaumatua (elder) and/or community leader.

For women and their whānau who experience miscarriage, silences are linked to whakapapa (genealogy) and wairuatanga (spirituality) and may be considered tapu (sacred) (August, 2005). Silences shape the context within which miscarriage stories are related. The roles of narrator and listener are socially assigned on the basis of whakapapa (genealogy), and narration may be situated within specific temporal, geographic and social settings to ensure that iwi (tribe), hapu (sub tribe) and whānau (family) tikanga (cultural traditions) are respected (Jenkins & Pihama, 2001). In relating the granting of permission by the kuia (elder) to share her kōrero (story) with the researcher, Raukaraka silently alludes to shared iwi affiliation. The kuia has positioned me as an insider based on her whakapapa, which facilitates the narration of Raukaraka's story and potentially the miscarriage stories of other wahine (women) in the iwi. Whakapapa stories and iwi specific cultural narratives link Raukaraka's characterisation of miscarriage as a taonga (treasure) to spiritual beliefs specifically the creation of mankind. Miscarriage-related silences are constructed as enacting respectful spirituality.

However, as a result of colonisation Māori women frequently experience cultural disconnection from or marginalisation of, cultural practices (Morton-Robinson, 2000) that are associated with childbearing (Mikaere, 2003). Tangiwai's narrative stories cross-cultural silences within the family as hidden conflict.

**Tangiwai:** My in-laws, (names family) are Catholic religion, and my mother in-law is staunch Church of England, so, I sort of put behind me some of the things I knew in terms of growing up with the Ringatu whānau. It got a little bit..., confused in terms of being able to go and see a tohunga (Māori priest) that being my dearest wish, but living in, in the city, in the town and away from my roots I found it difficult to do that. But by the time I got to baby number three, and I was still having early miscarriages, te whare tangata (uterus) just wasn't...working, wasn't well...., and I couldn't get past 10 weeks (gestation) so I was finally brave enough to um.., keep quiet and sneak off from the whānau and seek out some guidance from the tohunga (Māori priest). And then I had to be engaged with my tane (husband) who was bereft as well, like a couple of ninja yeh wandering around in the dark and searching, searching for someone to listen to us and to say 'Where to from here?'... It was a drama in the middle of the night...Feeling guilty about what am I doing wrong, because my in laws..., who were very close to sort of the doctor stuff wouldn't like it. What I really wanted to do was be able to find a tohunga and eventually I did. So I kept very quiet (laughing). I wouldn't have opened my mouth about tohungas darling, no... not for all the tea in china (still laughing). I eventually caught up with my dad and said 'I need to go there!' So we arranged, my

husband and I to meet with a tohunga and after the tohunga talked about a fertility rock which is on my tane's side of our whakapapa once again we crept off in the dark. You wouldn't, you shouldn't go off creeping in the dark if you were Ringatu! That's the difference these days creeping off in the dark! And we went to this fertility rock at (name's coastal spot). In those days the fertility rock was quite close to the Marae, you didn't have to go far out in the water. So we secretly went out there, and I sat out while my tane was very patient but worrying about somebody seeing all this, you know... 'What are they going to say?' However, we were just very private about it and sat on the rock and hoped no one would see and hoped.

In Tangiwai's narrative, verbal and embodied silences are secretive and characterised as, or associated with, loss. She enacts self silence by 'not doing' cultural practices in order to conform with the familial values and Christian traditions of her in-laws. Corporeal silencing of the connection to her turangawaewae (her place of belonging) is achieved by geographical separation from whānau (family) land and residing in the city. Accessing indigenous cultural support and/or enacting cultural practices are constructed as activities associated with personal and social risks and are therefore conducted in secret. Maintaining secrecy about contentious issues, practices or behaviours in close personal relationships may minimize familial conflict (Cameron & Hargreaves, 2005). Alternatively, in a culture where pregnancy is considered the responsibility of the family (Rimene, Hassan & Broughton, 1998) it may be a source of personal conflict. Tangiwai suggests that potential risks are managed by acting like 'ninja'<sup>127</sup> in the physical 'dark' and the temporal silence of the 'night.' In positioning herself as a ninja she draws on cultural narratives that characterise ninja as masters of silence, deception, secrets, and stealth (Hatsumi, 2004) to construct herself as an expert in the application of silence as a technology. Expertise is associated with the exercising of technologies of power (Foucault, 1988b). However, in 'wandering around in the dark', Tangiwai alludes to her metaphorical blindness and disempowerment as a result of the social silencing of cultural knowledge and practices. She acknowledges that 'doing silence' is not culturally appropriate behaviour for a member of the Ringatu faith but suggests agency is constrained by the socio-temporal contexts in which she is embedded.

Colonisation has marginalised the Māori culture, so being visually and socially, seen as 'doing' indigenous cultural practices may be a potential source of social stigmatisation. Tangiwai's story of cross-cultural differences within the whānau constitutes a

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<sup>127</sup> The term Ninja constitutes singular and plural meanings within this thesis in accordance with Japanese grammatical rules.

narrative metaphor of the marginalisation and/or silencing of indigenous culture in Aotearoa New Zealand, by European colonisation. Marginalisation or ‘othering’ (Weis, 1995) as a form of silencing culture is also reflected in the narratives of midwives. In Totara’s story, ethno-cultural difference operates as an actant (Latour, 1993) which facilitates the hierarchical positioning of health practitioner and clients within the field (Bourdieu, 1977; Bourdieu & Wacquant, 1992) of miscarriage care.

**Totara:** I’ve had Phillipino women who have um, miscarried and it’s usually their mother that’s there. You see plenty of uncles and aunts as well. Um, in modern families it’s..., it’s often not spoken of to anyone else but to the woman’s immediate mother, rarely is everybody else there, involved... The Chinese don’t seem to worry..., or don’t talk about it with me, although, I have found it difficult to get them to talk more than ‘Yes It was a miscarriage, what a pity.’ But I’ve never had a sense of loss or grief. Maybe it’s there ..., but I think it could also just be communication... I don’t know what society thinks about miscarriage. But I think it’s not a big issue um..., in terms of the whole... I think other parts of childbearing get much more acknowledgement. Um..., and I think that terminations get more publicity. I’m always interested that when women have a miscarriage, invariably they say ‘Isn’t it amazing when you have a miscarriage, so many people come around and tell you they’ve had one too. I didn’t know so many women had miscarriages.’ Which means it’s a silenced topic, yep.

Miscarriage silences are socially and culturally determined. In this story the participant reflects on familial responses to miscarriage. She suggests that the ‘modern family’ predominantly silences miscarriage. Ethnicity and culture may be considered aspects of individual, familial, and community identities. Such identities influence how women, their partners and families, experience and construct stories about miscarriages. Totara’s ‘modern family’ is presented as a non-contextualised social creation without ethnic or cultural referents and therefore it may be assumed that the family is socially structured and positioned in accordance with the dominant Western European culture in Aotearoa New Zealand. Without explicitly stating her social bias, Totara has only disclosed a woman’s ethnic identity in the narrative where it differs from what she may perceive as the most common ethnicity; the socially ‘normal’ ethnicity. Cultural generalisations are evident in Totara’s story such as ‘the Chinese don’t seem to worry.’ Despite acknowledging communication challenges in interactions with clients who do not speak ‘English’, she presents assumptions such as ‘I’ve never had a sense of loss or grief’ as fact without any critical reflection regarding the accuracy of her assumptions. There is also no acknowledgement of the ways in which grief and loss may be expressed differently within different cultures.

The meanings associated with women's silences may be misconstrued due to cross-cultural differences (Poland & Pederson, 1998). Some cultures use silences to indicate agreement (Andrews & Boyle, 2007), disagreement or to emphasize a point (Falvo, 2004), for politeness (Mazzei, 2003), to indicate respect and to acknowledge shared understanding of cultural commonalities (Holmes, 2003; Poland & Pederson, 1998). Health consultations are invariably cross-class and/or cross-cultural social interactions with inherent power differentials. Silences in consultations may be perceived by health professionals as a metaphor for patient compliance (Falvo, 2004). Stapleton, Kirkham, Curtis and Thomas (2002a) also suggest that within midwife/client interactions, women's silences may be interpreted by midwives as "an absence of need for further information" (p. 393) and/or intervention on the part of the midwife.

Totara generically associates what she perceives as socially 'normal' women and their communities, with the social silencing of miscarriage. What is 'normal' goes unchallenged and she appears to privilege the habitus (Bourdieu, 1977) of Western European ethnicity, and midwifery within the field of miscarriage care. Marginalisation or 'othering' (Kitzinger & Wilkinson, 1996; Weis, 1995) through positioning at the macro level within social networks, for example marginalisation of ethno-culturally distinct populations within cities, may be repeated at the micro level within families.

The male partners of women who have a miscarriage experience significant psychological and emotional distress (Daly, Harte, O'Beirne, McGee, & Turner, 1996), but partner's miscarriage-related losses are minimally acknowledged within health care and social settings (McCreight, 2004). There is institutional recognition that the needs of male partners should be considered (Stratton & Lloyd, 2008). However, cultural conceptualisations of masculinity within Aotearoa, New Zealand construct stoicism as a manly virtue (Connell, 1995). Male partners of women who experience miscarriage in performing masculinity may silence their grief, or be encouraged to put aside their feelings, in order to enact the role of supporter for their female partners. Women's embodied losses and associated physiological processes may therefore facilitate their hierarchical positioning in relation to partners and other family members, within the field (Bourdieu & Wacquant, 1992) of miscarriage. The following two stories suggest women may use such hierarchical positioning as a basis for exercising power within intimate relationships.

**Auhunga:** I've often felt quite guilty in some ways because I was offered a lot of support from my family and friends. Not that he wasn't offered support but in terms of acknowledging our loss..., people acknowledged it all to me... We realised that this was a miscarriage and there was no going back. This was actually a miscarriage, he was..., upset..., but I think that it is very hard for men because often they have to be the support for their partner... It is awful to say, but it was quite nice to see him a bit vulnerable like I was, but only at the time, because then I needed him to be strong for me after that. For that one point in time it was OK for us both to be like that. And then he knew that he had to..., and he did become very much the support person, and it was very much me going 'Waah' and him listening and him offering things back. Not offering things back that he was feeling, but in terms of trying to help me, and he knew I needed him to do that.

**Kahotea:** It was very hard. My husband was away overseas, and he felt really terrible being away. Obviously he came back, I needed him you know. He had to come back early, earlier than he was planning to. I suppose he processed it in his own way. I talked about it a lot, and occasionally I would say that I felt it was harder for me, and um he said 'Yes probably but don't underestimate how hard it was for me.' But at the time it happened I was on my own and it was dreadful, the hospital was..., it was so impersonal and they just didn't seem to, have time to care. (2+) He had no idea really... Frankly he had to really look after me for quite a long time, and that meant that you know he just had to quickly sort things in a way. He had to help me out so it may have helped validate the whole thing for him in a way... Anyway he coped admirably as he always does.

Auhunga and Kahotea draw on public narratives of masculinity which construct men as stoic and strong, and public, disciplinary and institutional narratives that women who miscarry are vulnerable and need support, in order to silence partners' miscarriage stories and position partners in the role of 'support person'. Both women constrain their partners' bodies and private conduct by constructing temporal and geographical boundaries. The partners are represented as compliant with the women's demands. Within these final narrative excerpts, the women's practice of silencing partners demonstrates the application of silence as technologies of signification and domination (Foucault, 1977) and as enacting symbolic violence (Bourdieu, 1996).

### **Summary**

Narrative analysis of participants' stories suggests that women and midwives with experience of miscarriage become experts in the crafting and strategic application of internalised and externalised silences and silencing practices. Silences, and silencing practices are employed in the shaping and narrating of ontological narratives about

miscarriage. During the research women have reported using verbal, non-verbal, lexical, non-lexical, tonal embodied, metaphorical and cultural silences, in order to manage multiple risks, to 'ontological selves' within private and public settings. Women have also used silencing practices such as hiding by showing, minimising, and exiting and/or voicing disagreement regarding care. The strategic applications of silence(s) have enabled and constrained women's and midwives' agency and facilitated the construction and maintenance of their various identities. Silences have also operated as technologies which discursively position selves and other actors within ontological, disciplinary and public narratives, and various social, public, professional and health fields. Within women's and midwives' miscarriage narratives, silences operate as actants, hybrid actors, relational entities, agency and structure, and function as actor networks and technologies in the broadest sense. "Foucault distinguishes technologies of the self from technologies of production, techniques of signification/communication and techniques of domination" (McLaren, 2002, p. 147). Within this chapter, analysis of participants stories suggests that narrative silence(s) are, as described by Foucault (1988b), simultaneously co-constitutive of technologies of the self (Foucault, 1988b), signification, domination (Foucault, 1977) and desire (Foucault, 1963). Silences and voices are co-constitutive and therefore relational. In chapter eight women's voices are presented and considered in relation to technologies associated with power, desire, recognition and relationships.

# 8

## Voicing Women's Wishes

### Recognition and Relationships

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*Whāngai i tō tāua tuahine, hei tangi i a tāua.  
(Let us nurture our sister, and she will mourn for us)*

Men have had every advantage of us in telling their own story. Education has been theirs in so much higher a degree; the pen has been in their hands. I will not allow books to prove anything. (Anne Elliot as cited in Austin, 1818, 1993, p. 39)

Virtually every discipline of the academy - but especially fields such as literature, art, history, gerontology, sociology, and psychology have used the concept of voice as a methodology to recover women's experiences, meanings and resistance to their subordinate position. (Rakow & Wackwitz, 2004, p. 94).

#### **Introduction**

Within the preceding chapters, women's stories suggest that genealogies, corporeality, temporalities and silences shape women's selves in relation to miscarriage. These elements may also influence women's material and metaphysical, experiences of, and their personal (Davis, Leijenaar & Oldersma, 1991), social (White, 1992), and embodied (Williams & Bendelow, 1998) agency in response to miscarriage. The construction, and telling of miscarriage stories may also constitute a gender based technology for situating women's experiences in the wider context of their lives, voicing women's needs, concerns and wishes in regards to receiving and/or providing miscarriage-related care. As Totoweka states

Also the thing to me is; women's stories are important. We should be able to go and pick up a book and read about them. We read about women's war stories, we read about women's domestic violence stories, we read about, we read all sorts of women's stories. Why don't, why can't I go find something about women's miscarriage stories?

In querying '[W]hy can't I..., find..., women's miscarriage stories?' Totoweka asserts the personal importance of shared narratives as a means of developing self knowledge. Matipou suggests that the voicing of miscarriage stories is also important. In remarking '[Y]ou know there's a lot of um, like storytelling that needs to happen because unless they (the government) hear the stories they're not going to make a difference'; she infers that public transmission of women's stories is a political act that is essential for advocating changes to health legislation in order to improve miscarriage care.

In consultation with Pipiwaharauoa<sup>128</sup> I have chosen to present the story of Pipiwaharauoa as a response to Totoweka's and Matipou's desire for miscarriage stories that are both accessible and publicly voiced. Her miscarriage story is an example of one woman's ontological experience, and provides support for their concerns regarding miscarriage-related knowledge, experiences and care provision. Pipiwaharauoa's storying of her miscarriage-related concerns within a contemporary setting foreshadows issues of health care as constituting an ongoing problem within the Aotearoa, New Zealand context.

Within this chapter, through attention to the stories of the women who participated in the research partnership, women's concerns and desires in relation to miscarriage care, including theoretical rationales for their ontological experiences are explored and voiced. In conjunction with Pipiwaharauoa's story, research participants' narratives provide a commentary on women's key concerns in relation to recognition and relationships when developing, providing and receiving miscarriage-related care. An argument is also presented regarding women's expertise in constructing theoretical frameworks for facilitating change to miscarriage-related legislation with specific reference to women's wishes for recognition, and relationships.

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<sup>128</sup> Pipiwaharauoa is the name given to a particular aspect of pounamu that is characterised by interwoven layers of teal green and white jade. The participant selected this aspect of pounamu as her pseudonym because of its particular association with both her turangawaewae (place of belonging), and cultural traditions associated with childbirth that are practiced within her whānau.

## The Story of Pipiwharauoa

I was hanging out the washing and I felt this sort of pain and it just got progressively worse and the woman who I was living with said 'We better take you in to see the GP'... And by the time I got into see him about it, it was 4 o'clock in the afternoon, or thereabouts. He was very abrupt. He was very curt 'GET up on the bed!' And I said 'Oh I just need to go to the toilet.' 'Well! GO to the toilet then!' And so I went to the toilet and I suddenly felt like I couldn't move my legs and I was in absolute agony and I felt like I may as well have been in full labour. I just couldn't move and there was horrific pain in my upper thighs and whatever. So, I ended up getting off the toilet trying to wipe myself and flush you know? And then I started crawling along the passageway because I couldn't stand up. And this is what he, the Doctor said; he stood in that doorway and put his hands on his hips and said 'GET UP OFF THE FLOOR WOMAN!' And I said 'Aren't you going to help me?' He said 'You got yourself down there. Get up off the floor by yourself! Pull yourself together!' And I just struggled up the wall (becoming tearful) to the... the examination room and he shouted 'GET UP ON THE BED!' you know, and I swear to God... I'd never witnessed that; experienced being treated like that in my life... Then when he looked.., he went 'Oh my God! We need an ambulance now!' (tearful but wanting to continue) So he rang the ambulance, (crying) and the only pleasant thing that happened that day was the fact that the nurse on board was a registered nurse and she was a woman's woman, she was a mother's mother, she was a grandmother and you could tell that and she said 'Oh look sweetheart. You'll be alright with me now!' (Participant very tearful declined to take a break) I'm not stopping because I think it is important to tell it like it is, like it was, because those are the stories, that don't get heard... It's crap that it's not okay to cry. Well it IS OK to cry.

So, here I was miscarrying and it was blood pressure, the temperature, respiration, the whole nine yards and I'm thinking 'I need to get to bed, like NOW!' you know? And the house surgeon came to examine me and said 'Oh hell! Get her down to the Gynae ward for God's sake! And she's Māori so on the way you can get a routine chest X-ray!' And I said 'I'm not having no routine chest X-ray mate. I'm having a baby. Stuff it; that can wait until later! Get your priorities right. Who do you think you are talking to? I had enough strength in me to do that, because I wasn't intimidated... Well actually I was very intimidated, and upset, but I wasn't that intimidated that I didn't stick up for myself. So I went down to the ward. They wanted to admit me and I said 'No, I need to get to theatre; now would be good because I can feel something is happening.' But they didn't listen and they did the routine and all the rest of it, gave me the bell and said ring the bell when something happens and we'll come and they shut the door. I was left by myself in the room next door to the office, and within 2 minutes I rang the bell. Everything had ruptured and it was 'Oh my God! She wasn't kidding.'(2+) Well I showed them!

Too many things happened bang, bang, bang. So then it was all panic stations, ring the theatre, well they hadn't rung theatre, so then my bell goes again... They didn't listen, and there were doctors all around and no one listened. All I wanted was to have my baby and I wanted to take him home and to have him buried. But I wasn't allowed to see him. I wanted to but they said NO! And they took him out, they put him wherever and I never saw him again... I kind of wouldn't have a clue

about what happened to him and I don't think I want to know...And the next day I went to theatre and I went home the next morning, the Thursday morning....

So that's what happened to me and it was a terrible experience ... It was horrible really..., awful um ...(2+) (Becoming tearful) I knew I had been a mother. I knew it! I didn't give a stuff what anyone said! Because that part of me that feeling was still alive... This is what a mother was, is... I never saw that baby but in my mind I named him, and I didn't care what the rules and regulations were. I only know what the wairua is and to me I had a child. To me he had a name, dead or alive he had a name....

I am glad I have told my story today and I think to share this sort of korero with people I feel privileged to be invited to share it. Just simply, if it helps one other person to cope with going through miscarriages for whatever reason they happen, be they surgical due to stress, emotional or the whole nine yards or whatever or if it helps one doctor or nurse to think twice when they are providing care. If that is going to help I just think it's stunning and so important.

Pipiwaharauoa stories her experience of miscarriage-related pain, distress and lack of care as 'terrible' and 'horrific' and her analysis of her experience is consistent with recent research findings (Gerber-Epstein, Leichtentritt & Benyamini, 2009; McCreight, 2008; Simmons, Singh, Maconochie, Doyle & Green, 2006). Revisiting her experience and sharing the story is emotionally distressing. Storytelling 'it like it is' is justified as necessary resistance to the social silencing of women's stories; a resource for women who experience similar losses, and an exemplar to facilitate improvements to care provision.

Pipiwaharauoa characterises the general practitioner's initial interaction with her as 'abrupt' and 'curt'. Communication is perceived as inadequate because verbal interactions are construed as commands and miscarriage-related information is not provided during the consultation. Pipiwaharauoa also perceives the doctor as uncaring, disrespectful and judgmental. Her relational status<sup>129</sup> potentially alluded to by the general practitioner's comment 'You got yourself down there. Get up off the floor by yourself' may have an absent presence in the interaction and influence the general practitioner's behaviour. As Pipiwaharauoa also reports that verbal expressions of grief and/or responses to pain are not tolerated, it may be argued that personal agency is constrained within the consultation by medical governance. The physician's behaviour is subsequently contrasted with the response of the nurse in the ambulance,

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<sup>129</sup> In her story, Pipiwaharauoa presents herself as unmarried and living with a woman at the time of her miscarriage. It is possible that care provider's value judgements regarding her relational status may negatively influence social interactions and care provision.

and attention is drawn to the necessity for women-centredness, sensitivity and empathy in the provision of miscarriage-related care.

Admission to hospital is constructed as a routine exercise where ethical factors such as the provision of care choices and obtaining informed consent for interventions or care practices are not required. Health status is established through the application of standardised assessment technologies, but also through the construction of ethnicity based health risk. The Registrar's request for a chest X-ray suggests his familiarity with public health narratives which position Māori under the age of 40 as sources of, or being at risk for developing, tuberculosis (Das, Baker, Venugopal & McAllister, 2006; Howie et al., 2005). Within health care settings, the construction of health risk based on assumptions about ethnicity constitutes marginalisation due to ethno-cultural difference, and may be construed as institutional racism (Reid Robson & Jones, 2000). Such racism is detrimental to the health and wellbeing of indigenous women and their families (Harris et al., 2006a, 2006b; Jansen et al., 2008; Rumball-Smith, 2009).

Health related factors that demonstrate individual and/or contextual specificity such as woman's embodied knowledge are disregarded. Care processes may therefore act as technologies of silence, and/or as Foucault (1988) conceptualises, technologies of normalisation to constrain individual agency in order to ensure social conformity within the institution. Despite institutional and individual intimidation by the general practitioner, Pipiwharauoa resists being individually silenced and asserts her personal autonomy. In doing so she risks being conceptualised, as described by Russell, Daly, Hughes and op't Hoog (2003), as a patient who is "non compliant" with hospital procedures (p. 281). Within health care settings a patient's lack of compliance with health care recommendations is viewed as "a major health problem" (Vermeire, Hearnshaw, Van Royen & Denekens, 2001, p. 331) and a factor that may be detrimental to positive health outcomes. Patients that are perceived as sabotaging personal health outcomes are commonly positioned as "difficult" (Russell et al., 2003, p. 281) and may as a result of their positioning by, and within, health institutions, subsequently receive marginal care. As non-compliance has historically been primarily associated with those from the most socio-economically deprived populations (Becker & Maiman, 1975), the potential exists for exacerbating the problem of existing inequities associated with accessing reasonable health care.

Regardless of Pipiwharauoa's actions, in her story, hospital staff are repeatedly characterised as 'not listening', alluding to the non-recognition of her identity as an

autonomous agent, her expert knowledge of her body, and her ability to exercise agency in relation to care choices. Donchin (2001) suggests that such behaviours draw on “biomedical conceptualisations of autonomy that both disregard patients’ self knowledge and fail to recognise limitations to the generalisability of medical knowledge” (p. 365). Although Pipiwharauora perceives that she is consistently ignored, careful attention to the interpretive repertoire that she employs within her story suggests that she may be construed as an institutional insider. Personal familiarity with assessment procedures (checking respiration) and treatment protocols (surgical management of miscarriages) is evidenced within her story.<sup>130</sup> Pipiwharauora’s clinical and embodied knowledge is validated when miscarriage occurs spontaneously in the ward. Due to her enforced physical and social isolation within the ward setting as well as the inadequate resources to facilitate appropriate care provision, the material and metaphysical context within which miscarriage occurs is culturally unsafe<sup>131</sup>. Ramsden (1990, 2000, 2001) has explicated the essentiality for health professionals to provide respectful and recipient centred care that is regardful of difference. Such care demonstrates a valuing of the care recipients’ diverse cultures, practices, values, attitudes and worldviews, in order to maximise the health and wellbeing of both individuals and collectives.<sup>132</sup> Wilson (2004) adds that Māori women’s worldviews of what constitutes health and wellbeing may differ considerably from the perspectives of Non-Māori New Zealanders. The cross-cultural variance in worldviews may be due in part to a cultural perspective evident in *He Korowai Oranga: Māori Health Strategy*, which specifically recognises the collectively interdependent and inclusive nature of Māori wellbeing, and its foundation within the whānau unit (Ministry of Health, 2002, 2006). Māori perspectives do not require validation through endorsement in government documents. However, current health policy (Ministry of Health, 2007) supports the premise that Pipiwharauora’s enforced physical and social isolation from

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<sup>130</sup> Pipiwharauora is a health professional who has been employed in the areas of women’s health and health promotion.

<sup>131</sup> The Nursing Council of New Zealand (2002) states “Unsafe cultural practice comprises any action, which diminishes, demeans, or disempowers the cultural identity and wellbeing of an individual” (p. 7).

<sup>132</sup> ‘Cultural safety’ is a term legitimated by Dr Irihapeti Ramsden as a core aspect of nursing education and practice in Aotearoa New Zealand. It may be defined as “the effective nursing or midwifery practice of a person or family from another culture, and is determined by that person or family” (Nursing Council of New Zealand, 2002, p 7). This definition is not uniformly accepted by the legislative bodies of other health professions. In response to the Health Practitioners Competence Assurance Act (2003) the Midwifery Council of New Zealand and the New Zealand Medical Council have introduced the concept of cultural competence as a legislative requirement for professional practice. Cultural competence is individually validated through self reflection by practitioners rather than care recipients. This suggests the issue of the professional ‘self’ as powerful actor and a bearer of culture is ignored and that the potential exists for a reduction in practitioner accountability to women and their families in relation to care provision.

whānau may have been particularly detrimental to both her individual health status and the health and wellbeing of her whānau.

Within the hospital, institutional control is exerted through the application of what Foucault characterises as technologies of domination (Foucault, 1979, Lemke, 2001), which may construct Pipiwharaua as both a subject and an object, to be compulsorily scrutinized by medicine's "calculating gaze" (Foucault, 1973, p. 89). Institutional governance of embodiment is extended through applying technologies of domination, to construct the baby as miscarriage related by-products or products of conception, which are subsequently construed as objects delivered within, so belonging to, or owned by, the hospital. As a result, there is no institutional recognition of Pipiwharaua's identity as mother, or the human identity of her baby. It may also be argued that the absence of follow-up care, in conjunction with the lack of interpersonal support within the institution, is a reflection of the medical profession's marginalisation of miscarriage as a minor medical event (Cosgrove, 2004; Lee, Slade & Lygo, 1996; Swanson, 1999). Institutional marginalisation of miscarriage may subsequently contribute to the minimal allocation of resources for miscarriage-related care.

Pipiwharaua's story provides an exemplar of miscarriage-related issues that are synonymous with concerns reflected within this thesis and in international research. Research findings have suggested that care providers do not recognise women's identities as autonomous agents (Mansell, 2006), mothers (Wong et al., 2003) or the identity of their unborn babies (Corbet-Owen & Krueger, 2001). Personal agency in relation to care choices, and the provision of consent to care, may be constrained due to the exercising of bio-power<sup>133</sup> (Thompson 2008) which may have facilitated the subject positioning of women as subservient to the institution of medicine within the health system (Sawicki, 1991). Within the miscarriage-related literature, communication has been evaluated as ineffective (Moulder, 1999) particularly information provision which is perceived to be inadequate (Cecil, 1994; Friedman, 1989; Leoni, 1997; Speraw, 1994). Care is primarily conceptualised as risk management and treatment (Bigrigg & Read, 1991; Sagili & Divers, 2007; Sofiriadis, Makrydymas, Papatheodorou & Iannidis, 2005; Trinder et al., 2006). It is also suggested that 'caring' may be marginalised or lacking in sensitivity and empathy

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<sup>133</sup> Thompson (2008) draws on Foucault (1977), in conceptualising bio-power as disciplinary power exerted over populations by the discourses and practices of the sciences, in this instance more particularly the discipline of medicine.

(Abboud & Liamputtong, 2003; Atik, 2002; Harvey, Moyle & Creedy, 2001). Marginalisation due to ethno cultural difference is also a concern (Chalmers & Meyer, 1992; Erviti, Castro & Collado, 2004; Sobo, 1996). Physical, social and temporal settings in which institutional care is provided are not conducive to self care (Smith, Frost, Levitas, Bradley & Garcia, 2006) and due to minimal recognition within health policies and legislation, follow-up care and resources are compromised by inadequate funding (Evans et al., 2002; Lee et al., 1996; Niinimäki, Karinen, Hartikainen & Pouta, 2009; Stratton & Lloyd, 2008; Swanson, 1999).

### **Women, Midwives and the Desire for Recognition**

Women who experience miscarriage may desire recognition within the health system for their conceptions, pregnancies, unborn babies, and identities (Corbet-Owen & Krueger, 2001; Oakley et al., 1984; Wong et al., 2003). Particular desires for women in health care settings may include acknowledgement of women's personal autonomy (Mansell, 2006; Thompson, 2008) and being culturally respected. O'Malley (20005) suggests that midwives may also require recognition specifically, disciplinary institutional and/or public acknowledgement of midwifery as an autonomous profession, and recognition of midwives' professional expertise (Simmons et al., 2006). The shared desires of women and midwives in relation to miscarriage potentially encompass acknowledgement of professional, embodied and cultural knowledge bases, skills, personal practices, values and beliefs. When these desires are not met by health care providers or peer health professionals, health care provision may be negatively impacted (Abboud & Liamputtong, 2005; Brier, 2008; Bryant, 2008; Gerber-Epstein et al., 2009; McCreight, 2008; Simmons et al., 2006; Ministry of Health, 2007). The following stories provide an overview of research participants' key concerns regarding what should be recognised when developing, providing and receiving miscarriage-related care.

Kawakawa' story commences with her rejection of the Doctor's silencing of her pregnancy.

**Kawakawa:** I wanted him first to recognise that..., you know, that I had, that I was pregnant not try and just tell me that I wasn't. And I know that..., I just couldn't believe that he'd said that. 'Any woman who loses a baby under 12 weeks isn't pregnant.' You know to me, that is just crazy. I mean fair enough that, that might be his belief, but..., I guess I wanted him to just say that, um..., 'Look these results show that your levels aren't very high. I can't, can't say that you are miscarrying and I can't

say um ..., that you ..., that you don't still have the baby now and I guess we just have to wait and see what's going to happen to you. It just takes time to see what your body's going to do.... Like I had a vague, sort of idea what HCG (Human Chorionic Gonadotropin) levels were, but the doctor didn't explain really what it meant. He just said 'These levels are not very high.'...And I wished he'd said to me what um what ARE normal HCG levels! You know? Yeh! That he'd really explained what, what the levels were and what they meant! Not just doing his job. I just wanted him to say 'This must be so hard for you... I'll do all I can to see if I can get you a scan, but it might not be possible, because they may be too busy.' But it..., it..., I don't know..., I just, I got the impression that he just (1+) couldn't be bothered. There were much more important things. I don't know just! ... I wanted to be seen! To be recognised as... a mother, not just as um..., a silly woman that thought she was pregnant but she isn't actually, and is just sort of taking up my time.

### **Recognition and Identities**

In her story Kawakawa rejects the doctor's characterisation of her pregnancy as non-existent. In stating 'I wanted to be seen! To be recognised', she uses 'talk' to construct her desire for the physician to recognise her conception as resistance to the silencing of her pregnancy. Kawakawa disputes the medical conceptualisation of pregnancies that are less than 12 weeks duration as non-existent through construing such views as health professionals' personal or value judgements, which lack an evidentiary basis. Finalisation of pregnancy loss is challenged through expressing a desire for the doctor to acknowledge uncertainty; that he 'can't say' definitively that she is 'miscarrying' or that the baby is no longer present or viable. Allowing 'time to see what the body is going to do' is presented as an alternative method for facilitating the construction of both embodied knowledge and agency.

Kawakawa positions the doctor in the story as non responsive. Medical terms are not explained and his use of the interpretive repertoire of medicine is construed as a deliberate strategy to limit interpersonal communication and care involvement. The doctor is conceptualised as 'doing his job'. Kawakawa infers that his 'time' constitutes an expensive resource that must be carefully managed; alluding to her familiarity with public narratives which link care provision with economic risk factors that recommend careful management of health services (Dugdale, Epstein & Pantilat, 1999; Yarnall, Pollack, Østbye, Krause & Michener, 2003). She also alludes that her care is marginalised because the doctor constructs her as not-pregnant and therefore not able to claim health services. Kawakawa resists marginalisation because of her desire to 'be seen'. It may be argued that 'being seen' encompasses acknowledgement and/or

recognition of her individual autonomy as a free agent, her humanity, her conception and pregnancy, and her identity as mother. Such acknowledgement may also encompass her embodied self knowledge, the human identity and existence of the miscarried baby and the relational nature of the provider/patient interaction.

In the following story Rewarewa, a midwifery practitioner, acknowledges that professional medical narratives which construct babies as not human until 12 weeks gestation are widespread. She theorises that such conceptualisations are a technology for rationalising institutional time constraints.

**Rewarewa:** I have struck it now a few times with stories from women and other health professionals, that it's not really a baby until it's 12 weeks plus. I guess from their point of view it's time management. So from their point of view they don't really want to be involved in all of that. People say 'Oh it's just a miscarriage. What the heck. Get over it.' You know and it's like...move on... Actually I say to that it's so much more than that, because it's a big grief, it's a deep grief process, and unless you allow that woman and that man to work through the grief process there will always be baggage. It will always be there and it will always drag at them some of the time.

You know, that's so important, like when I've spent time with women, they often say 'When you told me that it's Ok to cry and it's OK to think about my baby and it's OK to say oh my baby was due now, because it's March and that's Ok. That made all the difference, because other people didn't say that it was ok to do that, and other people didn't say that it was a baby, but you always said it was a baby. And um, those, those words are really important to us, to women. We as health providers need to be acknowledging to women that it is a baby and not a medical event. It has to be a baby, because to them it is their baby, you know? They are mothers absolutely, that's the way it is.... Like calling it a baby, yep that's really important, to call it a baby..., and telling women that it's Ok to grieve. It's Ok to talk about it..., giving permission to talk about it...That's what women have said to me 'You gave me permission, you said it was ok.' And I think that has been important for women, for my clients, because society says it's not I think; not ok to talk or you know grieve.

Rewarewa constructs a counter narrative of care to Kawakawa's story of care interaction. Midwifery care is presented as permissive and encouraging of women's views and values and therefore professionally congruent with midwives' disciplinary philosophies and ethical tenets that define midwifery in Aotearoa New Zealand as a women-centred profession (Guilliland, Tracey & Thorogood, 2006). Rewarewa is familiar with the concerns expressed by Kawakawa, and theorises that care providers

avoid becoming emotionally involved with women who miscarry by minimising women's experiences. Although time management is presented as the rationale for such practices, it may also be inferred that minimisation is employed to facilitate psychosocial protection for health care professionals (Ujda & Bendiksen, 2000).

Strategic silencing of women's stories is interpreted as also silencing women's ability to grieve which Rewarewa perceives as being counter productive to women's and their families' wellbeing. She asserts that providing women with permission to voice their experiences, and grief as well as acknowledging their unborn babies, is a key aspect of miscarriage care and facilitates psychosocial healing. Her perspective is supported by current research (Brier, 2008; Evans et al., 2002; Jacobs & Harvey, 2000; Lee et al., 1996; O'Malley, 2005; Scroggins et al., 2000). In stressing the importance of what, and how, language is used in health care interactions, Rewarewa's story draws attention to the ways in which health professionals may provide acknowledgement of women's and babies' identities. She suggests that in doing so health professionals may also validate women's feelings, values and worldviews in regards to pregnancies, unborn babies and miscarriages. Validation of women's identities, values and worldviews is also an issue of concern in the following excerpt from Kahatea's story.

**Kahatea:** At the hospital you get discourses, like 'Oh well, its early days yet you can have another baby, you're young and you can have another baby' and another common one is 'It wasn't really a baby yet'. (1+) Oh I've had a little bit of that attitude, and it made me feel stumped! Just stumped, really. Well stoppered is a better word, corked! 'Just shove a cork in it we don't want to hear your experience if it was upsetting because it wasn't really much, you know... You know they called it a product or something, Products of conception that's what they called it. And I just kept referring to it as a baby because it is a baby to me. I think it would make it easier if they did call it a baby...Um..., although it could upset some women more, but for me it would kind of validate things that it was a baby and that I was a mother... But I also think they should wait and hear what the person, the woman calls it and then refer to it as that, because I was referring to it as baby... Whether or not that is what they thought it was because by then I'd heard the whole, you know, blighted ovum stories. That you know 90% of miscarriages, are actually there is no baby matter present.... Somebody said that to me, a friend's Dad is a Dr and he said it... 'Well a high percentage of miscarriages were you know not real babies but blighted ova... I definitely don't (agree). I'm pregnant from conception and there was nothing blighted about it... I got really upset that there was nothing in there, because it really..., like it really hit home and I felt like, well, what is this then, all this pain and discomfort, you know?

Kahatea's storying of the power of language to silence identity and disrupt social status within health institutions and community settings is supported by contemporary research (O'Malley, 2005). Her conceptualisation of the hospital as a setting which recognises and promotes discourses that marginalise miscarriage and dispute the humanity of miscarried babies is also consistent with current research findings (McCreight, 2008). Like Kawakawa and Rewarewa, Kahatea is familiar with the disciplinary narrative of medicine that gestation determines humanity. She suggests that the institutional normalisation of quantifying humanity through measurement acts as a technology of silence which prevents her from voicing her miscarriage reality. In her story the application of such technology is interpreted as strategic rather than neutral in that it facilitates the promotion of certain discourses over others. Institutional narratives privilege discursive conceptualisations of Kawakawa's miscarriage as 'products of conception' and as not 'a baby yet'. In doing so such narratives simultaneously 'hide' the human identity of Kawakawa's deceased child and her personal loss and may constitute an exemplar of what Bourdieu (1996) conceptualises as "hiding by showing" (p. 19). Kawakawa also theorises that voicing women's stories of the embodied experience of miscarriage is construed as undesirable within health institutions, and therefore such stories become marginalised and/or silenced within health institutions. Women's stories of miscarriage are about plight and involve risky transgressions of bodily boundaries (Lupton, 1999) by organic products that may be socially conceptualised as pollution (Douglas, 1966). They may therefore be silenced within the wider community (Hazen, 2003, 2006).

Kahatea resists institutional marginalisation by reframing her experiences as a pregnancy and alludes to her continued use of the term 'baby' as challenging institutional conceptualisations of miscarriage as 'products of conception' and therefore as non-human and processed objects. Terms drawn from the interpretive repertoire of medicine also inform public narratives about miscarriages. Kahatea encounters the term 'blighted ovum' which she perceives as not only silencing her pregnancy, her identity as mother and that of her unborn child, but also apportioning blame. Characterising her miscarriage as a 'blighted ovum' suggests that Kahatea's physiology is 'blighted' or faulty. Her reproductive cells are constructed as marred, substandard and/or of impaired quality, and therefore her pregnancy and her body are also marred and or impaired. Impaired fertility is a factor that may be used to marginalise women within both the field of reproductive health and the wider community (Liamputtong, 2007a). Kahatea vigorously resists being marginally positioned in this manner and reasserts the importance of language in recognising

women's worldviews as validation of their identities, values and experiences. She suggests that care providers should pay attention to women's use of language in relation to miscarriage and where appropriate, reciprocate such language in care interactions in order to facilitate validation of patient's identities, experiences and knowledge and enhance care experiences. Linguistic objectification of miscarriages is also evidenced within Kahikatea's story of providing care for her client within an institution.

**Kahikatea:** My client was so young. She came from a Māori family and was still living at home, and they wouldn't let any of her family stay with her while she miscarried. It wasn't hospital policy, something to do with fire risk or fire drill, whatever... Can you believe it? (sighs). And I couldn't be there either because I had a client in labour... Anyway afterwards they took the baby away for an autopsy, without asking permission, and of course I heard about it because she was upset. She rang her mother in the morning; who promptly rang me on my mobile and fortunately I was still in the hospital. My woman had just had her baby, and I was just about to leave. So it was back up the stairs... And I had a FEW things to say to the staff (starts laughing) about what had happened you know... Well the baby was duly returned and she was ALLOWED to take that baby... There's that lovely hospital word ALLOWED what is allowed (laughs), and I'm using it deliberately here. She was ALLOWED to take the baby with her. There was just no institutional recognition that the baby was a baby let alone her baby. The institution took it in the first place without asking because (puts on officious sounding voice) products of conception belong to the hospital don't you know, and get processed in the system... I think it's appalling, and you know they, the hospital, would have kept the baby too if I hadn't gone up to the ward and had a fairly substantial hissy fit...Um, I don't know actually, I don't know whether a hissy fit is always the best way to go, sometimes you've got to jump up and down or nothing happens, but it shouldn't have to be like that.

### **Recognition, Agency and Autonomy**

Kahikatea describes her client as 'young', and 'Māori' positioning her client within a cultural framework that values childbearing as the paramount role of womanhood (Palmer, 2002; Mikaere, 2003) and a corporeal, and metaphysical resource for transitioning to adulthood (August, 2004, 2005; Mikaere, 2003). However, in positioning her client as 'still living at home' she infers that her client may be subject to parental care and may therefore be conceptualised within a western worldview, and potentially within the institution, as a child. Children require familial support, yet this requirement is contradicted within the health care setting. Culture and familial positioning are linked with what is perceived as the institution's non-recognition of her client's need for support and denial of family access. In asserting that practices

which facilitate institutional risk management are privileged over familial involvement, the midwife also alludes to the absence of culturally safe and/or respectful care. The essentiality of cultural acknowledgement of and respect for individual and collective Māori wellbeing is well established (Durie, 2001; Wepa, 2005; Wilson 2004) as are the negative outcomes and health disparities that arise when such acknowledgement and respect are lacking (Blakely et al., 2005; Harris et al., 2006a, 2006b; Jansen et al., 2008; Reid et al., 2000, Rumball-Smith, 2009).

Midwives, as autonomous practitioners, have an ethical responsibility to facilitate where possible, safe and supportive environments for their clients, including when primary care is transferred to secondary or tertiary level care. In providing a rationale for her non-presence with her client the midwife may infer her awareness of this responsibility. However, midwifery practice philosophies vary amongst practitioners, and some midwives do not provide miscarriage support. An alternative interpretation of the midwife's rationalisation may be that 'non attendance' is contradictory to her usual practice as midwifery philosophy constructs 'being there' as a core element of midwifery practice in Aotearoa New Zealand (Foureur & Hunter, 2006).

Removal of the miscarried baby without maternal consent is constructed by Kahikatea as violating her client's rights as a consumer of health services<sup>134</sup> and her personal autonomy and agency. In responding to the client's mother Kahikatea demonstrates that her care relationship encompasses the client's family. It may be argued that she also alludes to her cultural awareness that within Te Ao Māori, childbirth is centred within, and is the responsibility of, Māori whānau (families). In immediately visiting the ward in order to address staff and facilitate the baby's return, Kahikatea simultaneously enacts the roles of client and cultural advocate. Practising advocacy on behalf of childbearing women is an ethical responsibility assumed by professional midwives in Aotearoa New Zealand (New Zealand College of Midwives, 2005). In storying her resistance to institutional practices on behalf of her client the midwife demonstrates her professional competence and culturally safe practice.

Communication theorists suggest that laughter is used as a technology to mitigate awkwardness in conversational interactions (Allen, Reid & Riemenschneider, 2004)

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<sup>134</sup> Health professionals that carry out care interventions without patient's consent contravene Right 7. The right to make an informed choice and give informed consent (in regards to care) and possibly Rights 1-6, 8, & 10, of the HDC Code of Health and Disability Services Consumer's Rights Regulation (1996). Health Practitioners that contravene the rights may be subject to disciplinary procedures; and in instances where assault has been deemed to have occurred may be subject to criminal prosecution.

particularly when discussion may encompass contentious topics or behaviours. In Kahikatea's story it is discursively intimated that the hospital and staff are uncooperative. Her use of laughter when reporting her interaction with ward staff infers the problematic nature of her interdisciplinary communication in this setting. In her statement 'I had a FEW things to say to the staff', Kahikatea also alludes to her conversational approach to ward staff as transgressing social rules that constitute appropriate professional communication.<sup>135</sup> In emphasising 'few' she intimates the opposite; that she had a large number of problematic issues that required addressing with hospital staff. Her confrontational approach to addressing the lack of cooperation in interdisciplinary communication is confirmed when she characterises her interaction as a 'hissy fit.' In justifying the initiation of confrontation as enacting advocacy, she asserts the need for institutional recognition of women's identities, personal autonomy and agency.

Kahikatea draws attention to the problematic work done by the interpretive repertoire used within the hospital, in 'allowing' or permitting behaviours and/or actions. Institutionalised language and actions are simultaneously construed as technologies of silence and control that facilitate hospital ownership of objects (the baby as 'product[s]') and bodies. Kahikatea's client is discursively positioned as both subject, and subservient and therefore marginalised by, and within, the institution. Kahikatea suggests that marginalisation facilitates the continuous non-recognition of her client as an autonomous agent. Non-recognition is also extended to her client's culture, family, identity as mother, relationship with her miscarried baby, and the baby's humanity. Care provision within institutional settings is presented as problematic and change is advocated.

Non-recognition of personal autonomy and agency is also evidenced in the following narrative.

**Tangiwai:** I have certainly had the experience of being a mother, having gone through all the loss. At the hospital, not too much attention was paid to talking to me as if I was a mum though..., (1+) The miscarriage didn't count as a baby... And there were lots of internals I found whether you wanted them or not ... And I DIDN'T! So I didn't really count either.., as even a person. Some of them said 'You'll have another one and there's plenty of time

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<sup>135</sup> Within hospital settings, institutional and public narratives shape communication between health care professionals in response to the hierarchical structuring of the professional field. An example relevant to Kahikatea's story might be that 'doctors decisions regarding health interventions are not challenged by health professions perceived as subordinate or having less capital within the field of health care.'

because you are young', but there was not too much attention about 'We're sorry this has happened or we're sorry this has happened to you and the baby... No, it wasn't good enough. It is still not good enough.

Tangiwai stories her miscarriage as 'being a mother' and experiencing 'the loss', of a child. Her ontological narrative of her 'baby' is challenged in hospital interactions in a similar manner to, as previously mentioned in this chapter, Kahatea's story. Tangiwai's identity as a mother and the identity of her baby are linguistically silenced and hospital narratives construct her miscarriage experience as homogeneous with the experiences of other childbearing women. Like Kahikatea's client, her identity as an autonomous agent is also not recognised. Kahikatea's client was initially denied personal choices in regards to accessing support and being able to retain and care for her miscarried baby. In contrast Tangiwai is subjected to unwanted and invasive procedures without her consent, which contravene her rights under the HDC Code of Health and Disability Services Consumer's Rights Regulation (1996) and which may also constitute personal assault. She perceives care providers' actions, regardless of the lack of consent, as non-recognition of her humanity and infers that such objectification constrains her personal agency. As she is disempowered within the health setting, she is unable to challenge care practices.

The absence of 'caring' is represented as problematic and Tangiwai asserts that providing miscarriage care that is not caring, or lacks empathy is not acceptable and should be addressed. Her viewpoint regarding necessary changes to institutional care practices is supported by recent research findings (McCreight, 2008; O'Malley, 2005; Simmons et al., 2006; Murphy & Merrell, 2009). Tangiwai's perception that she does not 'count even as a person' within the hospital is supported by the following midwife's story that describes culturally unsafe care.

**Matipou:** Women have told me that they've had to wait a long time, or that they didn't know what they were supposed to do because the staff, they ignore them. Then I have had to give the staff the whole story all over again when I got there. The staff want to talk to me even when I might have already rung and told them everything over the phone. The staff want to talk to you because they don't see the woman, and so she can't speak for herself. They don't acknowledge her at all... These are Māori women actually, not the Pakeha women... So the Māori women are so silenced that their korero, who they are, their whole identity is silenced, by staff who won't acknowledge them, won't listen to them, and won't put any value on their knowledge.

That's pretty shocking actually when you think about it...It's disgraceful and it needs to be sorted!

Matipou reports that non-recognition of women's identity, culture, autonomy and agency in hospital settings is established through the strategic application of silence as a technology of power by care providers who do not communicate with, and/or physically isolate, women in marginal care spaces. She alludes to the lack of communication between women and institutional care providers as a deliberate practice that ensures women's social, cultural and embodied knowledge in relation to their miscarriages goes unrecognised and, it may be argued, ensures that medical knowledge retains dominance within the institution. However, Matipou also suggests that the institutional practice of silencing is ethnicity specific. She argues that women's ways of knowing and knowledge bases are positioned in a hierarchical relationship, and that the knowledge bases of only some ethnicities (Pākeha) are recognised by staff within health care settings. The inequality in recognition is perceived as a form of institutional racism and is therefore construed as a problematic factor that needs radical change in order to enable appropriate care provision for Māori women who experience miscarriage. Matipou's concerns are supported by recent research findings (Harris et al., 2006a, 2006b; Jansen et al., 2008; Rumball-Smith, 2009) that suggest that Māori are generally disadvantaged in relation to other ethnicities, within the New Zealand Health System.

### **Recognition of Knowledge**

Non-recognition of women's autonomy and ways of knowing is also evidenced in Rewarewa's story.

**Rewarewa:** I remember a woman who was 9 weeks (gestation) and the scan said that she was miscarrying. She wanted to have a D&C (dilation and curettage), and I had to fight with the registrar to get her in to have a D&C. He was like..., 'No she should just do it herself at home. There was a complete lack of recognition of her; of her choice... I think that although expectant management might be shown to be the best way to do it. I still think that we have to remember that informed choice and the best choice are not always the same. I am concerned that might change, because that registrar said to me 'What are they (women) doing coming in here? They should be just doing it at home' And I don't think that should happen. It should be women's choice.

Rewarewa presents herself as advocating for her client in a similar manner to Kahikatea. Her 'fight' with the registrar may be construed as a micro-level exemplar of the interdisciplinary debates of the medical and midwifery professions regarding professional philosophies, knowledge bases and practices (Jordan, 1997; Lay, 2000; Pairman & Donnellan-Fernandez, 2006). Rewarewa asserts the importance of informed choice and recognises her client as individualised; as 'she'. In doing so she demonstrates her conformity to midwifery ethical tenets which advocate woman-centred midwifery care. In contrast the registrar is very reluctant to provide individualised care. Non-recognition of her client's informed care choice is therefore still a concern. The potential exists for generic 'evidence-based' care to be imposed upon her client within the health care setting, which would constitute a violation of her client's consumer rights.

As medical research proposes expectant management as the most effective care for uncomplicated miscarriages (Ogden & Maker, 2004; Sotiriadis et al., 2005; Trinder et al., 2006; Wiebe & Janssen, 1999), the potential for gate-keeping of services has an absent presence in Rewarewa's recollection of the registrar's challenge regarding her client accessing hospital care. Concern with generalising 'best' care to the population may be inferred from the registrar's reported use of a plural pronoun (they) in reference to the client's care episode. Rewarewa perceives this as significant and suggests that the registrar's narrative also promotes expectant care as best regardless of individual context. The de-contextualisation of care reflects the growing popularity of population based approaches to health care which focus on management of generalised health risks (Peterson, 1997). Such approaches diametrically oppose the woman-centred and individualised approaches to care provision which are advocated within the field of midwifery.

Competition for validation of knowledge and authority within the health arena has resulted in the hierarchical positioning of health disciplines within dynamic and un-finalised relational networks. Medicine is publicly perceived as the authoritative 'voice' of evidence-based, and therefore socially accepted, 'best' care (Fitzgerald & Dopson, 2005; Goldenberg, 2006). In challenging medicine's dominance midwives may have facilitated disciplinary non-recognition of women's individual identities, personal autonomy and agency being extended to encompass the midwifery profession as a whole (Papps & Olssen, 1997). Alternatively, medical animosity<sup>136</sup> towards midwifery

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<sup>136</sup> In this thesis it is not the researcher's intent to reiterate polemical rhetoric in regards to the disciplinary tensions that exist between the medical and midwifery professions. However the Royal

may facilitate lack of recognition and marginalisation of midwifery clients. The following comment from Karaka's story suggests that midwifery may already have become a non-recognised profession.

**Karaka:** I liked the continuity of midwifery practice so I practiced for three years in Britain and then moved to... (City)... New Zealand. I was used to a multidisciplinary approach; people worked together, so when I was interviewed by the DHB (District Health Board), I expected that the interviewing panel would include Obstetricians. I quickly found that they (the doctors) didn't listen or value your input at all. Midwives didn't count... I wanted more than that, I wanted recognition as an autonomous practitioner so I left the DHB and I became an independent midwife.

Karaka stories herself as a midwife with multinational experience in a variety of settings whose practice is embedded within the professional philosophies of continuity of care and multidisciplinary collaboration. Immigration to Aotearoa New Zealand is perceived as movement to a new geographical space whilst maintaining continuity of professional philosophies, values and practices. Karaka's expectations infer the international influence of circulating professional narratives which conceptualise midwives in Aotearoa New Zealand as autonomous and respected care providers (Daellenbach & Thorpe, 2007; Surtees, 2003). She constructs her initial experiences within the health system as disillusioning. In contrast to Britain, she perceives midwifery is not recognised as a profession in New Zealand health institutions and therefore within hospital settings. Even as an employee her professional identity is undervalued and her knowledge base is construed as valueless in comparison to medicine's knowledge base. Karaka resists non-recognition of her identity within the hospital. Rather than voicing her concerns she resigns and employs the strategy of exiting (Fougere, 1990; Hirschman, 1970) from the health institution. She subsequently establishes herself as an independent lead maternity care provider working with peer midwives in a collaborative practice setting. Her story alludes to inequitable recognition of midwives within some institutional settings, for example, self employed midwives may have more autonomy than hospital employed midwives. In choosing to become a self-employed midwife, Karaka infers that the professional

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Australasian College of Obstetricians and Gynaecologists' recent submission to the Australian government which comments on the introduction and current professional practices of the midwifery profession in Aotearoa New Zealand is titled 'The unfortunate experiment'. In strategically labelling the report to draw a parallel with gynaecological research conducted in Aotearoa New Zealand by Doctor Herbert Green that has been internationally recognised as unethical, non-evidence based and having resulted in numerous fatalities and/or permanent ill health for research participants, the submission infers that midwives are practising without an evidentiary basis, and that therefore midwives are unsafe and unethical health professionals.

autonomy of self employed midwives is more readily acknowledged by other health professionals within institutional and community health care settings. Kauri's story suggests that regardless of a midwife's sphere of practice, institutional recognition of a midwife's professional autonomy and agency remains problematic.

**Kauri:** I would ring A&E and they would say (Alludes to A&E) 'Oh, but you can't refer the woman because it (the referral) has to come from a doctor' and I'd say, 'Well. No, actually I can refer them because I'm a midwife, the law has changed, and you have to take (chuckled) a referral from me. I know quite a few midwives had that problem to start with where the A&E doctors did not consider that they could take a referral, and nurses didn't want to take a referral from a midwife either. That has improved over time, but it will still depend who's on duty, and you may still get staff in A&E who will put up barriers. I think that was certainly a problem when I accompanied women. I was treated like a support person. They didn't really know what to do with me or how to treat me, and they tried to ignore things I was saying. It was like I was an Auntie or something and I didn't know what I was talking about. They didn't treat me like a health professional. They didn't take in anything I said, and they ignored some of the information I gave them and found it out themselves. And I do remember this feeling of annoyance. I would say 'The blood pressure is this; the pulse is this, she has filled so many pads' (Hospital staff member) 'Oh, oh, oh' and it was like go away you're just a nuisance. (Alludes to hospital staff member) 'We will do this (take care of this woman).' It was that sort of feeling I had, and I'd have to say 'Well, no actually, (chuckled) I am her caregiver. You know I am the professional in here.' I had to actually explain myself and point out that I did actually have the right to come in with her, and I would say that there are still times that it happens, in fact it really is still a problem that needs fixing. The other problem is that the hospital forward copies of blood or any other assessments in relation to women's miscarriages usually to the GP. I have had situations where they have..., sent stuff back to the GP not to me. You are dealing with people who don't know the system, and don't know you. And it's mainly the house surgeons. They call the GP or they ring the GP and say 'Your client is coming back' or they send the discharge papers to the GP. They just don't accept, aren't accepting that a midwife has the same rights as a GP in relation to that woman, and that you actually look to see who referred the woman rather than just sending it to the GP. Yep and that's an ongoing practice concern.

## **Recognition and Professionalism**

Kauri stories institutional practices that deny self employed midwives' 'rights' as autonomous health professionals within the institutional 'field'.<sup>137</sup> Bourdieu (1996)

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<sup>137</sup> Bourdieu (1996, p. 40) defines a 'field' as "a structured social space, a field of forces, a force field. It contains people who dominate and others who are dominated. Constant permanent relationships of

suggests that fields are invariably sites of contestation where agents struggle over accepted forms of capital in order to assume social position. Social position is relationally linked to the enabling of personal, social and professional agency and therefore an individual's ability to exercise power. As medical knowledge is publicly and institutionally perceived as authoritative health knowledge (Foucault, 1963; Goldenberg, 2006; Jordan, 1997), access to such knowledge is considered privileged and potentially restricted (Clarke, Shim, Mamo, Fosket & Fishman, 2003; Papps & Olssen, 1997; van Teijlingen, Lewis, McCaffery, & Porter, 2004). In reporting that hospital staff members assert that admission referrals must 'come from the doctors' Kauri draws attention to institutional privileging of the medical profession in relation to midwives who are perceived as lacking disciplinary authority within the health setting. She suggests this is a deliberate strategy for perpetuating the hierarchical positioning of the discipline of medicine in relation to other health disciplines within the micro field of the health institution and potentially wider field of health in general. In storying her perspective that in Aotearoa New Zealand doctors consider midwifery as a subordinate profession, Kauri alludes to the historical antecedents of professional midwifery in New Zealand.<sup>138</sup> Nurses are also positioned within her story as not 'wanting' to accept referrals from midwives, suggesting that the loss of the nursing profession's regulatory control over the midwifery profession in 1991 also has an absent presence in Kauri's story.

As public narratives are informed by the disciplinary narratives of medicine and potentially nursing, which perceive midwifery autonomy as a challenge to both medical authority and knowledge, midwifery professional authority and practice knowledge may be marginalised within both health institutions, and the wider community. As a result, in the field of health, women and midwives are required to self position,<sup>139</sup> and/or resist being marginally positioned by other agents, within dynamic, hierarchical relationships in order to retain personal and/or professional autonomy. Foucault (1963, 1977) argues that power always exists in relationship with knowledge and is invariably challenged. He suggests that both resistance and power are co-

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inequality operate inside this space, which at the same time becomes a space in which various actors struggle for transformation or preservation of the field. All the individuals..., bring to the competition all the relative power at their disposal. It is this power that defines their position in field and as a result, their strategies."

<sup>138</sup> The Midwives Act (1904) ensured that midwifery practice was evaluated and supervised by medical practitioners. Midwifery was eventually subsumed by the Nurses Act (1977) and full professional autonomy was regained comparatively recently with the passing of the Nurses Amendment Act (1991).

<sup>139</sup> Due to social perceptions regarding the allocation of symbolic and cultural capital, in contrast to physicians, women and midwives may need to self position in specific ways in order to retain particular status within the field of health.

constitutive in that without resistance power may become non-existent, and he asserts that resistance is provoked through the exercising of power. In this story resistance to medicine's authoritative position and knowledge base is evidenced when Kauri resorts to drawing on another privileged and restricted body of knowledge, 'the law', to counteract institutional resistance to her professional autonomy.

Despite her explanations to hospital staff, Kauri acknowledges that acceptance of midwifery autonomy, and the practitioner's rights to access, refer and arrange admissions to the institution is contingent due to individualised resistance at the micro level by health professionals rather than by health disciplines collectively. She asserts that hospital staff use subject positioning and silences as technologies of power to ensure non-recognition of midwifery, reconstitute midwives' identities as non-authoritative, disregard midwifery knowledge, and silence professional agency.

Institutional resistance to midwives' professional autonomy is also constructed as an effective constraint to the personal and professional agency of self-employed midwives who practice outside health institutions in the wider community. Kauri suggests that therapeutic follow-up care for women post hospital admission is compromised by hospital practices. An example is house surgeons' practices of forwarding discharge summaries for women who miscarry to the women's general practitioners, in preference to communicating with the referring practitioners who are self-employed midwives. She theorises that establishment of communication and collaborative relationships with house surgeons is disadvantaged due to their frequent practice rotations through health care settings. She suggests that communication is non-existent because the house surgeons 'don't know you' (as a professional colleague). In doing so she infers that some peer provider interactions may encompass familiarity and potentially constitute relationships. Doctors (who are not house surgeons) may communicate and collaborate effectively with the midwives whom they 'know'. Although Kauri is not an indigenous woman, her comments draw attention to the cultural value of the Māori concept of *te kanoahi kitea* (the known face) and allude to the concept as having cross-cultural significance or relevance. Relational recognition is also a key concern for Nikau and her following comments support Kauri's perspective that hospital staff may extend non-recognition of midwives' professional roles and autonomy beyond hospital settings regardless of pre-existing relationships with professional colleagues.

**Nikau:** I think in some circumstances the GPs have actually got a discharge summary. Whereas the midwife lead maternity carer you haven't. These are midwifery referrals in, and the GPs getting the discharge information. So in that way there's a lack of recognition of the role of the midwife... I think it's, I think it's inappropriate! You know the doctors; they all know me and they should know better! I think that if you're the referrer, then you should get the feedback or the discharge information, or a copy of it..., because anything could have happened, you know?

Nikau suggests that the absence of discharge summaries is problematic. Women who miscarry in hospitals may experience medical complications during their miscarriage related admissions. A lack of information provision to referring practitioners may compromise the women's follow-up care and have a potentially detrimental effect on their immediate health and wellbeing. The absence of information may also impact on women's health outcomes in relation to subsequent pregnancies. Institutional non-recognition of midwifery autonomy may therefore constitute a risk to women's health. In the following excerpt, Mahoe suggests that non-recognition of midwifery professionalism and autonomy may not be confined to institutional practices.

**Mahoe:** Some of it is the mindset. Midwives are..., not recognised. And the GPs do not communicate back you know, no they never... Oh only via women. Like I've sent letters to GPs and informed them about care I've provided but no communication directly back from them..., (Sighs) So I guess you just don't exist as a health practitioner for the GPs... It is a problem... And it's not fair to the women either, but I don't know what you do about it.

She reports that the general practitioners do not reciprocate communications and theorises that this is because, like hospitals and other health institutions, general practitioners may draw on the disciplinary narratives of medicine which position midwives as subordinate health professionals. Disciplinary and public narratives reflect professional and social cultures.

### **Recognition and Culture**

Women draw on cultural narratives in the construction of identities and worldviews (Garro & Mattingly, 2000; Klapproth, 2004). Midwifery narratives constitute the provision of midwifery care to childbearing women as an art (Marland, 1993), a science and a cultural practice (Kirkham, 1999; Kirkham & Stapleton, 2000; van Teijlingen et al., 2004). Institutional non-recognition of both women's concerns and midwives professional autonomy may therefore silence or displace culture, through silencing, minimising, ignoring, devaluing and/or othering women's cultural values,

beliefs and practices. In the following narrative Pohutukawa suggests that non-recognition of indigenous culture and cultural practices may also be a problematic issue within health care settings in Aotearoa New Zealand.

**Pohutukawa:** One of things I still want to say I still think with Treaty of Waitangi training, and having to prove that you can provide for Māori within the health care sector, that people still don't understand what it (miscarriage) is about. And even when women have miscarriages and they turn up with 25 aunties and 70 uncles, they are not allowed into the hospital. People don't understand that to Māori any blip, you know... You might have got pregnant last night but that's someone's mokopuna there, and they want to be there, and they do not want total disregard for their practices. So, I still don't think that tikanga practices are understood in hospitals. I think the midwives are getting with it, but I don't think all midwives know... I think that it is a very big job; they (the midwives) say that they know, and they get it in their training but when you go out into the community it is not always put into practice. In fact some midwives can be very judgemental themselves as well.

Pohutukawa's story draws attention to New Zealand health legislation and professional competencies that require health practitioners to acknowledge the principles of partnership, protection and participation that have been developed from the articles of the Treaty of Waitangi<sup>140</sup>. She argues that institutional health settings and some health providers are non compliant with legislation, and Government health policies, and she suggests that this has a detrimental effect on whānau ora (family wellbeing) particularly in relation to the cultural importance of whakapapa.

In stating 'I think the midwives are getting with it' Pohutukawa infers that in comparison with other health professions at the macro level of health care provision, midwifery is positioned as culturally supportive and knowledgeable in regards to Māori traditions and practices associated with childbirth.<sup>141</sup> However, Pohutukawa also asserts racism is evident both within health settings and across the health disciplines when she comments 'I still don't think that tikanga is practiced in hospitals'. Midwifery is not excluded from her critique as she remarks 'I don't think all midwives know' what is right in terms of their education, and adds that 'some midwives can be very judgemental' inferring that individual practitioners may be culturally unsafe. Her

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<sup>140</sup> The principles were developed in response to the findings of the Royal Commission on Social Policy (1988).

<sup>141</sup> Midwives are required to undertake professional development to develop skills in relation to providing care for Māori. Practice reviews are regularly undertaken by the midwifery professional body to evaluate midwives' competence in relation to meeting obligations in accordance with the Treaty of Waitangi, and professional requirements (Ngā Turanga Kaupapa principles) in relation to tikanga whakawhānau (Māori birthing traditions).

assertion of racism by care providers and care institutions is supported by current research (Blakely et al., 2005; Harris et al., 2006a, Harris et al., 2006b, Jansen et al., 2008; Reid & Robson, 2006).

The preceding stories voice women's wishes for recognition as both care providers and care recipients within the New Zealand health care settings. Women who experience miscarriage desire recognition and validation of their individual needs, conceptions, pregnancies, unborn babies, families, culture, and their personal and social identities as both mothers, and autonomous agents. Midwives tell stories about collectively perceiving midwifery to be a silenced profession and desire disciplinary, institutional and public recognition of both their wider profession, and themselves as individual and professionally autonomous practitioners. The collective stories of women who receive miscarriage-related care and midwives who provide such care demonstrate a shared desire for professional and public recognition of their disciplinary, embodied, and cultural knowledge bases, skills, personal practices, values and beliefs.

### **Women, Care Providers and Care Relationships**

Careful attention to the preceding stories suggests that the nature of relational interactions between and amongst midwives, childbearing women, other health professionals, families and health care settings is influential in facilitating recognition of women's wishes. Midwifery literature suggests that childbearing women and midwives report higher levels of satisfaction with care provision when it is associated with 'caring' relationships (Guilliland et al., 2006; Wickham, 2009), and continuity of care/care provider (Waldenström, 1998). Midwives also value the reciprocity of intimacy within care provider/care recipient relationships (Flint, 1991; Gaskin, 2002; Hunter, 2006).

The following narrative excerpts story women's experiences of the interactions between health care providers and care recipients. Women's views regarding what constitutes appropriate interactions are explored and factors that are deemed to be essential to care interactions are identified.

**Raukaraka:** I'd have preferred to have a midwife come to the house when I had my miscarriage because they can and do come to your home. I had midwives with my last two pregnancies, because we lived rurally and that was better for me because I couldn't you know get into town, she'd come to us, because you are in YOUR home, and you're more comfortable, and you're more likely to share a lot more that you would in an

office which is really clinical, and ah... You know you have the midwife sitting on the floor with you... You have the doctor behind the big desk in a chair, you know, you have him here and you there... The white gowns, and the medical things; the tools. But the midwife I prefer her she takes her shoes off and gets down on the floor with you in every sense of the word (Laughs).” Like today with you, you are one of us, us women. I’d want you to be there for me to visit me in my home until I was healed... But I think it also might depend on the woman and how she feels about that baby, but you know I think most would want you to come at least until the bleeding stopped.

### **Relationships and Settings**

Raukaraka presents herself as an experienced and knowledgeable woman and mother. In relating her experiences as a childbearing woman, and through drawing on both public and ontological narratives about midwifery practice that construct midwives as responsive to women’s needs, she justifies her preference for midwives providing miscarriage-related care. Her story draws attention to the importance of the setting in which miscarriage-related care is provided. Raukaraka perceives her home as the ‘better’ location for care foreshadowing a comparison with institutional health settings. Spatial ownership, familiarity, and control, are relationally linked to being ‘more comfortable’ and ‘more likely to share a lot’, inferring that physical and psychosocial comfort and effective interpersonal communication are essential elements of miscarriage-related care. It may therefore be argued that the physical setting in which care interactions occur operates as a determinant of the care provider/recipient relationship. In shaping care provider/care recipient interactions, the setting may also facilitate women’s personal agency in relation to care choices, and therefore potentially the effectiveness of care provision.

The importance of physical and/or geographical settings in shaping care interactions has only recently received recognition across the health disciplines (Curtis & Jones, 1998; Diez Roux, 2001; Johnson, 2000; Macintyre, Ellaway, & Cummins, 2002; Cummins, Macintyre, Davidson & Ellaway, 2005). Current research that explores the influence of physical and/or geographical settings on health care interactions has focused primarily on cross-cultural interactions in clinical and/or institutional settings (Goel & McIsaac 2000; Johnson, 2000; Kagawa-Singer & Kasim-Lakha, 2003, Smedley, Stith & Nelson, 2003) in an effort to identify variables that contribute to health disparities (Poland, Green & Rootman, 2000). However, research (Cummins et al., 2005) suggests there is a lack of contextually relevant concepts and/or measurements for evaluating the specific effects of place (settings) on individual health status. The

narrative voices of health care recipients may provide an initial evaluation of place effects on individual health outcomes. Within Aotearoa New Zealand, tangata whenua (indigenous peoples) have genealogical relationships with particular geographical sites and/or regions. Raukaraka's story evidences the relational association of turangawaewae (place of belonging) with individual and whānau wellbeing.

Raukaraka stories a comparison of care interactions within domestic and clinical settings. She uses spatial positioning to highlight the separation between herself as care recipient and the doctor within the office setting; and infers that his 'big desk' operates as a deliberate barrier to the development of intimacy within the care interaction. The doctor's chair, white gown, and medical tools are also construed as actants that draw attention to the positivistic nature of the communication exchange, and to the doctor's authority in relation to the client, and identity as a proponent of health science. The doctor's cultural perspective on health and wellness is also unfamiliar to, and problematic for, Raukaraka as she draws on Māori and Pacific narratives and epistemologies to construct her identities, values, and beliefs about health. Raukaraka suggests that clinical settings engender a detrimental effect on her care and potentially her health and wellbeing. Cultural conflict within the care provider/care recipient relationship may have a detrimental effect and compromise related health outcomes (Boulton, 2005; Jansen et al., 2008).

### **Care Providers and 'Caring' Relationships**

Raukaraka also indicates her preference for a midwife to provide miscarriage-related care. In contrast to the interaction with the hypothetical physician, the midwife is perceived as taking off 'her shoes' and 'getting down on the floor' and being 'with' Raukaraka. It may be inferred that Raukaraka's storied conceptualisation of the midwife draws on the disciplinary narratives of midwifery (Page & McCandlish, 2006) to position the midwife as an equal who establishes a caring and intimate relationship with her. Her conceptualisation of the midwife also asserts the importance of cultural respect within the care interaction. Removing footwear is an important tikanga (tradition) when entering a Māori family's home, so the midwife may be perceived as behaving in a culturally appropriate manner. The act of 'getting down on the floor' could also be interpreted as a reference to correct behaviour in a wharenuī (meeting house); enacting proper etiquette for a meeting. It may be argued that Raukaraka stories the midwife's actions within multiple metaphors relating to cultural respect, and the cultural practice of hui (meetings to discuss important matters). The

metaphors also encompass the meeting of midwifery competencies that require midwives to 'be with' women, and construct midwife/woman relationships as intimate and caring. In reiterating that the midwife gets 'down on the floor in every sense of the word' Raukaraka alludes to the importance of disrupting power differentials within health care interactions, in order to facilitate relational equity and personal agency. In situating me as 'one of us, us women' and someone that she 'would want..., to be there' (in the event of miscarriage), Raukaraka constructs me as a pan identity that is representative of the midwifery profession. Midwives are conceptualised as generically successful at both disrupting the problematic power differential within care interactions, and establishing caring relationships with individual women and their families. Raukaraka also infers that midwives' woman-centred and relational approach to professional practice acknowledges the individuality and diversity of women's desires in relation to miscarriage-related care.

Kawakawa also asserts the importance of a relational approach to care provision for women who experience miscarriage through comparing the miscarriage-related care provided by midwives and medical practitioners.

**Kawakawa:** I respected her wisdom in Midwifery, you know? When you talk to her you know she knows what she's talking about. Yes, she's very knowledgeable, but she hasn't lost, um..., like a lot of doctors they have the knowledge but they don't have the empathy. And she's got both. And I guess, she just, she was just there and she included the family in it too. My husband, you know, he's not, sometimes he doesn't talk when he's upset but she kind of just asked him questions to make sure that he was OK, which I thought that was really important to recognise..., the father too. Because I don't think, I mean women don't get the recognition, but fathers, for fathers it's even worse. You know, that they don't, they've lost the baby too... She (midwife) cared for all of us... And that is so important; caring not just providing treatment.

In comparing her midwife's miscarriage-related care with her experiences of care provided by physicians, Kawakawa constitutes her midwife as knowledgeable, caring and empathetic whereas doctors are perceived as having generic rather than practical knowledge, and not providing care in an empathetic way. Empathy is discursively constructed as a key element of care provision, and re-conceptualised as caring throughout her ontological narrative, in order to emphasize the essentiality of empathy to the care provider/care recipient relationship.

Kawakawa perceives the midwife's provision of contextually relevant care as important. She presents the midwife as caring for the entire family, in addition to herself as the registered client, and observes that the midwife also offers where necessary, individualised care to other family members. Her acknowledgement that the midwife's communication with and support for her husband both aided his healing process and supported family wellbeing, draws attention to partners' issues and/or losses in relation to miscarriage. Research (Cumming et al., 2007; McCreight, 2004; Swanson et al., 2003) suggests that partner's losses may not be recognised within health settings and/or amongst the wider population. Pregnancy loss represents a significant emotional burden for both women and their partners regardless of the partner's gender (McCreight, 2004; Wojnar, 2007), and the cultural significance and/or psychosocial impact of such loss on family wellness may not be acknowledged (Binney & Chaplin, 1986; Rimene, Hassan & Broughton, 1998; Swanson, 1999; Swanson et al., 2003).

Kawakawa emphasizes that a caring, rather than treatment focused approach, is required when providing health care to women and their families who experience miscarriage. Her narrative stories the distinction between medicine's population based (Castel, 1991; Peterson, 1997) risk centred (Lupton, 1999; Nettleton, 1995), treatment focused and technocratic (Baldwin, 1999; Davis-Floyd, 2001) approach to care and midwives' women/whānau focused (Stewart, 2009) and relational approach (Page & McCandlish, 2006; Pairman & Donnellan-Fernandez, 2006). She theorises that the midwifery care philosophy and model of practice is most effective for ensuring individual and family health and wellbeing. Kawakawa's viewpoint has particular relevance to the Aotearoa, New Zealand context, as the Ministry of Health has recently appointed a taskforce to evaluate, and develop strategic health policies in relation to facilitating whānau wellbeing (Turia, 2009).

Like Raukaraka and Kawakawa, in the following story Kahurangi draws comparisons between the miscarriage-related care provided by physicians and midwives and agrees that it is essential for health professionals to adopt a relational approach to women and their families when providing miscarriage-related care.

**Kahurangi:** What I want from midwives is respect for individuality! That they see you as a person and they get to know YOU, is my big preference. For midwives, well they kind of become part of you... The other thing is um, the practical side of their knowledge is great, especially for after a miscarriage.

Doctors and everything refer about nutrition but they never refer about the specifics. They don't give you the practical stuff. So that's..., and the information yeh..., and knowledge is what I want as well as knowing that they are experienced as well... I wanted practical advice. Um..., I wanted to know what the likely procedures or processes that you were going to go into, in terms of physically, this or that. That's important to outline, so you can get your head around your life and how that is going to work. You get told that it's a blighted ovum or something like that which makes you feel like crap. And I remember telling my midwife that and (names midwife) her giving me a hug and saying 'Sometimes miscarriages are nature's way of selection'. That helped but it takes a while, you get told by the doctors that your baby is 'blighted' and not a real baby but it takes a long time to go from that, to take those feelings and process that and actually sort of think oh ok, that, that's ok! Um..., (long pause) and just that opportunity to talk about it later with the right person. You know, it is having the support that is crucial, you know, and even though I wouldn't say I was a high needs person... I really needed my midwife, and wanted her too because she listened and was there in the right way, she cared..., I think that the right person to provide the care for someone who has experienced a miscarriage, if it's between midwives and GPs and you know regarding hospital care follow-up visits in the home and information provision, empathy, support, listening to your needs being available, of course it's the LMC, yep the midwife, very much so.

Kahurangi's storied comparison of the care provided by midwives and doctors also asserts the importance within care interactions of relational factors such as temporalities, communication, language use, respect, and identity acknowledgement. In advocating that midwives 'see you as a person', 'get to know you' and 'become part of you', Kahurangi like Raukaraka acknowledges that midwives share a professional relationship with women that is characterised by intimacy. Relational intimacy is perceived as incorporating and requiring empathy, support, and caring. Within the context of midwifery practice in Aotearoa New Zealand, ideally Kahurangi's conceptualisation of an intimate relationship is constructed as a woman-centred partnership (Freeman, Timperley & Adair, 2004; Page & McCandlish, 2006; Pairman & Donnellan-Fernandez, 2006) that promotes the best outcomes for, as determined by, childbearing women (New Zealand College of Midwives, 2005).

Kahurangi narrates her specific concerns regarding physicians' communication skills and their provision of inadequate and/or generic rather than practical miscarriage-related information. Information 'specifics' are interpreted as assisting or facilitating the cognitive processing of the miscarriage experience, and the discursive positioning of the miscarriage event within a life narrative. In suggesting that developing a

comprehensive awareness of all aspects associated with miscarriage may facilitate individuals and families to cope with child loss, it may be argued that Kahurangi alludes to the ways in which knowledge may enable agency and potentially facilitate the actions and/or processes associated with technologies of the self.

Within the story the interpretive repertoire of medicine is also presented as problematic. The physician's use of terms such as 'blighted ovum' may, in addition to silencing multiple identities as Kahatea has previously suggested in this chapter, constitute women, their bodies and their miscarried babies as faulty. Emily Martin (1989) suggests that such terms allude to a childbearing woman's body as a metaphor for an imperfect "factory" (p. 45) and may apportion blame to childbearing women for their miscarriages. In characterising such linguistic practices as victim blaming, Reid, Robson and Jones (2000) may allude to such terms as politicized in that they divert attention from the social shaping of both miscarriage and health care. Explanations for child loss, for example, that focus on the performance of women's bodies construct inadequate miscarriage provision within the New Zealand health system as natural and inevitable, and infer that health professionals need not intervene to address substandard care. In facilitating the social marginalisation of women's health, linguistic labels may subsequently constrain both women's and potentially their families' abilities to cope with miscarriage-related losses and relationships with care provider(s). Kahurangi resists being linguistically positioned as 'other'<sup>142</sup> within the health care interaction through drawing on her relationship with, and voicing her concerns to, her midwife. Relational intimacy is expressed through physicality, in this instance hugging. In characterising the midwife as the 'right' person with whom to share her experience, because she listens, cares, and is supportive, Kahurangi may infer that both talk and listening constitute metaphors for acknowledgment of her experience of, and identities associated with, miscarriage.

Kahurangi's discursive comparison of midwives' and medical practitioners' miscarriage-related care suggests that she perceives there are considerable differences in care approaches. Midwives are characterised as more accessible, receptive, investing more time in care, providing follow-up within various settings, communicating more effectively, offering specific and/or practical information, and caring to women, and being responsive to, women's needs. Professional competencies require that midwifery practitioners be responsive to the needs of childbearing women, including being both

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<sup>142</sup> Weis (1995) theorises 'othering' as a form of marginalisation.

available, and/or accessible, to their clients (Midwifery Council of New Zealand, 2009). In asserting that midwives' availability and relational approach to care positions them as the most suitable care providers for women who have experienced miscarriage, Kahurangi validates disciplinary narratives about and professional competencies that shape midwifery practice within Aotearoa New Zealand. Her views regarding the accessibility and availability of midwives are shared by Pohutukawa who states.

**Pohutukawa:** I think that for me, if you've got a midwife, that should be the first port of call, unless something happens and you're away and you can't get to your midwife.

Although, Pohutukawa privileges midwives as the most suitable individuals to provide miscarriage care, she infers that doctors and other health professionals may have an absent presence in situations where midwives are not accessible as is the case in the following excerpt from Kahatea's story.

**Kahatea:** And as for the hospital and having a D&C it is all business. There's no recognition of what has happened, and I think that's what's missing, having a..., spiritual connection with another human being, that, that.... I would actually have fallen off my seat if I heard from the hospital doctor later and he said 'Hi we saw you at the hospital, just ringing to see how you are doing?' whereas I wouldn't quite fall off my seat if the midwife had done that. It would be..., that would have been lovely. I would have loved it... But it was just the usual experience of being in the hospital, of being..., one of many people being there treated, and that there's no time..., to establish a relatedness with anyone because of the turnover of staff with shift changes for example you know... And my negative view of hospital is unfortunately that you just get treated like a..., I don't know..., there is just a factory element to your care. You go in and get your stamp of..., you know, and out you go, out the door again... You are part of a processing line. Yes! You're processed! But then there are specific individuals that help, but what makes me sad is they are the exception to the rule, but they shine out of the experience which is otherwise dull, and they are just giving you a level of care that is just caring, and that's exceptional and I think that's sad.

### **Institutions, Disciplines and Relational Care**

Kahatea's story focuses on her relationship with non midwifery care providers in an institutional setting. She draws attention to how institutional narratives about health economics and risk management operate as actants to constitute institutional temporalities. It is inferred that such temporalities may subsequently act as metaphysical determinants of care provider/patient relationships within health care

settings. Through discursively re-evaluating institutional non-recognition of the miscarriage experience and the loss of her unborn child, she theorises that non-recognition is the result of the absence of relationality between women, families and their care providers. Establishment of spiritual connections between care providers and care recipients is advocated as a method of facilitating relational interactions within health care settings. In advocating for the introduction of spirituality into the care provider/care recipient relationship, it may be argued that Kahatea alludes to her familiarity with, and the value afforded to, spirituality within midwifery disciplinary narratives and philosophies of practice (Flint, 1991; Gaskin, 2002).

Kahatea stories her comparison of miscarriage care provided by midwives, and physicians in a similar manner to Kahurangi, Kawakawa and Raukaraka. Public narratives that outline appropriate professional behaviour for midwives and medical practitioners when providing miscarriage-related care have an absent presence in the narrative. Doctors are perceived as unlikely to follow-up and enquire as to a patient's wellbeing whereas it is inferred that such follow-up might be part of a midwife's practice. Kahatea's expectations of the care provided by midwives are supported by midwifery narratives which promote the practice philosophy of midwives as 'being there' for women (McHugh, 2004) and inform public narratives which conceptualise midwives as 'caring' (Guilliland et al., 2006; Page & McCandlish, 2006, Pairman & Donnellan-Fernandez, 2006; Stewart, 2009).

Hospital practices are shaped in response to risk management policies, and economic imperatives which promote a population based approach to health care provision (Peterson, 1997). The disciplinary practices of medicine within health care settings facilitate the deconstruction of patient individuality and the constitution of generic collectives (Castel, 1991). Such practices construct individuals as subjects (Foucault, 1963) through facilitating the social control of bodies (Nettleton, 1995) and the homogenization of care provision to specific patient populations (Peterson, 1997). Kahurangi's storied metaphor of hospital care as a factory processing line culminates with patients receiving a final 'stamp' (of approval) before discharge. Her narrative draws attention to how both the hospital setting and the discipline of medicine operate as institutions of social control in order to ensure that individual patients conduct themselves in socially approved ways. Institutional cultural practices facilitate generic treatment-centred relationships with patients, and the 'caring' behaviours of individual staff members are construed as culturally aberrant within health care settings. The cultural attitudes and beliefs of various health disciplines may also influence relational

interactions within institutional settings as evidenced in the following excerpt from Rewarewa's story.

**Rewarewa:** I think generally health professionals are not particularly good at dealing with miscarriage. I think they just, especially doctors..., (aside: this is terrible isn't it saying that), because they like to fix things, they like to make it better. So with the doctors it's like 'we can make it better by cleaning out the uterus and getting rid of it and then you can go home and then you can get pregnant and then you will be fine... No time for empathy really and that is not good, not ideal.

Rewarewa suggests health professionals may be positioned within hierarchical relationships within public and disciplinary narratives based on how they are perceived as managing their personal responses to, and providing care for women who experience, miscarriage. Doctors are specifically mentioned as being 'not particularly good at dealing with miscarriage'. However, Rewarewa perceives her negative conceptualisations of the medical profession as socially unacceptable. She attempts to mitigate her discursive positioning of physicians by drawing on medicine's disciplinary narratives about curative treatment to re-conceptualise doctors as liking to 'fix things ..., to make things better', in order to justify their behaviour.

Within the narrative, linguistic references such as 'cleaning out the uterus' draw attention to the work done by the interpretive repertoire of medicine. In associating dirtiness with the physiological processes of the female body (Douglas, 1966) women's bodies are constructed as materially and metaphysically unclean. In stating that doctors 'get rid of it', Rewarewa also infers acknowledgement of the ways in which medicine may construct the body as both object and subject (Turner, 1992) and situate the subject in "complex power relations" (Foucault, 1982, p. 778) shaped by risk, economics and culture. The relational connection between temporality and empathy is also highlighted, and further commented on by Kahotea.

**Kahotea:** As for doctors, after my experience in the hospital, they need to be, there is a certain sensitivity needed there. I mean I think that doctors need..., the more they think of patients the better, and you know that might be a given, but it's not the way all doctors behave. They are doing a job and their time is of the essence, yes. But you know they see themselves as doing a job and the job encompasses everyone they see during the day, whereas for the individual patients it's quite different.

Kahotea infers that institutional temporalities disadvantage care provider/care recipient relationships. Doctors are characterised within the story as work focused, due to temporal constraints and she alludes to their behaviour as not being 'caring' towards women who experience miscarriage. In advocating the need for health professionals (doctors) to become patient focused and sensitive to patients' needs and feelings she draws attention to the tensions created through attempting to provide patient-centred care in an institutional environment. The promotion of individualised care may conflict with institutional cultures within health care settings (Nettleton, 1995) and potentially the disciplinary culture of medicine. The following excerpt from Kohuwai's story focuses on an institutional insider's experiences of relational interactions within a hospital setting.

**Kohuwai:** It was pretty much Ok and people were Ok afterwards, but I must say even, even my own colleagues a lot of them were like, um..., were like me. Like I used to be, you know. 'You've had your miscarriage, get over it' type thing... You know, 'Move on!' (1+) I found the attitudes..., a lot of it difficult 'Well you know worse things happen' and that's true you do see all the yucky stuff. But I mean to the person at the time, having the miscarriage, it is the worst thing in the world... So in a way it (miscarriage) was good because I learned that it is important, you need to be more caring, to take time with people and then I was better at that, being empathetic. I know I was better at looking after people!

Kohuwai outlines her reflection on experiences as both an insider (staff member) and outsider (patient who receives miscarriage-related care) within a hospital setting. She suggests that collegial attitudes inferred by remarks such as 'worse things happen' demonstrate care providers' lack of understanding of women's experiences. Dismissive remarks are also relationally linked with statements that allude to care related temporalities. The comments 'get over it' and 'Move on!', infer that institutional allocation of time for processing miscarriage experiences may be limited.<sup>143</sup> Although it may be argued Kohuwai's embodied experience of miscarriage shaped her future practices as a health professional, her story draws particular attention to her response to the emotions such remarks have evoked. Through altering her professional practice, she perceives herself to be 'a better' health practitioner. Kohuwai's story demonstrates the power of language to operate as a metaphysical actant that facilitates change within an individual and that has the potential to reshape the cultural beliefs, and

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<sup>143</sup> Although not discussed within this narrative, the processing of miscarriage experiences may also be temporally limited within community settings.

associated behaviours of institutional populations. However, institutional cultures may be deeply embedded, and resistant to change.

In the following narrative Matipou theorises regarding the relationship of institutional culture and ethnicity within the context of health settings in Aotearoa New Zealand.

**Matipou:** I do feel that the Pakeha women tend to get more kind of sympathy. That's the kind of feeling I get. From the Staff at the hospital, you know A&E. From the time they first walk in the door really. An unsupported Māori woman, a young Māori woman in particular you know, who may have some history that they are aware of, is kind of left up to their own devices. They turn up and sort of, you see them crying on the couch..., looking very, very lonely, not given privacy sometimes...The Pakeha women are generally not on their own... Yeh generally the Pakeha women are going with someone with them, often with their partners and husbands; their loving partners and husbands with them and fair enough, but they tend to get, just from what I have seen, maybe just a little bit more sympathy. I don't really know for sure if that means some babies are more privileged, valued over other babies, or maybe some women's care, time and space are prioritised over other women, but it would appear to be that way... And you know it's a mix of the staff that behave like that. Māori staff are doing exactly the same thing... You know, I wouldn't want to say that, but I mean A&E can get very busy, no doubt about that, but just sometimes..., I've arrived and thought you know they've been waiting an extrao::rdinarily long time even for A&E, and not just given that bit of privacy that other women get, you know? I'm sure there would be some place where they could just be, and just have a bit of space and wait, rather than be sitting out there in the A&E waiting room or whatever.

In proposing that staff within health institutions appear to prioritize care provision based on care recipients' ethnicity, Matipou infers that cultural practices within health institutions may be shaped by racism. Institutional racism within health care settings is an ongoing concern for health professionals (Jansen et al., 2008) as a factor that both contributes to health disparities (Blakely et al., 2005; Durie, 2005a; Harris et al., 2006a, 2006b) and perpetuates inequitable health care provision (Robson, 2008; Rumball-Smith, 2009) in Aotearoa New Zealand. Matipou suggests in her story that Pākeha women may be hierarchically positioned by hospital staff in relation to other women in regards to accessing spatial, temporal and relational (privacy, empathy) aspects of miscarriage care. She perceives that institution based care providers consistently marginalise care provision for indigenous women, and proposes that indigenous care providers may marginalise women and families with whom they share ethnicity. Her discursive acknowledgement draws attention to the embedded nature of

institutional culture, and the ways in which culture is perpetuated in health care settings. Through constituting hospital staff as subjects who comply with health protocols and policies, Matipou alludes to the influence of power relations and/or governmentality<sup>144</sup> (Foucault, 1979) within hospital settings. It may also be argued that her story demonstrates that such cultural and positioning practices facilitate the continuance of existing inequities within the New Zealand health system. Although not stated, the need for cultural change within New Zealand health care settings in order to ensure equitable and culturally safe health care regardless of ethnicity is inferred within her story.

### **Absence, Care providers and Care Relationships**

In the following narrative excerpts Kahatea, Kahotea and Auhunga present their views on experiencing miscarriage without the support of care providers and present their desire for equitable, contextually relevant and individualised care from specific care providers, namely midwives.

**Kahatea:** We wanted a point of reference, when we were going through the bleeding and who to contact, and somebody to talk to, and check it out, um..., I think..., I think (names midwife) said she was going to give me a call, to follow-up how I was feeling and I don't think she ever did, but something like that would have been nice just a..., just a month later, or two weeks later, just to say 'How's it going? How are you feeling about... ? Is there anything you need?' I don't know, I don't know, just somebody who knew what we'd gone through... But it is kind of like that, that's what you want, the person that you have, at your baby's birth, you wanted them to be somebody that would care when you had a miscarriage...That would ring up, and just, just give you, just one call, just one phone call even... But that didn't happen..., there was just nothing really.

In acknowledging that her care provider's actions were not congruent with a verbal commitment to provide care, Kahatea draws attention to the importance of both relational intimacy and reliability in care interactions. The ideal care provider is theorised as a familiar and knowledgeable individual, who communicates effectively, and relates to Kahatea and her family in a caring manner. Kahatea's use of a plural pronoun (we) when outlining care requirements infers that she is voicing a collective desire; potentially that of her family, for a care provider who both acts as a 'point of reference' during, and provides follow-up care after, miscarriage. In proposing that

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<sup>144</sup> Exercising governmentality in the health institution may be concerned, as Foucault (1979) suggests, with "men (and by default women) in their relation to..., things which are customs, habits, ways of doing and thinking" (p. 11).

the preferred individual might be the health professional that provided care during childbirth she may allude to miscarriage constituting a form of birth. In Aotearoa, New Zealand the majority of care provision for childbearing women is provided by midwives who practice continuity of woman-centred care (New Zealand College of Midwives, 2005; Guilliland et al., 2006). Kahatea's comparison of birth and miscarriage may also be interpreted as reflecting her un-stated desire for her miscarriage-related care to be provided by a midwife in accordance with the midwifery practice ethic. However, Kahatea's willingness to be satisfied with a minimal gesture of contact from the midwife, suggests her awareness that legislated recognition for miscarriage is minimal and that as a result of governmental non-recognition, funding for miscarriage care remains limited and effectively inadequate. Funding of and/or remuneration for care provision may also have an absent presence in the following narrative.

**Kahotea:** If perhaps I could have seen my midwife afterwards. I could of, I'm sure I could have phoned her, but I..., I wasn't sure quite where things finished..., with her, and I assumed that basically she had tried to get to the hospital. You know, she had tried to spend those times after the miscarriage um..., which you know after birth..., um, kind of off her own bat and that now we didn't have a professional relationship anymore because I was no longer pregnant so the D&C had effectively (finished it)... Um I think it would have been really good to have had a debrief with her in a way. An official, official..., you know..., just finishing, finishing the time together.

Kahotea's story suggests that after her miscarriage she desired a caring relationship with a familiar care provider. The intimacy of the connection is demonstrated in Kahotea's use of the term 'my' which infers ownership of her midwife, and facilitates the positioning of her relationship with the midwife in the wider context of her life story. Her lack of surety regarding the etiquette of contacting the midwife may suggest that Kahotea is aware of public and disciplinary narratives that define a midwife's role as caring for pregnant and childbearing women (Page & McCandlish, 2006; Fairman, et al., 2006, Wickham, 2009). Surgical treatment (Dilation and Curettage, [D&C]) for the miscarriage effectively deconstructs Kahotea's identity as a childbearing woman. In her story it is inferred that she is subsequently excluded from the collective of childbearing women and that her miscarriage-related care is situated outside the midwife's professional scope of practice. It is therefore interesting to note that despite positioning herself as a non-childbearing woman Kahotea 'assumes' that her midwife 'tried to get to hospital' and 'tried to spend time' with her after the miscarriage. Kahotea's assumptions suggest she is cognisant of midwifery disciplinary narratives

and philosophical underpinnings that encourage midwives to ‘care’ (Kennedy, Shannon, Chuahorm & Kravetz, 2004), be woman-centred (Wickham, 2009) and metaphysically and materially ‘be with’ (Hunter, 2006) women in distress.

In commenting that the midwife may have attempted to be available for her ‘kind of off her own bat’ Kahotea infers that such actions are potentially not remunerated. Her comments also allude to familiarity with public narratives about midwives’ relational commitment to facilitate continuity of carer for women (Green, Renfrew, & Curtis, 2000; Waldenström, 1998) regardless of allocated remuneration. In her story Kahotea acknowledges that the professional relationship with the midwife has ended, but does not interpret the D&C as having ended her personal relationship (time together) with her care provider. This suggests that Kahotea may interpret her relationship with the midwife as dually personal and professional. In asserting her desire for an ‘official’ face to face meeting with her midwife after her miscarriage, Kahotea may perceive such a meeting as finalising both personal and professional relationships, facilitating her self-processing of the miscarriage experience and marking an end to miscarriage as a physiological event. Kahotea’s perspective that midwifery care is important for women who experience miscarriage is supported by Auhunga, who advocates the value of the midwife as miscarriage care provider in her story.

**Auhunga:** I never saw my midwife, and so I had a miscarriage, so I hadn’t seen a midwife before the miscarried baby... It would have been more helpful I think to see more of her, and that yes she was available post miscarriage. It’s that follow-up, physical support. And perhaps in some ways too, which is a very odd thing, but that it legitimizes a wee bit your experience of the miscarriage, that you WERE pregnant, and maybe afterwards that rounded it off a wee bit too; but that is that whole concept that because the midwife has actually been involved, that is a further validation that you’re a mother and it legitimizes your pregnancy.

Auhunga acknowledges that her miscarriage occurred before commencement of a relationship with a midwife. Like Kahatea and Kahotea she perceives the availability of midwifery during and after her miscarriage as essential, and despite the lack of remuneration for care providers, she advocates for follow-up care to be specifically provided by midwives. Public narratives characterise midwives as providing care for childbearing women. In a similar manner to Kahatea, and Kahotea, Auhunga demonstrates her awareness of such narratives in conceptualising the midwife’s relational presence as social legitimacy of her pregnancy. The midwifery relationship

also validates her change in social status related to her new identities as pregnant woman, and mother, and verifies the human identity of her unborn child. Her story infers that midwives may constitute both hybrid actors and tools or resources that facilitate childbearing women's agency in relation to employing technologies of the self in that they validate women's identities, experiences, feelings and knowledge.

### **Summary**

Research participants suggest that in Aotearoa New Zealand women who experience miscarriage desire recognition of their personal and social identities, the identities of their unborn children, and their families. Midwives are perceived as desiring professional and public acknowledgment of their discipline and themselves as individual practitioners. The collective stories of women who receive miscarriage-related care and midwives who provide such care demonstrate a shared desire for recognition of disciplinary, embodied, and cultural knowledge, as well as personal skills, practices, values, and beliefs. Women and midwives assert that professional, institutional and public acknowledgement of personal and professional autonomy is essential for professional development, ethical care practices and equitable health outcomes for women and their families.

Interactions between midwives, health care providers, childbearing women, and families are construed as influential in informing and facilitating institutional recognition of women's wishes. The lack of recognition of women's and midwives' wishes is linked with the absence of relational factors that research participants view as essential to health care interactions. Women and midwives suggest that care provider/care recipient interactions should be conducted within relationships characterised by mutual intimacy, interpersonal respect and effective communication. Research participants' stories infer that the temporalities associated with, and the spatial settings of care interactions, may shape care provider/ care recipient relationships and influence related health outcomes. The essentiality of health professionals offering support, empathy, personal respect, and providing contextually relevant information is asserted to ensure care recipients make informed choices, and give informed consent to miscarriage-related care.

Women's stories acknowledge that the cultural attitudes and values portrayed by health disciplines and institutions may influence interactions. Institutional racism is interpreted as contributing to inequitable health care and consequently to health disparities across diverse ethnic and socio-economic populations. Valuing cultural

diversity is promoted as a remedy for ethnicity related and/or class based racism within health care settings. In theorising the variance of cultural beliefs and values amongst health care professions, participants conduct critical comparisons of disciplinary approaches to care provision.

The discipline of medicine is associated with the objectification of women's bodies and subjugation of women's autonomy. Linguistic practices which derive from the interpretive repertoire of medicine are associated with the deconstruction of identities, victim blaming, and the constraint of personal and professional agency. Medical practitioners are discursively located within institutionalised health care settings and perceived as providing care that lacks empathy, is treatment oriented, and population focused. Medicine's disciplinary approach to miscarriage care is theorised by research participants as the result of subjugating health care to financial, spatial and temporal constraints.

In contrast to medical practitioners and health institutions, midwives are perceived as providing an individualised, contextually relevant and relationship-based approach to care for women and potentially their families. Midwife/women relationships are conceptualised as personal and professional. Midwifery care is characterised as culturally respectful, empathetic, supportive, caring and woman-centred. The philosophy of continuity of care and carer that is enacted through midwives 'being with' women facilitates relational equity and intimacy, and may disrupt power differentials within care provider/care recipient relationships. Midwives support women's autonomy and agency in relation to self determination through recognising women's multiple identities and the identities of their miscarried babies. As midwives are publicly perceived as care providers for childbearing women, in legitimating identities, midwives may constitute hybrid actors or actants that facilitate women's use of technologies of the self to construct self esteem and 'normalised' selves.

The desire for radical change to contemporary health legislation, funding, policies, and care practices, is evidenced within women's and midwives' narratives. However, legislative, institutional and disciplinary cultures are frequently deeply embedded and resistant to change. The accessibility, availability, and the disciplinary approach of midwives may position midwifery practitioners as the best choice of care provider for women and families who experience miscarriage and the most appropriate advocate for legislative and cultural change in relation to miscarriage and care provision. Chapter 8 has presented women's voices and theorising regarding temporalities,

narratives, silences and technologies drawing attention to the way's in which those elements impact upon miscarriage-related care in Aotearoa, New Zealand. Chapters within the thesis have separated out themes at work that occur simultaneously within different relational settings. These elements are summarised in chapter nine of the thesis.

# 9

## An Un-finalised Ending: The Light at the End of the Tunnel

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*I te kore, ki te pō, ki te ao mārama.*  
(From darkness through the night into the world of light).

“We can easily forgive a child who is afraid of the dark; the real tragedy of life is when adults are afraid of the light”  
(Plato, 428 BC-342 BC).

“Enlightenment is not imagining figures of light but making the darkness conscious” (Carl Jung, 1875-1961).

“There are many paths to enlightenment. Be sure to take the one with heart”  
(Lao Tzu, 600 BC - 531 BC).

### Introducing Final Comments

This final discussion draws together the elements presented in the thesis, methodological development, research design and implementation, midwifery, miscarriage and women’s stories. The interweaving of multiple epistemologies, theoretical tenets, philosophical concepts, and indigenous and Western European worldviews is outlined. Main arguments within the thesis in relation to methodologies, narratives, genealogies, temporalities, silences, and voices as well as a final reflection on the research are presented. Drawing primarily on the works of Michel Foucault, Bruno Latour, Pierre Bourdieu and Rom Harre it is argued that methodologies, narratives, genealogies, temporalities, silences and women’s voices are simultaneously co-constituted metaphysical and material technologies. It is suggested that these heterogeneous and relational entities may be contemporaneously understood as

actants, hybrid actors, actor networks and technologies that are situated within hierarchical relationships in dynamic, un-finalised networks and/or fields. Research limitations are acknowledged and attention is drawn to the challenges posed by the contextually specific and qualitative research design employed within the thesis. The chapter concludes with an outline of the implications of the research for midwifery research, education, professional development and practice. The relevance of research findings to health research, Māori health, and miscarriage-related care provision, is also outlined.

### **Designing and Implementing Te Whakamāramatanga**

Development and implementation of the research methodology/model, 'Te whakamāramatanga' has been facilitated by consultation with key stakeholders, communities, professional and women's organisations, research participants and their families. Methodological tenets, illustrated in the style of consultation, research participation, collection of narratives through dialogical interviewing and a narrative analytical framework, were collaboratively agreed upon by members of the research partnership. Participants' stories have, where appropriate, been represented in their entirety in the thesis in order to respect participants' experiences and worldviews and facilitate reader and/or listener accessibility to, and comprehension of, 'storied meanings'. The narrative approach to analysis has incorporated aspects of thematic, narrative elements and whole narrative analysis. The theoretical framework for analysis interweaves the narrative concepts of Somers and Frank, the social theories of Foucault, Bourdieu, Latour and Harre, as well as Kaupapa Māori concepts, particularly whakapapa and whakawhanaungatanga.

Within the analysis, Frank's (2005) conceptualisation of narrative identities as dialogical, contingent on setting and perpetually revised in future stories intertwines with Somer's (1994) theory that personal, public, conceptual and meta-narratives are relationally constituted. Analytical conversations are also crafted through integrating Foucault's (1984) ideas about genealogies, Latour's (1993, 1999) conceptualisation of material technologies and kaupapa Māori theorising of genealogies as epistemologies. Linking Foucault's (1988b) theory of metaphysical technologies with Latour's (1999) ideas about material technology enabled the main argument in the thesis to be developed; that methodologies, in conjunction with the analytical themes relating to time(s), silence(s) and narrative(s), are simultaneously co-constitutive metaphysical and material technologies. Potential critique of the technology argument as relativistic

is mediated through introducing Bourdieu's (1996) theories about fields and capital into the conversation.

### **Research Findings: Methodologies and other Relational Entities**

An argument is advanced in the thesis, that 'Te whakamāramatanga' constitutes a culturally and contextually relevant technology for facilitating the development of multicultural research partnerships. The theoretical concepts of the research methodology/model were continuously relational and co-constitutive during the research process. Methodological implementation facilitated development of a relationally intimate network incorporating heterogeneous actors, objects and actants such as research participants, researcher, texts, institutions, temporalities and narratives. The network operated as a metaphysical and material technology that facilitated the constitution of contextually relevant knowledge in culturally appropriate ways.

The application of methodology as technology is presented in the thesis. Relational elements such as participants' identities, values, beliefs, behaviours and experiences in regards to miscarriage are traced from bodies, and translated through intertwined voices and silences that are embedded within oral narratives. These relational elements and the narratives themselves are subsequently folded through time and space through the process of inscription into text, and translation into chapters, within the thesis. The central argument in the thesis has been crafted through interweaving Foucault's and Latour's theories in order to conceptualise methodologies, narratives, genealogies, temporalities, silences and voices as relational entities that are simultaneously co-constitutive as well as material and metaphysical technologies. These technologies through constructing and situating un-finalised events, bodies, identities and practices in text, mobilise these elements across the chapters in the thesis.

### **Whakapapa as Narrative and Genealogy**

Within the thesis narratives are situated within metaphysical, corporeal and embodied, entities and environments. Narratives shape, are shaped by and situated in relation to, and may be considered synonymous with genealogies. As the comparative aspects of narratives and genealogies are encompassed within the term 'whakapapa', whakapapa constitutes a metaphysical, corporeal and embodied metaphor for narrative. Drawing on Davies and Harre (1990), whakapapa is constructed in this thesis as a positioning tool which through locating actors in contestable situations shapes class, subjective

habitus and fields (Bourdieu, 1977). Whakapapa as a relational element that ‘acts’, also constitutes a technology. Callon (1987) and Latour (1999) theorise technologies as relational and material entities that simultaneously constitute actors networking heterogeneous elements and networks. Foucault (1988a, 1988b) conceptualises technologies in their widest sense as relational, dynamic, material and/or metaphysical. Within the thesis, whakapapa is simultaneously constructed as a technological actant, hybrid actor, a dynamic, un-finalised actor network (Latour, 1993, 1999) and technology of power.

### **Corporeal Temporalities**

Multiple and contradictory temporalities are associated with women’s reproductive health. Embodied temporalities are incorporated into medical, social and institutional discourses. Participants’ stories demonstrate that corporeal temporalities are networks of social relations in which struggle occurs over certain types of capital and therefore within the context of this research it is argued that they constitute fields. Analysis of narratives presented within the thesis suggests that temporalities simultaneously and hierarchically position actors within fields. Diverse corporeal temporalities, as evidenced in measurements of health status, health risk, and moral values, facilitate the determination of humanity and identity. Through shaping identity, corporeal temporalities determine research participants’ choices regarding, and access to, miscarriage-related care services, care providers and care interventions. As corporeal temporalities are relationally engaged in expertly shaping identities, behaviours, narratives and social networks, within the context of the research, it is suggested that they constitute metaphysical and material actants, hybrid actors, fields, actor networks and technologies.

### **Narrative Silences**

Participants’ stories demonstrate that women are knowledgeable about and have developed expertise in the crafting and strategic operation of silences within social interactions and activities. Silences have been employed by participants in shaping, narrating and relating to ontological, public, conceptual and meta-narratives about miscarriage. The application of verbal, non-verbal, lexical, non-lexical, tonal embodied, metaphorical and cultural silences are particularly evident in participants’ stories about how they manage risks to self within inter-personal interactions and in relation to health care settings. Expertise is evident in the application of silences and silencing practices to facilitate personal agency, social conformity and resistance to hegemony, as well as shape performances of professionalism and culture. Exemplars of

silence employed as a technology within participants' stories include participants' practices of hiding by showing, exit and voice, as well as minimisation. Within miscarriage stories silences through simultaneously operating as actants, hybrid actors, and relational and co-constitutive entities, enable or constrain agency and structure, and function as actor networks and metaphysical and material technologies.

### **Women's Voices**

Women's concerns and desires in relation to miscarriage care, including theoretical rationales for their ontological experiences, are expressed through the technology of voice. During the research, within interview settings, participants provided commentary on women's key concerns in relation to recognition and relationships when developing, providing and receiving miscarriage-related care. In using voice as a technology to express their concerns, women demonstrated expertise in constructing and advocating theoretical frameworks for facilitating change to legislation governing miscarriage-related health care in Aotearoa New Zealand. The voicing of miscarriage stories draws attention to the personal importance of shared narratives as a technology for constituting 'selves' and developing self knowledge. The construction, and telling of miscarriage stories may also constitute a gender based technology for situating women's experiences in the wider context of their lives, voicing women's needs, concerns and wishes in regards to receiving and/or providing miscarriage-related care. Therefore public transmission of women's storied voices may be considered a political act that reconstitutes such collaborative stories as political technologies of production and signification.

### **Thesis as Actant**

A text, or by default a thesis, can be understood as a network of aligning heterogeneous elements (people, narratives, literatures, equipment, procedures institutions, ideologies and more), to achieve a particular goal.<sup>145</sup> Each of these aligned elements has a reality outside the text.<sup>146</sup> This reality outside the text allows enforcement of the meaning and strength of the text. To paraphrase Latour (1988, 1999) if miscarriage did not exist independently of this thesis then representing them in such a text would be meaningless. Miscarriage is aligned with the diverse elements in the text – bodies, narratives, silences, temporalities, technologies, ideologies and actors. In doing so

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<sup>145</sup> Such as proving a scientific discovery, manufacturing a product, or introducing a new procedure.

<sup>146</sup> For example, if microbes did not exist independently of a scientific text, then representing them in such a text would be meaningless. Pasteur aligned microbes with diverse elements in his texts. In doing so he constructed microbes as the acknowledged source of infections, and made microbes (social) actors (Latour & Woolgar, 1986; Latour, 1988).

miscarriages are configured as (social) actors. It may therefore be argued that outside the text, the aforementioned elements (methodologies, bodies, miscarriages, narratives, temporalities, silences and voices), presented in this thesis are actants, entities that have an independent reality. Inside the text, they become actors, entities that do things and which act precisely because they are represented in the text. The thesis is therefore simultaneously constituted as an actant and a material technology.

### **Research Limitations**

Research limitations specific to the project presented in the thesis include the lengthy consultation process associated with development and implementation of the research, the limited number of research participants, the lack of transferability of results and the context specific nature of research findings.

Developing and trialling a research methodology that is contextually relevant within Aotearoa New Zealand has required extensive and ongoing consultation with key stakeholders, communities, professional and women's organisations, research participants, and their families. Such processes are temporally demanding and require extensive financial resources to mitigate the associated costs of consultation and acknowledge the costs incurred by research participants in relation to lost opportunities and or taking part in the research. The lengthy consultation process has increased the temporal duration of the research process, and therefore my research-related costs. It is suggested that economic requirements be noted as key considerations in developing and conducting future research in a similar consultative manner.

Qualitative research is concerned with ascertaining depth rather than breadth of knowledge. Such research approaches invariably focus on the detailed accounts of events provided by a limited number of research participants. Although qualitative research may draw attention to potential issues for larger contextually similar populations, transferability of research results is not possible. In a narrative research project as in this instance, participant numbers may be particularly restricted. Detailed examination of participants' stories has provided sets of understandings about only those participants' specific experiences, for example analysis of Matipou's narrative in chapter five.

Conceptualising the narrative research methodology/model presented within this thesis as an actor network has drawn attention to the co-constitution of the researcher as a related heterogeneous element and hybrid actor. My varied identities as a Māori,

childbearing woman and midwife, have influenced methodological development and the ways in which the research methodology has been trialled. My bi-cultural genealogy has facilitated access to, and the authority to incorporate aspects of, tikanga in shaping methodological principles and modes of narrative analysis. I as research 'tool' have therefore simultaneously embodied the methodology and constituted a heterogeneous element within the developmental process. Such heterogeneity may present a challenge to non-Māori researchers who do not have the requisite cultural knowledge and authority to draw on tikanga when attempting to replicate this research study. Despite potential limitations, research participants suggested that 'Te Whakamāramatanga' provides an ethical and contextually relevant theoretical framework for conducting midwifery research in Aotearoa New Zealand.

### **Implications of the Research**

#### **Midwifery Research, Education, Professional Development and Practice**

Midwife participants commented that the methodology in successfully integrating the philosophical underpinnings of midwifery practice in New Zealand should be more widely adopted for conducting research in Aotearoa New Zealand. Application of the methodology to future midwifery research projects is therefore recommended. In analysing the practical relevance of 'Te Whakamāramatanga' midwife participants also asserted the methodology's potential for adaptation and development into a model for clinical practice. Further development and trialling of the methodology as a practice model is advocated.

Public and inter-disciplinary acknowledgment of their profession, knowledge, clinical skills, ethics, beliefs and autonomy is advocated by midwives as essential for professional development, ethical care practices and positive health outcomes for women and their families. Interactions between midwives, health care providers, childbearing women and families have also been construed as influential in informing and facilitating institutional recognition of women's wishes. In the course of the research, participants have recommended that comprehensive education be provided for midwives and midwifery students in relation to clinical knowledge about the diagnosis, pathology associated with and treatment of first trimester miscarriage. The development of effective interpersonal skills and caring relationships with women and families that experience first trimester miscarriage are promoted as key aspects of midwifery professional development.

Women participants report that midwives provide an individualised, contextually relevant and relationship-based approach to care for women and potentially their families. Such relationships are perceived as both personal and professional. Midwifery care is characterised as culturally respectful, empathetic, supportive and woman-centred. Research participants assert the philosophy of continuity of care and carer enacted by midwives facilitates relational equity and intimacy, and disrupts power differentials within care provider/care recipient relationships. As midwives are socially understood as health care providers for childbearing women, through providing care to women who experience miscarriage, they also legitimate women's identities as 'mothers'. The accessibility, availability and the disciplinary approach of midwives, positions midwives as the best choice of care provider for women and families who experience miscarriage. Midwives may also be appropriate advocates for legislative and cultural change in relation to miscarriage and related care provision. Further research that explores midwives' roles as primary health care providers for women who experience miscarriage, and as health advocates for legislative change, is recommended.

### **Māori Health**

Narrative analysis of the research stories indicates disparities in terms of women's access to care providers, care choices and care provision for miscarriage-related health concerns. More specifically, some Māori women indicated that they, or their clients, experienced marginalised care as a result of care providers' views and/or judgements regarding ethno-cultural difference. In highlighting such disparities, women's and midwives' stories have inferred a need for future research that would specifically examine Māori women's experiences of miscarriage-related care in primary and institutional health care settings.

### **Health Research**

The methodological principles encompassed within 'Te Whakamāramatanga' are broadly relevant to health research and may be adapted and integrated into research designs for application by other health disciplines. I acknowledge the cultural specificity of values and beliefs to particular ethnicities. However, as the methodology presented within this thesis has been successfully trialled in the conduct of cross-cultural research, further research that explores the possibility of trans-cultural and/or trans-national adaptation of the methodology for research purposes is advocated. Due to cultural and epistemological resonance amongst indigenous peoples,

‘Te Whakamāramatanga may be particularly suitable for adaptation by indigenous researchers in order to conduct research with diverse indigenous populations.

### **Miscarriage-Related Care Provision**

Participants’ voices highlight the need for radical change to contemporary health legislation and policies in order to develop adequate resources for providing appropriate miscarriage-related assessment, management and follow-up care. Provision of contextually relevant information is recommended to facilitate women in making informed choices and giving informed consent for miscarriage-related care. Women also require health professionals to recognise their knowledge, embodied ways of ‘knowing’ values, skills, cultural practices, agency, autonomy, identities as mothers, and the identities of their unborn children, within health care settings. Acknowledgement of women’s wishes regarding the nature of care interactions, and support for women’s choices in relation to care options and care providers is therefore recommended.

Attention to the settings in which health care interactions occur is advocated as temporalities and spatial elements influence care provider/care recipient relationships, and potentially care recipients’ health outcomes. Cultural attitudes and values evidenced by health disciplines and institutions also influence interactions. Institutional racism is evidenced within participants’ stories and interpreted as contributing to inequitable health care and potentially health outcomes. Cultural respect and valuing cultural diversity are advocated as measures for preventing ethnicity and/or class based discrimination within health care settings. Participants also report that linguistic practices within health care settings marginalise women’s identities, perpetuate victim blaming and constrain personal and professional agency. Health professionals are therefore encouraged to conduct care interactions within relationships characterised by intimacy, respect, empathy and effective communication.

### **Concluding Remarks**

This thesis stories the interweaving of multiple epistemologies, theoretical tenets, philosophical concepts, indigenous and Western European worldviews as well as women’s narratives in creating and implementing a contextually relevant research methodology. Women’s and midwives’ experiences of first trimester miscarriage are explored through the application of the methodology, ‘Te Whakamāramatanga.’ New

theories regarding the conceptualisation of research methodologies, narratives, genealogies, temporalities, silences and women's voices as simultaneously co-constituted metaphysical and material technologies, are also presented. These diverse relational entities are collectively perceived as actants, hybrid actors, actor networks and technologies which exist within dynamic and hierarchical networks and/or fields. The research presented in this thesis addresses gaps in the midwifery, miscarriage-related and methodological literature. In doing so, the research is demonstrably of value to midwifery research, education, professional development and practice, Māori health, and miscarriage-related care provision.

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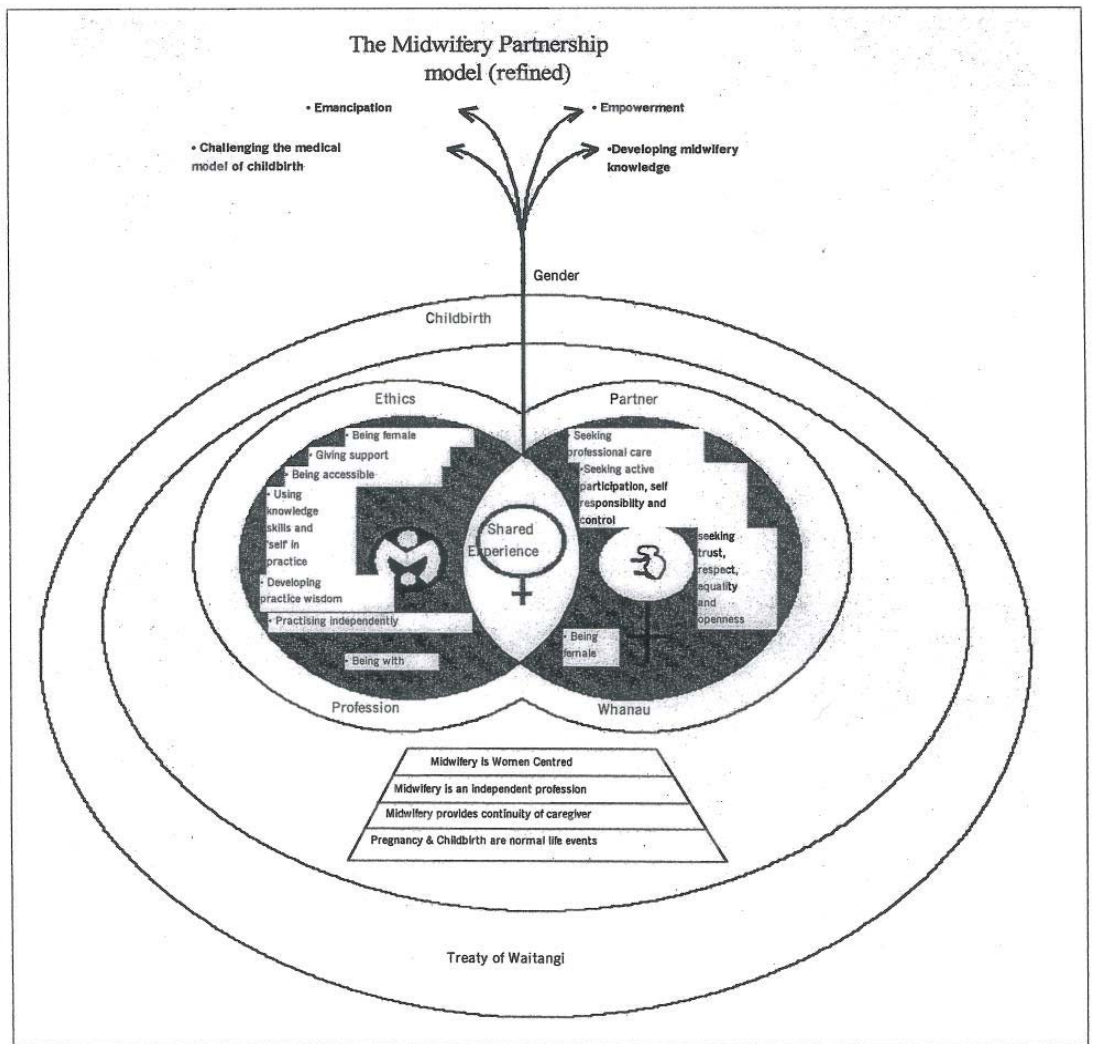
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Appendix A

Midwifery Partnership Model.  
 Pairman, S. (1999). Partnership revisited: towards midwifery theory.  
*New Zealand College of Midwives Journal*, 21, p.12.



Appendix B



21 December 2005

Cassie Kenney  
School of Health Sciences  
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Dear Cassie

**Re: HEC: PN Application – 05/116**  
**Te Whakamāramatanga: Development of a research and healthcare model based on an analysis of women's and midwives' narratives about first trimester miscarriage in New Zealand**

Thank you for your letter dated 20 December 2005.

On behalf of the Massey University Human Ethics Committee: Palmerston North I am pleased to advise you that the ethics of your application are now approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

A handwritten signature in blue ink, appearing to read "J. O'Neill".

Dr John O'Neill, Chair  
**Massey University Human Ethics Committee: Palmerston North**

cc A/Prof Cheryl Benn & Dr Suzanne Phibbs  
School of Health Sciences  
PN351

Prof Carol McVeigh, HoS  
School of health Sciences  
PN351

## **Appendix C**

[Print on Massey University departmental letterhead]  
[Logo, name and address of Department/School/Institute/Section]

**Title:** Te Whakamāramatanga: Development of a research and health care model based on an analysis of women's and midwives' narratives about first trimester miscarriage

**Researcher:** Christine (Cassandra) Kenney

**Interview schedule:**

**Definition of first trimester miscarriage:**

The spontaneous ending of pregnancy during the initial 14 weeks following conception. Commonly occurring signs and symptoms of first trimester miscarriage include frank vaginal bleeding, abdominal cramping, pain, and passage of the products of conception. As first trimester miscarriage may be incomplete, there is a risk of continued haemorrhage.

**Introductory question for women who have experienced first trimester miscarriage:**

Please tell me your story about miscarriage?

Events (what happened)

Your feelings (then and now)

**Experience of health care providers:**

**Women:** Please tell me about the health care you received?

**Midwives:** Please tell me about being a care provider?

**Views on the midwifery profession:**

Please tell me your views about midwives and their role in caring for women experiencing first trimester miscarriage?

**Views on the medical profession:**

I would like to know about your views of doctors and their role in caring for women experiencing first trimester miscarriage.

**Views on Hospitals:**

I would like to know your views about hospitals and their role in caring for women experiencing first trimester miscarriage.

**Partners:**

**Women:** How did your partner respond to your first trimester miscarriage? (Do you think that they felt supported? How do you think they coped? Describe your partner's role in supporting you).

**Midwives:** Please tell me your views about your midwifery practice partner's attitudes towards first trimester miscarriage?

**Whanau/family:**

**Women:** How did your whanau/family respond to your first trimester miscarriage? If you did not tell them, what factors led you to make that decision?

**Midwives:** Explore perspectives on support levels within families and the role of the midwife within this context.

**Immediate community:** (friends, work colleges, neighbours for example): Please tell me your views about the attitudes of your immediate community to first trimester miscarriage?

**Wider community:** Please tell me your views about the attitudes of the wider community to first trimester miscarriage (What gets written in magazines, how miscarriage is represented in TV dramas or films for example may help you to think about these attitudes)?

**Government:** What are your views about the Government's role in, and the legislation governing, care provision for women who experience miscarriage?

**Additional comments:** Are there any further remarks, concerns, feelings recommendations that you would like to share regarding first trimester miscarriage?

## Appendix D

[Print on Massey University departmental letterhead]  
[Logo, name and address of Department/School/Institute/Section]

### **Te Whakamāramatanga: The development of a research and healthcare model based on an analysis of women's and midwives' narratives about first trimester miscarriage in New Zealand**

#### **Information Sheet**

My name is Christine (Cassandra) Kenney. I am a registered midwife, a staff member at Massey University, and I am enrolled in the Doctor of Philosophy programme at Massey University. In keeping with my commitment to women's health and in order to satisfy my degree requirement, I am conducting a qualitative study to examine women's and midwives' stories about first trimester miscarriage in order to develop a research, and health care, model that will incorporate a Māori world view. The study has been approved by the Massey University Human Ethics Committee, and will be conducted over the next 3 years. The aim of the research is to collect and examine women's and midwives' stories about first trimester miscarriage, to gain an understanding of the key issues and contextual relationships associated with women's and midwives experiences in order to develop a model for health care provision that is appropriate for New Zealand.

#### Definition of first trimester miscarriage

The spontaneous ending of pregnancy during the initial 12 weeks following conception. Commonly occurring signs and symptoms of first trimester miscarriage include frank vaginal bleeding, abdominal cramping, pain, and passage of the products of conception. As first trimester miscarriage may be incomplete, there is a risk of continued haemorrhage.

#### Who am I looking for to participate in my research?

There is no published research about women's and midwives' experiences of first trimester miscarriage in New Zealand. As first trimester miscarriage is a common occurrence that may cause women great distress, grief and in some instances, mental ill health, I am interested in finding out more about women's and midwives' experiences.

If you are a Māori and/or European woman aged 16 years or older and,

- Have experienced first trimester miscarriage(s)
- And/or**
- Have provided midwifery care for women who have experienced first trimester miscarriage(s)
- And**
- Are fluent in English, then you are the woman I am interested in listening to, and talking with.

#### What are you expected to do?

If you consent to participate in this research, I will need your written consent to participate in an audio-taped interview for 1-2 hours (you can still participate even if you do not wish to have the interview audio-taped. I would take notes during the interview).

This interview can either take place via the telephone or face to face, depending on where you live. I will ask you some questions to help you get started telling me your story and I have attached an interview schedule to give you an idea of the questions I may ask and the topics I am interested in hearing about. I will also ask some personal questions such as your age, how many children you have and what experiences you have had with child birth in general.

What will happen to the information you provide?

When your interview is completed, I will transcribe the audiotape and forward the transcription to you to ensure that you are happy for me to use the information you have provided, and/or give you the chance to delete or change any aspects that you may not want included in the research. If I do not hear back from you within two weeks, I will assume that you are happy with the information you have provided and give me permission to go ahead and include your interview in my analysis.

The analysed information will be used to write my thesis, for conference presentations, and to develop papers and publications for academic journals. A summary of the research findings will also be available to you upon request.

It is my intention that you should not be harmed in any way, through exposure to, and/or participation in, my research. If you find recounting your story about miscarriage very distressing, at your request I will provide the details of a counselor who, resides within your area, is easily accessible, and has agreed to provide support for any research participants should it be required. You will not be able to be identified from any of the material that is presented or published.

I hope that my research will provide information that may enhance the ability of midwives, and potentially other health professionals, to provide care for women experiencing first trimester miscarriage.

How will the information be stored and accessed?

I will be the only individual with direct access to your contact details, consent forms, interview tapes, and transcripts. However, my supervisors will have access to the interview transcripts upon request and after signing a confidentiality agreement. Your interview tape and transcript will have a code number assigned to ensure that you cannot be identified and will be stored in a document safe. You will have the opportunity to have your tape returned to you on completion of the research or you may wish to have it archived or destroyed. Your contact details and consent forms will have the assigned code number but be stored in a separate location in a combination lock safe to preserve privacy during, and after completion, of the study.

What are your rights?

As a potential participant in this research study you have the right to:

- Decline to participate;

- Refuse to answer any particular questions;
- Have the tape recorder turned off at your request
- Refuse to have the interview audiotaped
- Withdraw from the study at any time up to 2 weeks after having received the transcript back for verification
- Ask any questions about the study at any time during participation;
- Provide information on the understanding that your name or any identifying information will not be used in the thesis , articles or presentations unless specifically requested by you
- Be given access to a summary of the findings of the study when it is concluded.

A small koha (petrol or grocery vouchers to the value of \$20.00) will also be provided to you in recognition of, your support for the research, and any personal costs that may have ensued due to your participation in the research.

Who can I contact if I have any questions about the research?

After reading this information sheet, if you would like to participate in my research or should you require further information or have any concerns about the study, please do not hesitate to contact me and/or my supervisors, Associate Professor Cheryl Benn and Dr Suzanne Phibbs. Our contact details are recorded as follows:

Christine (Cassandra) Kenney  
 Telephone No: (06) 356 9099  
 Ext: 2249  
 Email: [C.M.Kenney@massey.ac.nz](mailto:C.M.Kenney@massey.ac.nz)

Associate Professor Cheryl Benn  
 Telephone No: (06) 356 9099  
 Ext: 2543  
 Email: [C.A.Benn@massey.ac.nz](mailto:C.A.Benn@massey.ac.nz)

Dr Suzanne Phibbs  
 Telephone No: (06) 356 9099  
 Ext: 2319  
 Email: [S.R.Phibbs@massey.ac.nz](mailto:S.R.Phibbs@massey.ac.nz)

This project has been reviewed and approved by the Massey University Human Ethics committee, PN Application 05/116. If you have any concerns about the ethics of this project please contact Dr John G O'Neill, Chair, Massey University Human Ethics Committee: P N telephone 06 350 5799 x 8635, email: [humanethicspn@massey.ac.nz](mailto:humanethicspn@massey.ac.nz)

**Appendix E**

[Print on Massey University departmental letterhead]  
[Logo, name and address of Department/School/Institute/Section]

***Te Whakamāramatanga: The development of a research and healthcare model based on an analysis of women’s and midwives’ narratives about first trimester miscarriage in New Zealand***

**PARTICIPANT CONSENT FORM**

**This consent form will be held for a period of five (5) years**

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to provide information to the researchers on the understanding that my name and any other identifying information will not be used by them.

I agree to the interview being audio taped.  Yes  No

I wish to have my tapes returned to me.  Yes  No

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

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Full Name - printed** \_\_\_\_\_

Telephone No:

I wish to receive a summary of the research findings.  Yes  No

(If yes, please provide your address and telephone contact details.)

Address: \_\_\_\_\_

\_\_\_\_\_

**Appendix F**

[Print on Massey University departmental letterhead]  
[Logo, name and address of Department/School/Institute/Section]

***Te Whakamāramatanga: The development of a healthcare and research model based on an analysis of women's and midwives' narratives about first trimester miscarriage in New Zealand***

**AUTHORITY FOR THE RELEASE OF TAPE TRANSCRIPTS**

This form will be held for a period of five (5) years

I confirm that I have had the opportunity to read and amend the transcript of the interview/s conducted with me.

I agree that the edited transcript and extracts from this may be used by the researcher, Christine (Cassandra) Kenney in reports and publications arising from the research.

**Signature:**

**Date:**

**Full Name - printed**

Appendix G



**Massey University**  
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES  
Te Kura Pūkenga Tangata

SCHOOL OF HEALTH AND  
SOCIAL SERVICES  
Private Bag 11 222  
Palmerston North 4442  
New Zealand  
T 64 6 356 9099 extn 2822  
F 64 6 350 5681  
www.massey.ac.nz

***Te Whakamāramatanga: The development of a  
research and healthcare model based on an  
analysis of women's and midwives' narratives  
about first trimester miscarriage in New Zealand***

**CONFIDENTIALITY AGREEMENT**

I Cheryl Ann Benn

agree to keep confidential all information concerning the project named above.

I will not retain or copy any information involving the project.

**Signature:**

  
.....

**Date:**

1.1.2006

Appendix H



**Massey University**  
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES  
Te Kura Pūkenga Tangata

SCHOOL OF HEALTH AND  
SOCIAL SERVICES  
Private Bag 11 222  
Palmerston North 4442  
New Zealand  
T 64 6 356 9099 extn 2822  
F 64 6 350 5681  
www.massey.ac.nz

***Te Whakamāramatanga: The development of a  
research and healthcare model based on an  
analysis of women's and midwives' narratives  
about first trimester miscarriage in New Zealand***

**CONFIDENTIALITY AGREEMENT**

I Suzanne Rachel Phibbs

agree to keep confidential all information concerning the project named above.

I will not retain or copy any information involving the project.

Signature:

Date:

01.01.2006.

## **Appendix I**

[Print on Massey University departmental letterhead]  
[Logo, name and address of Department/School/Institute/Section]

**Advertisement** (to go to New Zealand Miscarriage Organisation Web Site)

### **Doctoral Research Study:**

**Te Whakamāramatanga: The development of a research and healthcare model based on an analysis of women's and midwives' narratives about first trimester miscarriage in New Zealand**

#### **If You**

- Have experienced first trimester miscarriage(s)  
**And/or**
- Have provided midwifery care for women who have experienced first trimester miscarriage(s)  
**And**
- Are fluent in English, then you are the woman I am interested in listening to, and talking with.

Please contact me if you would like to receive further information about this study in which I plan to interview a minimum of 12 women about their experiences of, and with, first trimester miscarriage.