CONFLICTING CONTEXTS

Midwives' interpretation of childbirth through photo elicitation.

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of the requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help I have received in my research work and preparation for this thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Felicity Copeland

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ABSTRACT

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Midwives' interpretations of childbirth through photo elicitation.

BACKGROUND

The increasing rates of interventions during childbirth in Australia raise serious concerns about how to keep birth normal. As midwives are the primary care givers for women during labour, it is conceivable that they have a direct influence on birth outcomes. Limited research has been undertaken regarding midwives' beliefs about childbirth and how they interpret the process of labour. This research examines the thought processes and cognitive frameworks that midwives construct around childbirth in order to understand if midwifery care is influencing the use of interventions during childbirth.

METHOD

A qualitative interpretive study was undertaken using a technique called photo elicitation. The study involved interviewing 12 midwives recruited from a variety of metropolitan maternity hospitals in Sydney, Australia. Photo elicitation is used to draw out in-depth responses from the midwives about their beliefs in relation to labour and to explore how and why they make clinical decisions. During the interview, participants were shown a photograph of a labouring woman and asked specific questions about how they would care for her. This was in the form of semi structured open-ended questions. The data were analysed using thematic analysis, which provided a flexible yet rigorous method for the interpretation and application of the themes.

FINDINGS

Six themes emerged from the data that clearly indicated midwives felt challenged by working in a system dominated by an obstetric model of care that undermined midwifery autonomy in maintaining normal birth. These themes were: Desiring Normal, Scanning the Environment, Constructing the Context, Navigating the Way, Relinquishing Desire and Reflecting on Reality. Most midwives felt they were unable to practice in the manner they were philosophically aligned with, that is, promoting normal birth, as the medical model restricted their practice. Midwives described a sense of frustration and powerlessness about having to conform to the protocols and procedures that reflected the institutionalised culture of the hospitals.

DISCUSSION

As the profession of midwifery comes from a history of marginalisation there remains a culture of subordination that inhibits the visibility and validity of midwifery philosophy. This research offers the concept of *parrhesia*, a Greek word, meaning to *speak without fear*, as a constructive and pragmatic way to challenge the dominant obstetric model. Parrhesia is suggested by Foucault as a technique to challenge unequal power relationships (Foucault 1983). This research recommends that midwives become skilled and confident in using parrhesia as an effective method to articulate their beliefs and desires for normal birth in the increasingly technological environment of childbirth.

CHAPTER ONE: INTRODUCTION

Childbirth in Australia is characterised by a hospital-based model of care and increasing rates of caesarean section birth. The current rate of caesarean section in Australia is 31%, approximately double that of the World Health Organization's recommendation and well above the OCED (Organization for Economic Growth and Development) overall rate of 22% (Commonwealth of Australia 2009). These rates are predicted to rise further, and can be, amongst other factors, linked to the cascading impact of interventions during the process of childbirth (Tracy et al. 2007). Caesarean births have many associated health risks and problems for babies, women, their families and the community, which will be discussed in this thesis.

Using photo elicitation, the study seeks to explore midwives' beliefs about childbirth and the impact these beliefs have on the care they give to women during labour.

AIMS

The aims of this study are:

- To explore the beliefs that midwives have about childbirth
- To explore midwives' perceptions of normality and risk in relation to birth
- To examine how these perceptions influence their clinical decision making in relation to the use of interventions and their impact on normal birth

The study is positioned within the policy framework *Towards Normal Birth* (NSW Health 2010) which will be discussed in Chapter Three. The study will thus focus on the role that midwives have in caring for women in labour whilst promoting normal birth. In particular, the study explores the ways in which midwives interpret childbirth and the underlying thought processes that guide their clinical decision-making. In addition, issues of conflict that midwives experience in delivering care that is consistent with the philosophical framework that defines midwifery practice, is examined. In the study I use the Australian College of Midwives (ACM 2009) philosophical statement of midwifery as my basic premise, which states:

> *Midwifery is emancipatory because it protects and enhances the health and social status of women, which in turn protects and enhances the health and wellbeing of the*

> *community…. is informed by scientific evidence, by collective and individual experience and by intuition*. (p1)

It is from this statement that I identify the central responsibilities of midwifery care.

ARRIVING AT THE QUESTION

I have always been interested in how and why midwives come to make decisions in their clinical practice. This was highlighted as I moved from working in a traditional labour ward with fragmented care to a birth centre where care is provided in a midwifery continuity of care model. Fragmented care in the labour ward is characterised by labouring women being assigned an unknown midwife when arriving at the hospital to give birth. A birth centre, which is a midwifery continuity of care model for low risk women, operates on the philosophy of building therapeutic relationships with women during the antenatal period in addition to giving intrapartum and postnatal care (Kirkham 2003).

Both the labour ward and birth centre are usually in the some hospital yet the outcomes for the women can differ widely (Hodnett et al. 2010). The lack of interventions and generally uncomplicated births in the birth centre (Hodnett et al. 2010) compared to a higher intervention and caesarean section rate in the labour ward, even for women who have similar risk factors, have made me think that possibly the midwives in the labour ward may be complicating the birthing process. Differences in outcomes are unlikely to be exclusively due to the perceived medical status of the women, that is, complicated or low risk. As midwives care for all labouring women, it is possible that outcomes reflect the care they receive and the decisions that midwives make. What is not known, is whether it is the birth environment or the midwives' different beliefs about childbirth that influence birth outcomes. It may also be possible that midwives who work in both settings change their practice according to the different environments.

It appears from the literature, which will be discussed in Chapter Two, and from my own clinical experience as a midwife, that there are many factors that influence the ways in which midwives approach the birthing process. Although most births are not considered inherently dangerous, labour is at times unpredictable, dynamic and certainly unique for every woman. The specific social, emotional, physical and cultural contexts of the labouring woman must be taken in consideration by the midwife allocated to her care (Davis-Floyd 2001). The factors that take place outside of the labouring room may also be implicated in birth

outcomes. These include the culture of the workplace (Hodnett, Lowe et al. 2002; Cheyney 2008) managerial styles (McCourt 2006; Porter, Crozier et al. 2007), obstetric-led care versus midwifery-led care (Keating & Fleming 2007; Lee & Kirkham 2008) and the personal beliefs that each midwife has about childbirth (Regan & Liaschenko 2007). The latter is somewhat more difficult to access and define and the extent to which these beliefs play a part in the progress and outcomes of labour is not well understood. My research will seek to address this gap in the literature within an Australian context.

It is hoped that the findings from my research will highlight areas in midwifery education curriculums that can focus on exploring midwives' attitudes to birth and the influence that these may have on birth outcomes. It may be appropriate to assist in the development of education packages that aim to facilitate a belief and valuing of normal birth with the objective of potentially reducing intervention rates in childbirth and promoting normal birth. In addition, it is useful to examine current practices and beliefs of midwives in maternity settings with a view to further enhancing NSW State policy objectives in supporting normal birth.

It is important for the future of childbirth and the midwifery profession, that the obstacles that prevent midwives from providing care that lowers the rates of unnecessary interventions, are better understood. I come to this research project with the view that midwives are vital in the role of promoting normal birth and protecting women from unnecessary interventions. I anticipate that this study will reveal the cognitive frameworks that individual midwives construct around childbirth that subsequently influences their practice whilst caring for women during labour.

CONTEXT OF AUSTRALIAN MATERNITY SERVICES

In order to explore how midwives interpret the process of childbirth it is necessary to examine the context in which they work. This section focuses on maternity services and the scope of midwifery practice currently in Australia. I draw mainly from the recent Report on the Review of Maternity Services published by the Commonwealth Government (2009) as it is the most current and relevant resource available regarding maternity services in Australia.

Australia is considered one of the safest places in the world to give birth in (Commonwealth of Australia 2009). Despite this, the recent National Review of Maternity Services highlighted many areas of concern in relation to the needs of both the rural and metropolitan

populations. For example, the review highlighted the lack of unanimity between some medical and midwifery colleagues regarding perceptions and assessments of risk factors in pregnancy and birth (Commonwealth of Australia 2009). The report recognised the importance of childbearing women's personal and informed consent and argued that these be taken into consideration in the pursuit of safety and outcomes. This has relevance to my study, as I am interested in understanding the process of how midwives make clinical judgments about the women in their care whilst considering the broader context of their work environment

According to the Australian Institute of Health and Welfare (AIHW 2010) in 2008, there were 296,925 births in Australia, an increase of 3.6% from 2005. Over 97% of these births occurred in a hospital labour ward (AIWH 2010). Maternity hospitals in Australia offer a variety of midwifery and obstetric models of care depending on the location and the size of the institution. These include general practitioners-shared care, fragmented hospital antenatal and labour midwifery care, private obstetric care, team and caseload midwifery models and birth centre care (Homer et al. 2008). This study has recruited midwives who work in a range of models of care, some described in a following section.

There has been a growing demand from consumer groups in Australia to increase access to midwifery continuity models of care for all pregnant women (Commonwealth of Australia 2009; Reiger 2008). These include team midwifery, caseload and birth centre care. Midwifery continuity of care is defined as women being cared for in the antenatal, intrapartum and postnatal period by a known and trusted midwife or a small team of known and trusted midwives (Hatem et al. 2008). A systematic review of these models, including those within Australia, has indicated that women in these midwifery models experience a reduced rate of interventions during labour, have an increased likelihood of experiencing a normal vaginal birth and report a high level of satisfaction for the care they receive (Hatem et al. 2008).

Midwifery continuity of care fosters the building of therapeutic and trusting relationships and enables midwives to facilitate an equal exchange of information (Homer et al. 2002; Homer et al. 2008). This plays a significant role in the personal experience and levels of satisfaction for both the woman and her midwife (Homer et al. 2002; Homer et al. 2008). Despite recommendations from Government policy makers declaring their commitment to midwifery models of care, in particular models that ensured continuity (Commonwealth of Australia

2009), there appear to be obstacles that prevent the expansion and visibility of midwives as primary carers (Boxall & Flitcroft 2007; AMA 2010). These include opposition from various medical and obstetric bodies, allocation of funding and an overall shortage of midwives throughout Australia (Boxall & Flitcroft 2007; AMA 2010).

Birth centres provide midwifery continuity of care for low risk women who are seeking to give birth with a minimum of intervention (Kirkham 2003). Birth centres are managed solely by midwives, although women can access other health care professionals when required. Most birth centres in Australia are integrated geographically into the main hospital building. There are only two freestanding birth centres (meaning they are not co-located with a main hospital that provides midwifery care) currently operating in New South Wales (NSW). Despite good outcomes and a reported high level of satisfaction from women, only 2% of pregnant women chose, or currently have access to this model (Commonwealth of Australia 2009).

Another option in terms of giving birth is homebirth. Less than 0.3% of women in Australia choose to give birth at home with an independent midwife (Commonwealth of Australia 2009). Independent midwives practising in Australia currently have no professional indemnity insurance for intrapartum care, though they now have access to insurance for antenatal and postnatal care. This has implications for women's access to and choice of a homebirth (Dahlen et al. 2011). However in a recent move to improve maternity choices for women, several states have introduced publically funded homebirths that are attended by midwives who work from the local hospital (NSW Health 2006). The encouraging results regarding the safety of homebirth in the recent published research of over 500,000 homebirths in The Netherlands (De Jong et al. 2009) may influence policy makers to support this birthing option for Australian women.

Complex issues face the Australian Indigenous population and they can experience particular difficulties in accessing maternity services. The Report of the Maternity Services Review (Commonwealth of Australia 2009) identified the comparatively poor maternal and infant morbidity and mortality rates for these women, compared with non-Indigenous women in Australia. Aboriginal and Torres Strait Islander people make up less than 3% of the population and many Aboriginal women are forced to leave their communities in order to give birth. For these women the sense of dislocation and isolation should be taken into consideration when analysing risk assessment factors for remote and rural transfers (Kildea et

al. 2006). Geographical isolation was also identified as having an impact on the availability of birthing services in rural and remote Australia with increasing numbers of the smaller birth units closing (Kildea et al. 2006). Although my study recruited midwives solely from the Sydney metropolitan area, it is feasible that some of these midwives will have worked in rural and remote settings that may have influenced the ways in which they practice.

Currently under examination by consumers, government health policy bodies and health care services is the rate of caesarean section births in Australia (Commonwealth of Australia 2009). The implication of caesarean sections will be discussed in following chapters as this research focuses on how midwives view childbirth with particular reference to the use of interventions and caesarean sections. The Report of the Maternity Services Review (Commonwealth of Australia 2009) also drew attention to the disparity between women attending the private sector and those women who gave birth in the public sector. The report tabled the 2006 caesarean sections statistics, showing that private hospitals had a 42% caesarean section rate compared with the public hospital rate of 27% (Commonwealth 2009).

The previous section examined the complex arrangements surrounding maternity care systems in Australia in order to understand the scope and context of midwifery practice. The following section provides a background to this study and explores the history of the professionalisation of midwifery within the context of current issues facing maternity care providers today.

BUILDING ON PREVIOUS RESEARCH IN THIS AREA

This research is informed by the work of Regan and Liaschenko (2007). These authors undertook a qualitative study to examine how midwives in two North American hospital settings cognitively framed childbirth. Their research focused on understanding the motivations and meanings behind midwives' practice in relation to normal births and caesarean sections. Regan and Liaschenko (2007) found that most midwives perceived childbirth to carry varying degrees of risk. They hypothesised that the midwives who associated childbirth with a high degree of risk would intervene more in the process of labour with technological management thus possibly increasing the caesarean section rate. The study is based on the theory that *cognitive frames inform action* (Regan & Liaschenko 2007, p. 613) and that these cognitive frameworks guided the process of how individual midwives made decisions whilst caring for women in labour.

Regan and Liaschenko (2007) were aware of anecdotal evidence suggesting that some midwives appeared to retain a high number of normal birth outcomes for the women in their care while other midwives utilised more interventions and had a higher number of caesarean births. They attributed this to the midwives' subconscious beliefs about childbirth. Whilst their study did not test this theory, it does provide a reason to explore further the relationship between interventions and midwifery care. The significance of their research is that exploring the sub-conscious attitudes midwives hold around birth may elucidate factors that link these thought processes to clinical decisions regarding the introduction of interventions. More detail about their study and the similarities and differences to mine will be discussed in later chapters.

THE PROFESSIONALISATION OF MIDWIFERY

The current position of midwifery as a profession in Australia is important to consider at this point. This section discusses the gradual professionalisation of midwifery that took place in the latter part of the 19th Century in order to gain insight into its present professional identity that remains submissive to the discipline of medicine. I argue that this powerful culture of subservience presents a significant obstacle to creating a new generation of strong articulate midwives who are well equipped with strategies to challenge the status quo.

Historically, midwives have faced many challenges in maintaining their status as the primary care givers to women during labour. Despite extended periods through the early centuries where midwives were the exclusive birth attendants, by the Middle Ages men in medicine had started to assert their claim over the pregnant body (Leap & Hunter 1993). This often involved the use of some barbaric birth instruments that caused grievous injuries to women and their babies. In Medieval Europe, thousands of women thought to be witches because of their healing prosperities were persecuted and executed in the belief that they were aligned with the devil. Many of these are believed to have been midwives (Cassidy 2006).

Although contemporary feminist writers such as Coward (1989) and Purkiss (1996) offer differing accounts of the extent of this reported midwifery persecution, it remains clear that midwives throughout history have been marginalised. The church wielded enormous power and authority over its constituents and in 1486 a manifesto written by two monks, declared, due to their links with witchcraft that *no one does more harm to the Catholic faith than midwives* (Cassidy 2006, p.33). In England, by the 1600s, the Church had authority over midwifery practice and in order to purge the profession of the alleged sorcery, judiciously

issued midwifery licenses (Cassidy 2006). However, there remains throughout the Middle Ages and later periods, many examples of midwives who fought to practise autonomously in their communities, who implemented training for midwives and who were held in high esteem despite the efforts of the State and Church to limit and control the profession (Leap 2005).

In Australia, the industrial revolution brought childbirth from the home environment into the hospitals. During this period, medicine began to rise in status as the overall health conditions improved due in part to better sanitisation, hygiene and sewerage engineering (Barclay 2008). Medicine benefited from many of these advances and began to take an authoritative stance over other health care providers. This rise in status was closely aligned with gender and class as it was only the upper classes who had the opportunity to produce men of science who were thus elevated in society and by the State (Willis 1983).

In Australia in the early 1900s, the presence of the midwifery profession became less visible. A doctor-led campaign resulted in childbirth being predominately managed by general practitioners and obstetricians in hospitals and effectively diminished the role of midwifery in the community (Willis 1983). Although many skilled and experienced midwives of the time were respected and valued members of the community, it was no longer possible to compete with the political tactics of the medical fraternity. The training of midwives came later than nursing and was only possible after completing a general nursing degree. Midwives were unable to work in a hospital without this nurse training (Willis 1983). Interestingly, this arrangement suited both the medical and nursing profession, as Willis (1983) notes:

> *[For] nurses… it extended their occupational territory to include the tasks associated with childbirth, (and for) doctors because the incorporation of midwifery into nursing ensured its subordination.* (p. 10)

The nursing profession is closely aligned to midwifery in its struggle to gain recognition. Similar to the profession of midwifery, nursing has a strong theoretical and intellectual educational foundation and therefore experiences some parallel conflicts. However, it is important to note that midwifery has struggled to disengage from being seen as an adjunct to nursing and has fought for its own separate identity (Fahy 2007).

Until recently, midwifery qualifications in Australia were only possible as a postgraduate diploma for registered nurses (Gray 2010). In the past decade, a number of states in Australia

have commenced the three-year midwifery bachelor program leading to professional registration as a midwife. This new bachelor degree offered a separation from the nursing profession and effectively provides an opportunity to create a less medically and illness dominated professional model (Gray 2010). This has proved to be challenging for those who have opposed the move away from the traditional pre-requisite of being a registered nurse prior to studying midwifery (Barclay 2008). Historically doctors have been opposed to the training of midwives outside of the nursing profession as it was seen to be a threat to their jurisdiction over women and childbirth (Barclay 2008).

The nursing and midwifery professions are often seen by the public as being a *calling,* a *vocational occupation* that is best suited to women due to their caring and nurturing characteristics (Fahy 2007). Nightingale (1860) in her writings about the nursing profession expressed this enmeshment with nursing as being an inherently female occupation:

> *Every woman...has, at one time or another of her life, charge of the personal health of someone, whether child or invalid: in other words, every woman is a nurse.* (p.3)

This belief in the assumed naturally occurring nurturing aspect of femininity and the implications that this is the most important quality of a nurse or midwife, offers little encouragement to the educational endeavours of contemporary midwives and undermines the technical skills required and the capacity to critically analyse a clinical situation. Midwifery and nursing are feminised professions that have suffered similarly oppressive industrial agreements, or lack thereof, like other female dominated fields such as childcare, teaching and community workers. These include unequal gender-based pay rates, lack of career opportunities and promotions, and other industrial conditions that are not on par with the majority of male dominated careers (Heath 2004; Nelson & Gordon 2004).

The paradox here is that men who work in the nursing/midwifery professions have been shown to experience a substantially quicker career path, are afforded more opportunities for promotion and earn a greater wage than their female counterparts (Walker & Holmes 2008). It becomes difficult to separate this gender specific discrimination and the supposedly innate feminine qualities that lend themselves to the profession of nursing and midwifery. Nurses and midwives today are still negotiating for fair and equitable pay rates, reduced workloads and increased benefits for shift workers in an effort to re-address the power imbalance (Holmes 2010). These factors are significant to this thesis as they may have an impact on the ways in which midwives frame their beliefs about childbirth because these industrial

inequalities are indicative of broader workplace and professional inequalities that midwives are positioned within.

ORGANISATION OF THE THESIS

This thesis contains five chapters and is organised as follows:

> *Introduction, Literature Review, Methods and Methodology, Findings and Discussion chapters followed by appendices and references.*

CHAPTER ONE

Chapter One provides an introduction to the study including the background, the impetus for the study and my own personal motivation in undertaking the research. It introduced the reader to research work previously conducted that has informed this study which will be referred to throughout this thesis (Regan & Liaschenko 2007). An overview of the current maternity services in Australia is described in order to contextualise the research. Additionally a short history of the professionalisation of midwifery is examined to further understand the longstanding marginalisation that the profession of midwifery has experienced.

CHAPTER TWO

Chapter Two provides an exploration of the current and relevant literature that relates to my research. This includes the conflict between midwifery practice and obstetric management, which has been indicated in this research as a significant factor in the ways in which midwives interpret childbirth. Other literature that examines fear and risk in labour as well as childbirth management styles will be examined.

CHAPTER THREE

Chapter Three outlines the design of the study and includes the aims and objectives, method of recruitment and the data collection techniques. A discussion of the political, theoretical and philosophical frameworks applied to this qualitative study will also be examined. These include *keeping birth normal,* and conducting the research through the *lens of feminism*. The concept and implementation of photo elicitation will be discussed as one of the data collection techniques used in this research. This chapter will also discuss thematic analysis as the method of analysis employed in my thesis, which seeks to organise, recognise and give meaning to the themes that emerge from within data.

CHAPTER FOUR

Chapter Four examines the findings of the data and the themes that were identified in the process of analysing the data. Direct quotations from the transcripts are used to illustrate and justify the chosen themes.

CHAPTER FIVE

The final chapter of the thesis discusses the findings in relation to the relevant literature and the implications for contemporary midwifery practice. It explores the disconnection and the conflict between the rhetoric and the reality for midwives working in maternity facilities in Sydney. This chapter also examines the implications of this disconnect. It identifies the complexities that the medical and hospital cultures imposes on childbirth, midwifery care in particular, as expressed by the midwives in this study. The concept of parrhesia (Foucault 1983), which means *free speech, speech without fear,* is suggested as a means of addressing conflicting obstetric and midwifery ideologies, both within the academies and the clinical settings.

CONCLUSION

This chapter has introduced the research question, outlined the aims and briefly described an overview of the thesis. The background to the study, the impetus for this research and a description of previous research in this area has also been discussed. Additionally the context of childbirth in Australia has been examined with particular reference to the issues and concerns within the maternity services. The chapter also explored the professionalisation of midwifery and its historical ties with the discipline of nursing that has inhibited the visibility of midwifery. The next chapter provides a review of the current and relevant literature in relation to this study.

CHAPTER TWO: LITERATURE REVIEW

A comprehensive literature review was undertaken to inform this study. Chapter two begins with a brief overview of the research strategies used to access the literature. The specific issues that provide the context for this research are then discussed. These issues include the following: firstly, the ways in which midwives work within the framework of keeping birth normal; secondly, obstetric models of care and the impact these have on midwifery work; thirdly, the institutionalised culture of the hospital environment; fourthly, caesarean sections and their implications and finally, maternity care providers' perceptions of fear in relation to childbirth.

RESEARCH STRATEGY

In planning this study in 2008-2009, a literature search was undertaken. The databases accessed included Academic Search Elite, CINAHL, Cochrane Library Database, Medline, MIDIRS, OVID and Pubmed. The search terms used were *midwives' interpretation of childbirth, management strategies, perceptions, beliefs, midwifery decision making* in a variety of combinations using a range of relevant key words. There were very few Australian publications that matched these key search terms. I then added *risk factors*, and *obstetrician's beliefs*, as these were themes that had started to appear in the literature and were also relevant themes in Regan and Liaschenko's work (2007). It was apparent that there was very little published research about midwives' personal beliefs about childbirth and the ways these beliefs then impacted upon their interpretation and implementation of maternity care. However several factors appeared that influenced midwifery clinical-decision making during childbirth and the following literature review will focus on these.

MIDWIVES AND NORMAL BIRTH

In attempting to explore what shapes midwives' beliefs about labour, it is pertinent to examine the philosophical underpinnings of the profession. The Australian College of Midwives (ACM 2004) definition of midwifery includes the concept that midwifery is:

> *…a woman centered, political, primary health care discipline founded* on *the relationships between women and their midwives* (p.1).

The philosophical underpinning of midwifery knowledge is that childbirth is a normal process and in the current climate of increasing use of technology in childbirth, midwives

have been referred to as the *guardians of normal birth* (O'Connell & Downe 2009, p. 589). According to World Health Organization (WHO 1996) midwives are positioned as:

> *…the most appropriate and cost effective type of health care provider to be assigned to the care of normal pregnancy and birth* (p.6).

The International Confederation of Midwives (ICM 2005) advocates that midwifery work is also focused on safety, evidence based practice, providing a positive birth experience and promoting normal birth for the women.

Promoting normal birth has been the focus on an increasing number of studies that seek to make explicit the rising technological intervention in current childbirth practices. Powell Kennedy and Shannon (2004) conducted a qualitative study in North America, which involved midwives describing the processes that accompanied their midwifery care. They found that a key component of midwifery care was the ability to support normality and that midwifery was based on keen observational and intuitive skills that enabled midwives to remain connected yet not intrusive (Powell Kennedy & Shannon 2004). By maintaining an unobtrusive yet watchful presence, midwives were able to positively influence the woman's ability to labour effectively at her own pace. These authors described the principles that midwives valued most about their practical care included: a belief in the normalcy of birth, a tolerance for the wide variations of normal, a belief and trust in the woman's strength, midwifery presence in birth and the importance of teaching students to believe in normal birth (Powell Kennedy & Shannon 2004). The midwives chosen to participate in their study were considered by midwifery leaders in the USA to be *exemplars,* due to their experience and philosophical beliefs about midwifery. This may be a possible limitation in the research as it could be argued that these *exemplar* midwives were likely to hold similar beliefs about childbirth, thus creating a homogenous data set. The numbers in this study were small, similar to my own study. However the midwives recruited into my study had no set criteria other than they must have current experience working in a birthing unit. Additionally, midwifery training and registration in the U.S.A is quite different to Australian requirements, in that midwifery qualifications here require a substantial university and hospital training program that is more thorough than in America.

Within the context of the rising technological interventions and caesarean section rates in developed nations, midwives can find it difficult to remain advocates for normal birth. Downe (2006) observes that the concept of normal birth has shifted in the past ten years and

now includes intrapartum practices that routinely utilise technology. She challenges these practices as being far from normal. These practices include: the routine rupture of membranes in early labour, continuous fetal monitoring in the absence of risk factors and an increasing rate of the use of epidural anesthesia. She urges midwives to adopt practices that *entail supporting unique normality thinking via supervision and governance* (Downe 2006 p. 355). This concept of unique normality refers to the fact that every woman will experience labour in a way that is uniquely different from every other woman and seeks to challenge current, narrow clinical definitions of normal. Page (2007) in her discussion on midwifery-led maternity units, cites the medically dominated view of childbirth as being responsible for the increasing technological interventions during labour. She credits midwifery care to be based *on the need to respect, recognise, and support physiological processes while recognising deviations from the norm* (Page 2007 p. 643). Davis-Floyd (2001) urges maternity providers to embrace the individual and dynamic aspects of each woman to include her cultural, social and physical experience of childbirth. My thesis explores these notions of normality and midwives' advocacy for normal birth from the perspective of the midwife.

MIDWIVES AND MEDICINE

In examining the literature it was evident that a conflict exists between the philosophical underpinnings of midwifery practice and those of medicine, in particular, the practice of obstetrics (Walsh 2006; Lee & Kirkham 2008; Surtees 2010). This is certainly not always the case, as there are many examples in the literature that illustrate the success of collaborative practice between the two professions (Moore 2009; Hastie & Fahy 2011). However it would appear that there is a significant polarisation between the two discipline's approaches to childbirth (Leap 2005; Lee & Kirkham 2008; Hastie & Fahy 2011). I come to this research having had personal experience of this polarisation and thus I am drawn to the ways in which midwives navigate their practice within a culture that seems to operate under a prevailing belief in the superiority of medicine over other health care professions. The following section describes the characteristics of these two professions, as it is evident that these issues influence midwifery care.

THE CULTURE OF MIDWIFERY

It is generally accepted that midwives view the spiritual and emotional wellbeing of the women in their care to be as significant as the physical aspects of labour and birth (Hunter 2001). Blaaka and Schauer (2008) found that midwives described their work as one that involved their eyes, ears, hands and heart and that it also required them to become emotionally involved with the birthing process. Their study used a phenomenological approach to analyse how midwives cared for women during labour in a birthing unit in Norway. Their findings revealed 3 significant factors that underpinned midwifery care. There were: (1) sensing where a woman is in labour; (2) being near the woman without crowding her; (3) being in a room of struggle (Blaaka & Schauer 2006 p. 4). The midwives from this study reported that they used a combination of medical, technical and sensual skills whilst attending women in labour (Blaaka & Schauer 2006). This concept of holistic care defines midwifery in contrast to the obstetric model, which constitutes a more fragmented biomedical system that seeks to control and organise childbirth with an emphasis on safety (Fahy 2007).

The fundamental difference between midwifery and medicine is that midwifery primarily operates upon the premise that pregnancy and birth are healthy normal life events, as opposed to medicine which is intrinsically related to ill-health and is focused on prevention and curing (Davis-Floyd 2001). Davis-Floyd (2001) in her research that examines the culture of childbirth in the western world describes it as *technocratic*. She claims the highly medicalised and technologically organised obstetric approach to childbirth results in the problematising of pregnancy and childbirth. This, she asserts, has the effect of disempowering women and leads to the belief that childbirth is a dangerous event that needs to be managed by experts that is, obstetricians. This she argues ultimately creates a vehicle for the overuse of interventions and technologies during childbirth (Davis-Floyd 2001).

In examining the discourses of feminism, midwifery and medicine, Lee and Kirkham (2008) also found that midwifery and medicine held polarised positions on pregnancy, labour and birth. The authors analysed articles about caesarean section births published in the last decade written from a feminist, midwifery or medical viewpoint. Their study included examples within an Australian context, and in particular noted that an eminent obstetrician was urging doctors to reassert control over childbirth. The authors also reported that Australian midwives felt that doctors, in fact, had far too much control over childbirth (Lee & Kirkham 2008). In analyzing their data, they found that midwifery viewed medicine as paternalistic and

oppressive towards women and their bodies, whereas medicine described itself as being authoritative, scientific and technologically superior (Lee & Kirkham 2008). Fahy (2007), writing in a discussion paper, argues that these medical discourses are powerful constructs that have embedded themselves within legal and governmental bodies to retain power over nursing and midwifery.

In analysing the history of the subordination of midwifery in Australia, Fahy (2007) demonstrates how both medicine and nursing strategically implemented regimes of power and control over midwifery to diminish the profession's strength and visibility. Her work states that in Australia in the early 1900s, upper class white males had almost exclusive control in many of the institutions of society such as the church, the army, the media, the court system and the medical fraternity. Medicine was therefore able to assert both legal and disciplinary power over midwifery and nursing in order to increase its own professional territories. One example of this was that until the latter half of the 20th century, doctors chaired the Nurses Registration Board in all Australian states (Fahy 2007). Whilst it is generally agreed that midwifery has made significant progress in becoming a more powerful advocate for childbearing women, it would appear that the dominance of the medical model remains an obstacle for midwives seeking to work more autonomously in Australia (Barclay 2008).

Midwifery and feminism are closely linked. Feminists argue that medicine exercises power over women's bodies and operates within a social construct that is gender specific and patriarchal. This results in a loss of autonomy and choice, limiting options regarding childbirth (Lee & Kirkham 2008). Midwifery is a feminised profession, however it is within these conflicting frameworks that it must define itself, striving to keep birth normal and be an effective advocate for women in labour.

Conflicts between knowledge and the judgments of midwives and medical knowledge are evident in the literature. For example, in a qualitative study entitled *Doing midwifery between different belief systems,* Blaaka and Schauer (2008) describe the struggle that midwives experience when attempting to merge midwifery knowledge and judgment, based on intuition and observation, with the more logical biomedical model where control and rational scientific knowledge are given the highest priority. In their study, one participating midwife was quoted as saying:

> *I am afraid of losing my clinical judgment in a space where standardised knowledge has priority over my sensory knowledge* (p. 349).

This resonates with Hyde and Roche-Reid (2004), who found that midwives took a passive role in intrapartum care as they felt any clinical judgments had to conform to the obstetricians' view in the maternity unit. In a similar way, Keating and Fleming (2007) described midwives' working experience in an obstetric unit in Ireland. These authors reported a significant amount of conflict between the ways that midwives believed they should deliver their care as opposed to how the unit's medically orientated practices dictated their clinical decision-making without valuing collaborative practice (Keating & Fleming 2007).

An Australian case study involving 29 midwives and nine obstetricians, found a similar disparity between these two professions' beliefs about how labour should be managed (Lane 2006). The midwives in this study felt that until obstetricians were willing to relinquish some of the control and decision-making power to the midwives, true collaboration would not be possible. The author of this study found that obstetricians viewed childbirth though a biophysical scientific framework and did not acknowledge the significant emotional work that midwives did, and how this input contributed to reducing risk in labour (Lane 2006). She reported that there was resistance by some obstetricians in delegating care to midwives, with one obstetrician quoted as saying:

> (Midwives)…*are a different craft group...what if the orthopods had to work with chiropractors?* (p. 347).

This lack of willingness to work in collaboration is also seen in other research. An earlier Australian study that assessed a community based continuity of care model with collaboration between midwives and obstetricians, suggested that the caesarean section rate decreased when compared to the more traditional model of hospital care (Homer et al. 2001). Although this study highlighted the advantages for women when accessing midwifery continuity of care, it also indicated that collaboration between midwives and doctors was a significant factor in achieving optimal birth outcomes (Homer et al. 2001).

INSTITUTIONALISED CULTURE

In attempting to keep birth normal within the medical model, midwives often find themselves increasingly influenced by the powerful culture of institutions that prevents them from

delivering care that is congruent with the principles of good midwifery practice. Hodnett et al. (2002) described the phenomena of institutionalised culture as being the strict adherence to protocols and practices that practitioners must follow, resulting from the dominant influence of the institution of hospitals. They claim this has a direct relationship with the increasing medicalisation of childbirth, characterised by the over-use of routine interventions. In their study of continuous labour support by nurse-midwives, they suggested that the culture of some maternity institutions had a significant influence on birth outcomes, in particular those that used high rates of technology for low risk women (Hodnett et al. 2002). Although this research was undertaken in North America and the participants were *nurse-midwives* with a different set of educational requirements, this research remains relevant for its similarities between the institutionalised culture of both the American and Australian maternity facilities. In examining the role of the midwife in Australia, Homer et al. (2009) found that the barriers that prevented midwives from practising to the full scope of their profession included the domination of medicine and the institutional system of maternity facilities. The authors sought to explore the factors that defined the role and profession of the midwife in Australia and found that both these barriers diminished the visibility and understanding of their role perceived by the wider community (Homer et al. 2009).

Freidson (1970) defines a profession as distinct from other occupations in that is has been given the right to control its own work. However, many midwives currently practising in developed countries are not able to claim the autonomy and self-governance that the professional status of midwifery warrants because the culture of hospital organisations and their policy guidelines, create a conflict (Davis-Floyd 2001; Keating & Fleming 2007; Blaaka & Schauer 2008). Green's (2005) work is a typical example of this. Green conducted an ethnographic study of the practice of midwives and doctors in a large UK maternity unit. She found, in general, that midwives conformed to the guidelines and policies of the unit in order to avoid confrontations with the managers and obstetric consultants, despite feeling that some of these guidelines were not clinically indicated. Furthermore, the midwives in this unit felt although that they took responsibility for the care of the labouring women, they did not feel they had any significant control over the outcome of the birth as the units' protocols and obstetric consultant's presence dictated the progress of labour (Green 2005).

In a similar vein, Keating and Fleming (2007) found that the midwives in a hospital setting, despite their attempts to facilitate normal births, became disempowered by the authoritative knowledge embedded in the hierarchical status of obstetrics. Despite the commitment and

experience of the midwives, they were strongly encouraged to practice midwifery in a way that embraced medical technology. This was often contrary to their own philosophical beliefs of childbirth (Keating & Fleming 2007). One of the midwives in their study was quoted as saying:

The obstetricians here direct all the care and make all the decisions (p.552*).*

It is clear from their study that despite midwives' feelings and beliefs regarding childbirth, the dominant obstetric culture does not allow them to practise in ways they believe facilitates normal birth (Keating & Fleming 2007). The above quote also illustrates a particular autocratic management style by the obstetricians that suggests there is not much scope for midwives to make a contribution.

This differs to an Australian study by Moore (2009). Her study examined midwives working in a new continuity of midwifery care model. In contrast to the aforementioned findings, she found that none of the midwives she interviewed had experienced a sense of subordination or of being undervalued by their medical colleagues. She attributed this to the power of this new midwifery model being based on reciprocated and respectful collaboration between the doctors, midwives and other maternity care providers (Moore 2009). The numbers of the participating midwives in this study were small and recruited from the same maternity institution, which suggests that this particular facility may have already possessed a healthy culture of mutual respect amongst midwives and obstetricians (Moore 2009). Conversely, the midwives that were recruited for my study were from a variety of different hospitals, which was designed to avoid one particular maternity institution's culture.

MANAGEMENT STYLES

Midwifery philosophy is embedded within the concept of *communicative action* between the midwife and the woman with the central aim of facilitating autonomy for both parties (Hyde & Roche-Reid 2004). Communicative action can be described as a means of interacting and decision making by general consensus, resulting in a co operative coordination of resources (Habermas 1984). Additionally, human freedom can be defined by our ability to communicate in a way that is not corrupted by power, egocentricity or irrational concepts (Habermas 1984).

Porter et al. (2007) undertook a study in the U.K. designed to explore why midwives used a particular decision making style when relating to the use of technology during childbirth.

They found that despite being drawn to this positive style of communicative action, midwives in their study often adopted a bureaucratic decision-making method in response to the management strategies in the unit, workload pressures, medical dominance and fear of litigation (Porter et al. 2007). This descriptive qualitative study also found that some midwives were not comfortable establishing an equitable relationship with the women in their care as they felt confronted by any perceived shift in the dynamics (Porter et al. 2007). These midwives were not willing to relinquish the level of control they felt they had over the women in their care (Porter et al. 2007). One midwife in their study admitted that she struggled matching her ideological beliefs about her practice and decision- making with the reality of working in the *real world* (Porter et al. 2007, p.529*).* The authors suggested that managers examine strategies that encouraged midwives to include women in the decision-making process of labour and birth. They argued this would help to redress the power relations embedded in these institutions and instigate a managerial style they advocate called *new professionalism* (Porter et al. 2007).

New professionalism is described as *where control is shared between professional and client* (Porter et al. 2007 p.526). Although widely supported in midwifery circles, this has not been adopted as common practice (Porter et al. 2007). Rather, in their study, midwives appeared to prefer a style that was more paternalistic in approach, one that was more congruent with the hierarchy of medicine and nursing (Porter et al. 2007). Whilst their study did not examine midwives' beliefs about childbirth, it could be suggested that adopting a more woman-centered approach to childbirth would foster this new professionalism, and could significantly impact upon care that midwives offer women.

In contrast to the traditional paternalistic model of care, Walsh (2006) found that freestanding birth centres demonstrated an alternative organisational management ethos. These alternative models of care, encouraged midwives to be less task-oriented thus focusing on the intuitive caring aspects of midwifery practice. Walsh (2006) attributes this to the lack of centralisation of these free standing units compared to the larger hospital maternity units. This resulted in less surveillance by managers and more autonomy for the birth centre midwives. He argues that as women accessing birth centres experience lower intervention rates in labour, managers and health policy makers should embrace characteristics of the post-bureaucratic organisational styles adopted by birth centre midwives (Walsh 2006). My study seeks to explore how management styles and the resulting cultures are likely to influence midwives' beliefs and practice.

FEAR OF CHILDBIRTH INFLUENCES PRACTICE

It has been recognised that many women have a fear of childbirth (Cleeton 2001; Kitzenger 2005; Morris 2005; Fisher et al. 2006; Bergernon 2007). The concerns that contribute to the fear include concerns about fetal wellbeing, the pain of labour, loss of control and physical trauma. A literature search revealed only a small amount written about the influence that health care workers' fears have on the process of childbirth. In this literature there appears a specific link between perception of risk, fear and intervention (Saisto & Halmesmaki 2003; Regan & Liaschenko 2007).

Fear and risk are often intertwined in maternity care. The interpretation of risk during labour is often defined by external factors such as the culture of specific institutions, bureaucratic protocols and medical dominance. However, there is little in the literature that explores the internal experience of childbirth practitioners, in particular midwives, and the ways in which their interpretation of risk influences their practice. In an interpretive study involving interviews with midwives on their beliefs about normal birth, some midwives observed that if they began to feel fearful during the process of childbirth, they became less able to care effectively for the woman in labour (Powell et al. 2004). Furthermore the midwives thought their anxiety impacted negatively on the birth outcome.

A more recent study conducted in Scotland, examined 102 midwives' perception of risk in relation to their referral decisions and summoning assistance during the intrapartum period (Styles et al. 2011). The findings from this research established no direct correlation between years experience, personal perceptions of risk and the timing of referrals. However it did reveal a significant difference between particular area health boards, which could indicate that the culture of particular institutions influences midwifery care (Styles et al. 2011). In examining the data from this study, the authors found that midwives in one particular area health service referred significantly earlier than those in the others. On closer examination of this, it was found that this area health service had recently experienced several highly publicised adverse outcomes, which may account for the more conservative approach to intrapartum care by the midwives (Styles et al. 2011). This suggests that the memory of a negative clinical outcome can influence a midwife's perception of fear and risk and impact on further decision-making.

Similarly, Green (2005) in an ethnographic study about midwives' perceptions of caesarean section births in the U.K. observed that midwives often made conservative decisions and

intervened early rather than take what they perceived to be a risk and the subsequent responsibility for a poor outcome. This study concluded that some midwives struggled to cope with the uncertainty of labour and relied on the use of partograms, routine procedures, and strict adherence to protocols as coping strategies rather than using traditional midwifery skills, which involved a more individualised approach (Green 2005). This study was conducted in an inner city hospital in an impoverished area that had 3000 births per annum and an 18% caesarean birth rate. In general, the midwives in this study felt that most of the control and decision-making made during childbirth was done by the obstetric consultants in the unit and that they felt they had a limited sense of *ownership of the women* in their care (Green 2005, p. 295). Some midwives however were comfortable in having the ultimate responsibility of birth outcomes in the hands of the obstetricians as this alleviated their sense of anxiety around their perceptions of risk in childbirth (Green 2005).

In two large UK and European qualitative studies of midwives' perception of intrapartum risk (Mead & Kronbrot 2004; Mead et al. 2007), it was found that midwives underestimated the ability of women to give birth naturally and overestimated the positive effects of technological interventions. The authors in one of these studies suggested as midwives are central in recognising when labour deviates from the norm, it could be assumed that they are also instrumental in the rising use of intervention (Mead et al. 2007). The authors questioned whether this was due to a lack of ability in identifying true risk factors of labour or rather an underlying fear of labour that influenced midwives in seeking obstetric involvement (Mead et al. 2007). It would appear that in these studies, midwives have a great deal of influence over the initiation of obstetric intervention.

As midwives are strongly influenced by the practices of their obstetric colleagues it is of interest to know more about the perceptions held by their colleagues. In 2001, The Lancet published a review of North American's obstetrician's personal choices for childbirth, which demonstrated how the fear of vaginal birth, in particular, sexual functioning and bladder integrity post birth, influenced the swing toward elective caesarean sections in 31% of those interviewed (Wax et al. 2004). Clearly, professional experience influenced their beliefs about childbirth and this indicates that the obstetric frame of reference and experience was more about risk and fear minimisation (Wax et al. 2004). This has also been explored in a Canadian survey of self-reported attitudes of midwives, obstetricians and family medical practitioners (Reine et al. 2004). Their study found that obstetricians were the most supportive of women who requested an elective caesarean without a medical reason (Reine et al. 2004).

Furthermore, the obstetricians were reported as perceiving the increased use of childbirth technologies and caesarean section rates as a reflection of better maternal and infant outcomes and not the overuse of these interventions (Reine et al. 2004).

Fear of the ramifications of birth and the potential negative impact on caregivers also may drive practice asserts an Australian midwife Morris (2005) in her research entitled *Is Fear at the heart of hard labour*? Morris argues that both obstetricians and midwives are strongly influenced by the fear of litigation. Although midwives are not often the direct cause of birth trauma leading to litigation, they are encouraged to practice within a defensive*, just in case* framework and spend an inordinate amount of time documenting their justification of clinical decisions (Morris 2005). This atmosphere of anxiety has resulted in a loss of confidence by midwives to trust in their ability to facilitate normal births (Morris 2005).

In New Zealand a similar experience has been found. Crabtree (2008) reported that some midwives described their practice as being governed by a sense of fear, not only of things going wrong and being found to be negligent but also fearful of the authority of the obstetricians as demonstrated in this quote:

> *Sometimes I am a defensive practitioner, because if I'm not seen to be safe by the medical model I have to refer women… If I know that I am going to have to consult (*to the doctors*)... I may modify how often I do things* (p.6).

Again in New Zealand, Holland (2001 p. 17) notes that as *we live in litigious times* it is not surprising that midwives are fearful of a bad outcome resulting in a court case or a disciplinary hearing. She cites the media as being responsible in part for reinforcing the fear of childbirth, as these cases often become high profile as a result of the news coverage. Pearce (2000) recognises the problem of midwives becoming fearful of childbirth as she asserts that it has the potential to change the way a midwives cares for women. As she states:

> *…it robs us of our joy: it takes away our trust of women… it alienates us from our colleagues, both medical and midwifery…it also means that we start doing things for the wrong reason and that can result in harm* (p.17*).*

Australian midwifery academic, Dahlen (2011) in discussing childbirth and *the shroud of death,* describes the fear of losing a baby in their care as being the greatest fear of maternity care providers. She claims *fear proliferates* and that it can influence the way in which health care practitioners advise and counsel their clients, tending to respond according to an *action*

bias (Dahlen 2011, p.19). Action bias is described as an overreaction to the small likelihood of risk or harm, but additionally those who practice in this manner are often rewarded for being seen as safe practitioners (Dahlen 2011). She challenges midwives and obstetricians to *revere birth* and not *fear birth* (p. 21). In her recent research involving over 400 midwives and doctor's views on fear in childbirth (Dahlen 2011), she observed that midwives can be misguidedly reassured by the use of technological interventions as this quote from a student midwife illustrates:

> *It is sad but I feel more comfortable when it is all happening (induction, epidural, continuous electronic fetal monitoring) because it's what I know, normal birth frightens me* (p. 160).

It is evident from the literature that the perception and experience of the fear and risk during childbirth is a strong factor in determining the ways in which midwives and obstetricians care for women during labour.

The next section discusses common interventions used in childbirth in developed countries, the indications and implications of such technology and describes how midwives are positioned within this context. Understanding common interventions is important in this study as they have become an integral part of midwifery practice. I was interested in exploring why and how midwives engage with or resist these practices as they have been shown to influence birth outcomes.

MIDWIVES AND INTERVENTIONS

The increasing worldwide caesarean section rate has led to a body of research attempting to identify relevant influential factors. The next section focuses on several concepts identified as being significant in understanding midwifery care, interventions and caesarean section rates.

Interventions in childbirth are usually technological in nature and include use of continuous electronic fetal monitoring, epidural anaesthesia, routine artificial rupture of membranes and the use of syntocinon infusions (to speed up labour). These can be initiated by midwives, however all require obstetric supervision in some manner and can lead to the known cascade of intervention that results in further technologies being used to counteract the previous technological intervention (Tracy et al. 2007). Although studies regarding interventions have been inconclusive as to whether they are a definite predictor for the rising caesarean section

rate, there remains a tangible link between the two (Alfirevic et al. 2006; Green & Baston 2007; Tracy et al. 2007).

It could be argued that, as midwives are involved in all births in Australia, the increase in caesarean section rates in some ways reflect on the nature of midwifery care. In this current climate of increasing interventions during labour and birth, Downe (2006), questions whether these intervention rates are a result of midwives' actions in calling for obstetric assistance and a lack of belief on normal birth. I suggest that this question highlights the need to examine not simply the external factors that impact on midwives' practice, but also the influential factors embedded within the midwives themselves, that is, their beliefs about childbirth. Anecdotal evidence regarding different midwives' clinical outcomes within the same unit suggests that internal factors are at play, specifically the midwives' perceptions of birth processes (Regan & Liaschenko 2007).

CAESAREAN SECTION RATES: INDICATORS AND IMPLICATIONS

In Australia today, one of the most common surgical procedures performed is caesarean sections (AIWH 2010). Over the past several decades, Australia's caesarean section rate has risen from 18% in 1991 to 20% in 1997 and then to 31% in 2007 (AIWH 2010). These rates are in keeping with other industrialised countries. Clinical variants such as malpresentations, poor progress and fetal distress are cited as major contributing factors. Other indicators include advanced maternal age (Callaway et al. 2005), maternal request (Hannah 2004; Robson et al. 2008) and the increasing litigious climate of obstetrics. Obstetricians' preferences and personal practices have also been suggested as influencing these rates (Goyert et al. 1989; Studdert et al. 2005). Additionally, women in Australia who are being cared for by a private obstetrician in a private maternity facility have a significantly increased likelihood of having a caesarean birth (AIWH 2010). However one of the leading reasons for caesarean section births in Australia is having had a prior caesarean section and therefore it is paramount that women having their first baby are given every opportunity to give birth normally (Stavrou et al. 2011).

Of concern are reports of women in Australia and other western countries requesting elective caesareans for non-medical reasons although these numbers are small (Declerq et al. 2007: Wiklund et al. 2008: Stravou et al. 2011). An Australian study, undertaken by a private

obstetrician who strongly supports caesarean section births as safe, reported that the most common reason given by women who request caesarean births is that they believe it is safer for the baby (Robson et al. 2008). The same study indicated that these women had concerns about their pelvic floor integrity and the risk of perineal trauma post vaginal birth (Robson et al. 2008). Bewley and Cockburn (2002) make the point that many of these beliefs are grounded in misconceptions, fear and lack of medical evidence. However, other more recent studies indicate that elective caesarean sections can avoid serious birth trauma and morbidity to the neonate (Hankins et al. 2006; Signore et al. 2006) and have only significant risks to women once they have had more than two operative deliveries (Silver et al. 2006). There are, however, well-documented risks for women who undergo this major abdominal surgery. These include increased rates of re hospitalisation for uterine infections, wound break down resulting in sepsis, bladder dysfunction and thromboembolic complications (Hannah 2004). The consequences for further pregnancies include an increased risk for placental abruptions and accrete which can then be translated into a higher incidence of peripartum hysterectomies (Wax et al. 2004). American medical researchers Menacker et al. (2006) suggest that the increasing amount of elective caesarean section births following a primary caesarean, reflects the ways in which women are counseled by their maternity care provider about the risks and benefits of attempting a VBAC (vaginal birth after caesarean). They assert that the physicians do not fully explain the inherent risks for mother and baby regarding caesarean section births, possibly due to the conflicting interpretation of the evidence regarding both modes of birth (Menacker et al. 2006)

The complications for neonates arising after caesarean births are generally considered to be mild and temporary, however these vary according to gestational age at birth and whether any pre labour had occurred. Caesarean section births resulted in an increase of neonatal intensive care unit admissions than normal vaginal births (Tracy et al. 2007). Babies born at term and who had experienced some labour, exhibited less signs of distress at birth than those who were pre term elective caesareans (Tracy et al. 2007). These include respiratory distress syndrome and transient tachypnoea of the newborn, which often requires a short stay in the neonatal intensive care unit, resulting in separation from their mothers (Tracy et al. 2007). Of a more serious nature is the unexplained stillbirth rate that doubles for babies at or after 39 weeks gestation to women who have who had a previous caesarean section (Smith et al. 2002). Shorten (2007) found that the increasing rates of caesarean sections had not resulted in overall improved outcomes for women and neonates.

Although McFarlin (2004) claims that a woman has a right to make autonomous decisions regarding the mode of childbirth, it would appear that this option of requesting a caesarean section for non medical reasons is complex and indeed potentially dangerous, and has significant implications for allocations of health care resources. In a national survey in the U.S, entitled *Listening to Mothers,* the authors concluded that there is much evidence indicating the long term negative effects both physically and emotionally on mother and infant in regards to caesarean births (Declerq et al. 2007).

The increasing rates of caesarean section births has relevance to my study as this phenomenon creates a culture of birthing that is embedded in technology, risk and fear, and thus changes the ways in which midwives care for women.

CONCLUSION

This chapter has examined the current and relevant literature that is pertinent to my research. What is understood by the current literature available, is that midwives often respond to the culture of their workplace and feel compelled to practice accordingly to the accepted norms of their particular birthing unit. This has been revealed in the literature as being, in general, an obstetric model of care that diminishes the capacity of the midwife to work in a way that she sees best facilitating normal birth. This review of the literature has revealed a gap in the knowledge that surrounds midwives' thought processes as they care for women in childbirth. The thesis will expand on these issues in Chapters four and five where the findings and discussion of the data indicates that these issues influence the ways in which midwives care for women during labour.

The following Chapter discusses the study's methods, design, data collection and analysis, as well as the theoretical frameworks that inform my qualitative research.

CHAPTER THREE: METHODS

> *Doing effective interpretive research requires that we do something meaningful that furthers our understanding and stimulates us to more informed and, hopefully, more humane thought and action* (Angen 2000, p.392).

INTRODUCTION

This chapter describes the theoretical frameworks, research design and methods used to address the aims of the study. The chapter will also explore my own experience of undertaking this research, the ethical considerations encountered and the challenges in designing and carrying out the research rigourously.

The study used a qualitative approach with photo elicitation as the prompt for conducting interviews with midwives. Photo elicitation involves the researcher utilising images as a tool to evoke responses from participants. These responses are thought to originate within the deep sub-conscious level of the brain and therefore it is surmised that this provides insights into the thought processes that motivate a person's actions (Harper 2002; Oliffe & Bottoroff 2007; Regan & Liaschenko 2007). As my study's aim was to explore midwives' beliefs about childbirth, this methodology was chosen for its ability to access the cognitive processes that motivates midwifery action. Thematic analysis was then employed to analyse the data into a meaningful and relevant discussion about the ways in which midwives interpret labour. Thematic analysis involves recognising, organising and encoding the data into themes and sub-themes that have re-occurred within the data (King 2007). These themes are then interpreted in a descriptive inductive process that offers a synthesis of the data reflecting the views of the participants. Photo elicitation and thematic analysis will be further explained in this chapter. The next section describes qualitative research and shows why this was appropriate for my study.

QUALITATIVE RESEARCH

Qualitative research methods are commonly utilised in social and behavioural science disciplines, as they are designed to seek an understanding or clarification of a specific experience or phenomenon of human behaviour (Sandelowski 2000; Lavender et al. 2004). Midwifery, being a *practice* discipline, intimately involved with interactions between

women, is well suited to qualitative research as this method is often used to explore a particular experience (Burns & Grove 2005). Quantitative research, as opposed to qualitative, is frequently described as being a *hard science that involves rigor, objectivity and control* and suggests that there is only one *reality that one could define* (Burns & Grove 2005 p.133). Qualitative research offers a somewhat more organic and subjective approach to research (Oakley 1981; Angen 2000). Munhall (2001) asserts that subjectivity is necessary in qualitative research as it enables the researcher to gain a broad scope of understanding of the phenomena at hand. Although qualitative methods are often referred to as *soft and subjective*, (Grace & Hedges 2011, p. 90), I suggest that the nature of qualitative approaches such as in-depth interviews, presents a possibility of discovering a rich and varied data set that has the potential of illuminating truth and reality as described by the participants. Qualitative methods also have the capacity to expose the social constructs and forces that influence human behaviour by means of interpreting the participant's perceptions of specific phenomena (Beanland et al. 1999; Lavender et al. 2004). As this study seeks to interpret the experience of midwives working with labouring women, a qualitative method was employed.

THEORETICAL OR PHILOSOPHICAL FRAMEWORKS FOR THE STUDY

Finding a theoretical framework for this research proved to be challenging. As qualitative research is not testing a specific theory as in quantitative methods, it requires a different set of parameters in which to frame the research. The philosophical framework of any qualitative research guides the questions asked, the aims of the study and the interpretation of the data. It is therefore necessary to be specific about the philosophical paradigm in which the research rests (Munhall 2001; Burns & Grove 2005). In this way, the methodology and the philosophical framework can afford a symbiotic relationship, which is explicit in its connection to the data and with each other (Lavender et al. 2004; Burns & Grove 2005). Much of the literature pertaining to qualitative research points to well utilised methodological frameworks such as grounded theory, phenomenology, ethnography, critical social theory and philosophical inquiry (Simms 1981; Burns & Grove 2005; Schneider et al. 2007). However, Richards and Morse (2007) suggest that qualitative research need not adhere strictly to one particular philosophical viewpoint and that elements of several frameworks, that is, mixed methodologies, may be interwoven in the process of conducting the study. Sandelowski (2000, p. 335) describes how the increasing number of health related qualitative studies has

led to a plethora of methodologies resulting in *methodological acrobats* where researchers are unsure how to position their study within a particular theoretical framework. This was certainly my experience as I attempted to situate the research within a specific theoretical orientation. I draw upon the following two frameworks in undertaking the research: *Keeping Birth Normal* and *Feminism.* These are both explained in the following sections.

KEEPING BIRTH NORMAL

The research sits within a philosophical framework of *keeping birth normal.* This best expresses my personal, clinical and academic approach to my profession and encapsulates the underlying premise of my rationale for seeking to understand how midwives interpret childbirth**.**

As described earlier, there is growing concern from consumers, health professionals (Downe 2008) and politicians (Commonwealth of Australia 2009) about the increasing intervention rate during childbirth. Previous chapters have described the rates of intervention in childbirth in Australia. The predominant technocratic model of care in most maternity facilities in the western world is resulting in a diminishing number of women who are able to achieve a normal birth experience (Davis-Floyd 2008). Sandall (2004) estimates by the end of this century, less than one third of women in developed countries will achieve a normal birth. The concept and definition of what constitutes normal birth is contested amongst women, midwives and obstetricians (Page 2000; Downe 2006; Crabtree 2008; Davis-Floyd 2008). In the simplest terms it implies an *absence of technical intervention* (Downe & McCourt 2008, p.3). WHO (World Health Organization 1996) recognises the importance in maintaining normal birth rates and recommends specific care practices during labour that aim to facilitate physiological birth as outlined by Romano and Lothian (2008):

- allowing labour to start on its own
- freedom of movement during labour
- continuous labour support
- spontaneous pushing in non-supine positions
- no routine interventions

The implications for maternity heath care providers adhering to these practices during healthy uncomplicated pregnancies and birth are paramount for many reasons. There is evidence to

suggest that the experience of birthing normally enhances the infant bonding process, assists in initiating breastfeeding and builds confidence in new mothers (Kitzenger 2005). Normal births also result in reduced rates of morbidity and trauma to both women and babies (Page 2000), reduced length of stay in hospital (Tracy & Tracy 2003) and are far more economical for the health budget than childbirth that is technologically assisted (NSW Health 2010).

In 2010, as a response to the growing concern expressed by maternity stakeholders regarding the increasing caesarean section rates, NSW Health launched a policy directive entitled *Towards Normal Birth* (NSW Health 2010). The policy is designed to direct NSW maternity care providers in implementing ten specific steps in order to promote and support normal birth. These steps include the option of water immersion during labour for women, one-on-one midwifery care for all primiparous women and women undertaking a vaginal birth after a caesarean section birth, access to external cephalic version for breech presentations and having a written policy that informs all women about the benefits of normal birth and factors that promote normal birth (NSW Health 2010, p. 7). A comprehensive set of guidelines are provided to all Area Health Services in NSW that will assist in reaching the strategies outlined in this policy and all maternity facilities will be required to report annually against these goals (NSW Health 2010, p. 7).

Midwives are in a powerful position to facilitate normal birth for women, as they are the primary care givers during labour. In examining the literature and debate around normal childbirth one U.K midwifery leader, Mead (2008) states:

> *Instead of approaching labour from a perspective of a catastrophe waiting to happen, it is time for professionals to regain their trust in the physiology, which enables healthy women to labour and deliver, mostly without interference. Pregnancy and labour should be seen as normal until proven otherwise.* (p. xi)

The importance of approaching childbirth as a normal physiological life event is also iterated in The International Confederation of Midwives (2009) mission statement that outlines midwives as being th*e most appropriate caregivers for childbearing women and in keeping birth normal.* It is with this premise that I approach the research.

FEMINIST FRAMEWORK

The second framework that is embedded is this research is a feminist framework. Being a feminist I consider this research having been conducted and viewed through the lens of feminism. One nursing scholar (Rafael 1997) describes feminism as:

> *... based on the premise that gender is a central construct in a society that privileges men and marginalises women ... feminism seeks to expose patriarchal power relations in societal institutions, particularly those that generate knowledge* (p.34).

I choose this quote as I feel it reflects the position that midwives find themselves in, that is, being marginalised and somewhat overlooked in favour of men (that is, for the most part doctors). In this context I replace *men* with *medicine* as the patriarchal framework that midwives working in maternity institutions are situated in. This concept was addressed in both Chapters One and Two and will be discussed at length in Chapter Five.

The above quote also illustrates my own position in conducting the research and interpreting the data, as I have attempted to understand the ways in which medicine, constructed by society as being an authoritative body of knowledge, impacts on midwifery care. Barnes (1999) argues that as contemporary midwifery is an evolving discipline that seeks to offer more congruent models of care for women, midwifery research should embrace the philosophical underpinnings of feminist theory as it reflects midwifery's defining quality of woman centred care.

There are multiple theories of feminism that define the history, progress and interpretation of the scholarship of feminism (De Beauvoir 1943; Croft 1987; Sapiro 1990; Wolf 1994; Freedman 2002). I have opted for a broad conceptualisation of feminism in approaching this research. This focuses on placing the woman at the centre of the experience and seeks to acknowledge the profound significance and impact that childbirth has on the woman, her family and the community (Leap 2000; Brook & Barnes 2001). Seibold et al. (1994) in their examination of what constitutes a feminist approach to theory and research, offer the following principles in which to ground research. They note that these need not be a rigid checklist, but rather a guide through which to approach the research process within a feminist lens. Their principals are:

- That women's experiences are the key purpose of inquiry

- That the researcher(s) is committed to view the world (or experience in question) from the vantage point of the woman
- That the researcher(s) is proactive in attempting to better the outcome for women.

These principles informed the ways in which I approached this study and in particular guided my interview techniques and interactions with the participating midwives. I was aware that the interview situation has the potential to place the researcher in a position of power and authority over the participants, which is a contradiction of terms in relation to feminist research principles as Oakley (1981) points out. I will address the ways in which I approached the interview process with this in mind in a later section.

Feminist research is also concerned with the appropriate use of unbiased gender language. For example, the use of the word *soft* when describing qualitative research infers a feminine and less powerful quality. In contrast, quantitative research is often referred to as *hard* which indicates a masculine quality, one that is aligned with power and strength. This gender stereotypical language is criticised by feminist researchers as favouring male centred language that undervalues the essence of qualitative research, which focuses on the lived experience of a phenomena (Crawford 1995).

Central to feminism is the desire for all women to maintain agency (Meyers 2010). In other words, feminists believe in the right for women to have independence in their life choices and the ability to act autonomously without being oppressed, discriminated or devalued by virtue of their gender. Furthermore, feminism seeks to examine and debunk the influence of *gendered thinking* that constructs women's undervalued social and professional status (Crawford 1995). Holland, Blair and Sheldon (1995) describe feminist research simply; *to put the social construction of gender at one's centre of inquiry* (p.294*).* My study highlights the inequalities between the midwifery and medical models and seeks to address this imbalance. This will be discussed further in Chapter Five.

I approach this research with the explicit desire to interpret and understand the experience of midwives (women) caring for women in labour and to *unpick* the elements that disempower and undermine midwives in their workplace, in this instance the patriarchal domain of the hospital. In this sense, I see that midwives are struggling to maintain agency in their profession. It is my aim to construct a useful discussion through my research that suggests ways in which the midwifery profession can strive to maintain visibility, validity and

recognition whilst working within the dominant culture of medicine. The use of a feminist framework is therefore central to this research.

In order to draw useful insights, I have chosen to discriminate against the small percentage of midwives who are male, and classify midwives in general as being female. I apologise to these individuals and acknowledge their contribution to midwifery and also grant that they may well have experienced challenges in entering this female dominated profession.

In addition to the philosophical framework of keeping birth normal and research through the lens of feminism, I now expand on another significant viewpoint that has influenced the design and implementation of this study. The underlying principle of this research is based on the premise that our actions are a direct response to the way in which we frame our belief systems. In other words, what a midwife believes about childbirth should be congruent with her actions. This assumption is a well-accepted theory in behavioural sciences and psychology (Gopnik 1998). The next section examines the concept of how our cognitive frameworks influence our actions.

COGNITIVE FRAMEWORKS

It can be generally assumed that we take action based on a complex set of motivations, not solely influenced by our experience alone, but ones that are culturally, socially and emotionally constructed (Freud 1960; Reber & Reber 2001). This theory is grounded in psychology and social behavioral studies that seek to understand how and why we act in certain ways. Funder (2001) examined the concept of the way cognitive frameworks individuals holds about particular issues, motivate us to act in accordance with these subconscious belief systems. However, he asserts that our motivations are also enmeshed with the traits of our personalities, which have a direct influence on the way in which we choose to initiate action (Funder 2001). Regan and Liaschenko (2007) state that:

> *A cognitive frame is an abstract mental schema used to structure assumptions, attitudes and beliefs to generate understanding and guide action in a given situation* (p.613).

The study of cognitive neurology (examining the capacity of the brain to synthesise information and interpret this knowledge into action) has demonstrated that most of our responses to stimuli are reactive and reflexive and not purposefully deliberated upon (Westen 1999). However in any repetitive work, such as some midwifery routine procedures, once the

initial skills have been learnt and stored, they can be accessed without much conscious deliberation. In other words, the tasks that midwives perform frequently are things that seemingly require little attention. Kitson and Strauss (2010) believe that this is problematic, as this lack of attention to routine tasks has the potential to lead to a gap between practice and evidence. This has implication for my study, as although I am not concerned with the clinical tasks that midwives perform, I am examining the subconscious thought processes that motivate these tasks. The implications for this study being that midwives' interpretations of childbirth are based on both perfunctory skills and the existence of subconscious responses. I am interested in the midwives' cognitive frameworks that inform these subconscious responses and how these frameworks have the ability to determine how midwives understand childbirth.

Seligman's (1992) work in clinical psychology proposed that human behaviour originates from either a pessimistic or optimistic outlook on life and that it is from either of these frameworks that we construct the ways in which we approach life. Whilst my research does not investigate the participating midwives' personality traits it is conceivable that these have significance in relationship to their perspectives on childbirth. I have detailed in my literature review some of the factors that implicitly motivate midwifery decision-making.

ETHICAL CONSIDERATIONS

A number of ethical considerations were identified in planning for this research. Burns and Grove (2005, p.207) outline the principles that should inform the researcher when conducting research, these being *diligence*, *expertise, integrity and honesty*. Furthermore informed consent and the assurance of confidentiality and anonymity must be considered when carrying out research involving humans. These aspects were addressed in the proposal to the UTS Human Research Ethics Committee (HREC) in December 2008. The participating midwives were all given a written document describing the research process and what their participation involved. They were asked to sign the consent form. Additional information was made available to them and they were assured of confidentiality and the opportunity to withdraw from the study at any time with no obligation.

The storage of data was also addressed as per UTS ethics protocol that was outlined in the ethics proposal and includes the de-identification of the participants, the destruction of the verbal tapes and the storage of the hard copy data to be held in a locked secure place for a period of seven years (UTS HREC 2008).

Ethical approval was sought and final approval granted in February 2009 (see Appendix 2). It was recommended by the HREC that in view of the potentially revealing information midwives may disclose during the interview process that they be encouraged to seek counseling from their hospital's counseling service if they become distressed or concerned after the interview. Whilst I did not anticipate that this could occur, I am aware this is an ethical issue and endeavoured to make the interview process as safe and supportive as possible. Each participating midwife was made aware of her health facility's Employee Support Program. This service is available to any public hospital employee who wishes to discuss any work related issue in confidence and they can receive counseling as required. Additionally my contact details were made available to the midwives should they wish to speak or meet with me after the interview process.

I was guided in my approach to this research by the ethical qualities outlined by Burns and Grove (2005) who assert that the rights of the individuals involved in research need to be protected by the researcher. These include: *self-determination, privacy, anonymity and confidentiality, fair treatment and protection from discomfort and harm.* (p.207)

METHODS

SETTING

All 12 midwives in this study were currently practising in birthing service settings in various metropolitan maternity hospitals (n=5) in Sydney at the time of interviewing. These hospitals, on average catered for between 2000 to 4000 births each per year. One of these midwives also practiced as an independent midwife caring for women both at home and in the hospital setting.

The hospitals in which these midwives worked in were all described by the midwives as being *busy* most of the time, with a mixed caseload of both low and high risk women. Midwives were usually expected to care for at least two women simultaneously at any time during their labour as well as attending to additional tasks. All but one of the hospitals were public hospitals and all of the maternity wards were attached to a larger general hospital. Two hospitals had birth centres attached to the main maternity section. The public hospitals were staffed with obstetric doctors (residents, registrars and consultants on site) and midwives who worked in the private sector were able to call in the obstetricians when they deemed it necessary. Chapter One of this thesis outlined the context of maternity services in Australia.

SAMPLE

A purposeful sample of 12 midwives was selected from the Sydney metropolitan area who had a variety of experience and who worked in different hospitals and models of care. This was done in order to dilute any specific institution's influence on how midwives may interpret childbirth and to ensure a diverse sample. There was no age, gender, ethnicity or educational qualification restrictions in the sample. It is hoped that this sample, albeit small in size, would reflect a variety of practising midwives in NSW.

RECRUITMENT

The research was conducted in the latter half of 2009 and early 2010. An advertisement was placed in the midwifery newsletter *Midwifery Matters,* in June 2009 (see Appendix 3). This quarterly newsletter is published by the NSW Branch of the Australian College of Midwives. It has a circulation of approximately 1000 midwives in NSW .The newsletter publishes a wide variety of articles, photographs and stories that are relevant for contemporary midwifery practice. It also raises current political maternal and child health issues that the Australian College of Midwives is committed to. This newsletter was an appropriate vehicle from which to recruit midwives for my study as I felt many of the midwives who are both members of the Australian College of Midwives and who receive this newsletter would be interested in responding to, and participating in the research.

The advertisement specifically sought midwives who were currently employed in a birthing suite caring for women in labour or providing labour care at home. The advertisement outlined the specific requirements for those wishing to participate in the research (Appendix 3). Participation involved one interview face-to-face interview with the researcher (myself) in a quiet environment of their choice. Confidentiality and anonymity was assured according to the UTS Ethics Committee Research Guidelines (UTS HREC 2008).

Midwives who were interested and willing to take part in the study contacted me by telephone and I sent them an outline of the study, explaining the research and their participation as well as assurances of confidentiality (see Appendix 4). All midwives who responded to the advertisement were interviewed and became part of the study bar one, who was unavailable, due to work and family commitments, to be interviewed within the time frame of the research. All of the midwives were willing to meet with me and we organised a specific meeting time and place that suited them. Most of the interviews took place in a quiet room near or in the hospital where each midwife worked. Several others, at their request,

were conducted in the midwives' homes. This process took longer than I had anticipated as rosters, time, distance and other commitments required me to remain flexible and be prepared to postpone or change the meeting times.

At the beginning of each interview an explanation of the interview process was given and the midwife had the opportunity to ask any questions or express any concerns she may have. The midwives were asked to sign a consent form outlining the purpose of the study, their participation and an understanding of the option to withdraw from the study at any time with no consequences (see Appendix 5). Each midwife was aware that the interview was tape recorded, then transcribed, de-identified and that the data would be kept secure, and confidential as per UTS protocol (UTS HREC 2008).

DATA COLLECTION: PHOTO ELICITATION

> *Photographs and film are a form of documentation and can assume the status of evidence* (Riley & Manias 2004, p. 398).

Photo elicitation was used as the data collection technique as it is specifically designed to facilitate in-depth responses from participants. The next section outlines the origins and benefits of this particular research technique.

The way we view the world is dominated by visual stimuli that have a powerful influence on how we seek to understand and conceptualise meanings (Sturken & Cartwright 2001). Whilst photographic images are not widely used in nursing and midwifery research, the use of photographs for the purpose of interviewing participants in qualitative research has been shown to be effective in other disciplines (Killion 2001). These include psycho-therapy, social sciences, ethnographic studies and education (Epstein et al. 2006; Hurworth 2003).

The term *photo elicitation* was coined in the mid 1950s by American anthropological researcher John Collier who used visual images to engage his participants in the research process. Collier had been using images as part of the documentation of his study involving a long-term project with the Navajo Native Americans. However, when he begun to use photographs in the interview process during a later study involving communities in rural Canada, he reported a more revealing in-depth data collection. He stated that the use of the photograph had a *compelling effect upon the informant, its ability to prod latent memory, to stimulate and release emotional statements* (Collier 1957). Following on from Collier, Wagner (1978) described the use of photographic images in the interview process as one of

the most significant visual research strategies for its ability to stimulate responses. The use of photographs in anthropological and ethnological studies is well documented and has shown to have the ability to construct an understanding of a specific culture, to record historical facts and personal experiences in society and to enable a generating of knowledge (Prosser 1999; Hurworth 2003).

Prominent qualitative researchers in the field of visual techniques and health care, Wang, Burris and Xiang (1996) experimented with the use of photographs in several research projects they conducted in China. They expanded the idea of photo elicitation further, giving small cameras to village women in China to document and illustrate their poor health conditions. This technique was named *photo novella* or *photo voice* (Wang & Burris 1994*)*. Their research was reported to be a very powerful experience for the women as it involved them personally and gave them a sense of meaningful contribution (Wang & Burris 1994). It also enabled the researcher to witness first-hand the issues the women were describing and added validity to their findings as the images became proof of their situation (Wang & Burris 1994).

The research that has assisted with the development of my study used photo elicitation. Regan and Liaschenko's (2007) work in North America used a photograph of a labouring woman. The authors reported that they were able to make apparent the sub-conscious beliefs and explore the cognitive frames that the participating midwives held about childbirth by using an image to elicit their beliefs. They concluded that photo elicitation was an excellent tool that helped them gain insights into the varied ways in which midwives viewed childbirth (Regan & Liaschenko 2007).

There is evidence to suggest that this visual tool, photo elicitation, has many benefits for the researcher (Banks 2001; Prosser 1998; Rose 2001). It has been shown to prompt, remind and add depth to the answers in the interview process (Riley & Manias 2004). The photograph is something that participants can focus on and build stories around and begin to expand on their initial responses to the questions posed (Killion 2001). It also can de-formalise the rather artificial environment of the interview environment (Collier 1957; Hurworth 2003). Furthermore it takes the emphasis away from the participant and onto the image. It has the ability to draw the interviewer into the reality of what the participant is attempting to explain (Banks 2001). Both the interviewer and the interviewee can share information about the photo if appropriate and this can bridge the gap between professional and participant (Riley

& Manias 2004). These benefits were certainly obvious to me as I conducted the interviews, as the midwives were all very forthcoming about their perceptions of the photo and how this related to their own practice.

However, as a researcher I am aware that photographic images can be construed to be both emotive and manipulative in nature as they are often used to produce or elicit a specific response (Strurken & Cartwright 2001). Images chosen for advertisements are a prime example of this strategy. For this reason it could be argued that the use and choice of a research method that utilises photographic images is less than straightforward and should be used with caution. Mitchell (1994) in his observations of the theory of images writes that:

> *…we still do not know exactly what pictures are, what their relation to language is, how they operate on observers and on the world…*(p.13)

More recently Rose (2001) in her discussions of images used in research states that:

> *Visual imagery is never innocent: it is constructed though various practices, technologies and knowledges.* (p. 32)

Photo elicitation therefore, is a powerful tool and when employed in qualitative research has the potential to create a certain dataset of responses. It could be hypothesised that had I used a different image as a starting point in the midwives interviews, different themes and results would have emerged. However, by choosing a specific images, as I have done, affords the researcher a certain level of control in stimulating particular responses more relevant to the aims of the research.

THE PHOTO AND THE INTERVIEW

This section outlines the process of the interview, commencing with the importance of creating a non-hierarchical relationship between myself, (the researcher), and the participating midwives. With this mind, I communicated by phone and email with the participating midwives on several occasions prior to the interview to establish a rapport with them. The midwives knew that I was a practising midwife and my perception is that this helped in setting up an equal relationship as they felt we shared a common experience.

On meeting with each midwife and before the interview officially commenced, that is, the tape recorder being switched on, we chatted at length about our experiences of being a midwife and shared common stories. This relaxed us both and enabled a natural conversation to occur once the tape was activated. I was mindful not to appear as a *researcher*, but more as

a woman and a midwife interested in their personal experiences of caring for labouring women. Oakley (1981) in her critique of feminist research argues for a level of intimacy to be present between the interviewer and the interviewee as this allows for a spontaneous sharing of information that has the potential to produce rich and relevant data. This was certainly my experience during the process of conducting the interviews over six months.

To commence the formal part of the interview, the midwife was shown the photograph of the labouring woman (Appendix 1). This photograph was chosen for specific reasons, these being the amount of visual information in it that indicated various aspects of labour that the midwives could comment on. It is a *real* image, which was not constructed or re-constructed, depicting a woman in a hospital labour suite in early labour.

The photograph shows a heavily pregnant woman who is comfortable and looking relaxed in a room that appears to be set up for a normal and active labour. She has an intravenous infusion in place with a fluid (syntocinon) that is connected to a pump. This indicates that she is having some sort of medical intervention. Syntocinon is used to chemically induce labour for a variety of reasons. The reason it is being used in this scenario is because the woman's waters have been broken for some time (ruptured membranes) and she has not shown any signs of labour. Usually when this occurs for longer than 24-48 hours, it is recommended that the woman's labour is induced with this drug (Alfirevic et al. 2009). Additionally it is usual practice that the woman be attached to an electronic fetal monitor around her waist that continuously checks for any irregularities in the baby's heartbeat that may occur as a result of the infusing medication (NICE 2007). In this photo, the woman does not have any such monitor, giving rise to much discussion in the interviews about risk, safety and interventions. She is sitting on a ball, smiling, without monitoring evident. This was what I had hoped for in choosing this photograph, as I am interested in the midwives thought processes and perceptions around interventions. Consent for the use of this image was given by the woman in the photograph (Appendix 4).

I chose to use an image that contained multiple elements of visual information. The inclusion of the syntocinon infusion, for example, prompted the midwives to relate their experiences about this particular intervention and this led to a rich and detailed description of how they viewed caring for women who experienced this intervention. As I was particularly interested in how the midwives engage with or resist interventions, I anticipated that this strategy would be effective.

The midwives were given the following information as they viewed the photograph:

- the woman's pregnancy is at term (37 – 42 weeks gestation),
- she has had a healthy pregnancy,
- she has a strong desire for a normal natural birth
- she is being induced with an intravenous syntocinon drip for prolonged rupture of her membranes.

The process of the interview was semi-structured and for the most part I asked open-ended questions. Open-ended questioning has been shown to assist in the exchanging of ideas and information as it engages both the interviewer and the participant (Dillon 1997). Davies (Davies 2007) believes that engagement leads to learning and that the learning process is a social process that requires communication between both parties.

The questions I asked included:

- *What do you think is happening here?*
- *How would you care for this woman?*
- *From the information you have what do you think is important in planning your care for this woman?*
- *Tell me how you imagine this birth to progress?*
- *Why do you think this?*

There are many visual prompts in this photo that helped the midwife in the story she created around this scenario, in particular the use of a syntocinon drip and the lack of the electronic fetal monitor. As described in Chapters One and Two, Regan and Liaschneko (2007) asked specific questions that encouraged the midwives in their study to construct a hypothetical story of the woman's labour, giving rationales for their decisions made during the process of the birth. The authors reported a rich and detailed level of data was achieved using this *Projective Motivation Technique.* Projective methods are described as having the ability to access the participant's subconscious attitudes and beliefs and to identify implicit motives and meanings that they may not be aware of (Regan & Liaschenko 2007).

The process of conducting the interviews was an enriching experience for me. I was impressed by the ways the midwives described not only their work but also revealed their deeper expressions of emotions regarding their roles as midwives and advocates for women.

Casual chatting and informalities that in reality gave additional insight into the midwives beliefs about childbirth often accompanied the interviews. The midwives were engaging, open honest and forthright, which I attributed to the technique of using an image to stimulate their thought processes.

I chose to interview and to interact with the participating midwives personally during the interviews as opposed to the midwives being alone and talking into a tape recorder as in Regan and Liaschenko's study (2007). I feel this provided an opportunity to engage with the midwives about their thoughts on caring for women in labour and it offered an opportunity for clarification. The importance for clarification will be discussed in the section on rigour later in this chapter.

At the conclusion of the interview, the midwives were thanked for their time, participation and insights. They were aware that they could contact me if they had any concerns or if they had re-considered their decision to participate. We also discussed the possibility of any issues arising from the interview that were potentially distressing for them in their work as midwives. All of the midwives were aware of their own hospital's employee counseling service should they feel the need to seek some professional input. I followed up each interview with an email or phone call to the midwives approximately one month later to ensure that no issues or problems regarding the interviews had occurred. The midwives expressed no concerns regarding their interviews or participation in the research.

Once the data were collected, I began to transcribe the recordings verbatim. As I anticipated that this would take a large amount of time and therefore I employed the services of professional transcriber to lessen the load. This helped enormously and I was able to check the written transcripts against the audio data to ensure accuracy. However I appreciate the value of transcribing oneself as the data becomes more familiar and the intonations and expressions of meaning within the recordings are more evident to the researcher (Bewley & Cockburn 2002). I listened to each transcript at least three times to ensure I had an accurate understanding of what was being said prior to them being transcribed. As the process of listening and transcribing continued I felt confident that I had understood the essence of what was being described by the midwives.

DATA ANALYSIS: THEMATIC ANALYSIS

The data were analysed using thematic analysis. This section gives an overall description of this technique and also explains my own experience in analysing the dataset.

Thematic analysis is a qualitative research analysis tool widely used in the field of psychology but it is also appropriate for other related fields such as sociology, nursing and midwifery (Howitt & Cramer 2010)**.** Braun and Clarke (2006, p.78), in their discussion regarding the benefits of this technique, describe it as a flexible analytical tool that has the potential *to provide a rich, detailed and complex account of the data.* Furthermore, they say it makes evident the prevalence of occurring themes and directs the researcher to begin a hierarchical coding order that organises and clarifies the data set (Braun & Clarke 2006).

In using thematic analysis, Ryan and Bernard (2000) cited in Braun and Clarke (2006, p. 98), detail the use of a thematic map, which consists of a diagram of particular themes identified within the data, their prevalence, a description of and exemplars, as well as any opposing themes. The constant referring to, and adding of, subthemes, clusters and minor headings is a crucial step in the reporting and interpreting of the data as it provides a visual representation of the data set. Whilst I did not use a specific thematic map, I did have an intricate colour coding system that enabled me to identity, cluster, code and organise the themes and sub themes that emerged from the data. Braun and Clarke (2006) describe thematic analysis as a linear process, one that allows the researcher to thoroughly trace themes throughout the transcripts in order to fully experience both the subtleties and complexity of the data.

In their critique of thematic analysis, Braun and Clark (2006, p.80) draw attention to the often-quoted belief that themes *emerge from within the data*. This, they assert makes the assumption that the researcher is taking a passive role, when in fact they argue the researcher is engaging with the data in an active way. Ely et al. (1997) concurs with this and states that*:*

> *... if themes reside anywhere, they reside in our heads from our thinking about our data and creating links as we understand them* (p. 205).

This was interesting for me as I had become very familiar with the data and was also aware of practising a level of reflexivity so as not to influence the analysis process. I systemically checked and re-checked my identifying and coding of the themes against the data in order to be clear they were congruent with each other.

Thematic analysis differs from some other qualitative analysis tools such as descriptive analysis in that it incorporates and merges both inductive and deductive coding processes (Fereday & Muir-Cochrane 2006). Inductive coding originates from within the theoretical or philosophical framework of the research and thus reflects the position and direction of the

research question. Deductive coding is derived from themes that are identified from within the data themselves and from discussions that originate from the participants. Braun and Clarke (2006) argue that the ability to integrate both processes strengthens the rigour of this technique whilst allowing for flexibility and offers a broader interpretation of the data. This was evident in the analysis process as the themes and sub themes had a symbiotic relationship with both the frameworks of this research, keeping birth normal and feminist theory.

King (2007) comments that this form of qualitative research as: *the process of listing themes is about raising questions, not necessarily answering them* (p.6). This is relevant to the research question in this study as midwifery practice is not necessarily a prescriptive process, but is open to a variety of interpretations.

EXPERIENCE OF USING THEMATIC ANALYSIS

Once I had read through the transcripts several times and also listened to the audio tapes for intonation and expression, I was able to begin to gain an understanding of the nature of the data. This process, although time consuming as there were more than 20 hours of tapes to listen to, proved to be extremely helpful in the initial formulation of themes. The themes became quite obvious early as I begun to colour code the data with preliminary ideas for themes and sub-themes. This process continued over months as I refined the broad themes and became more and more familiar with the data. By the tenth interview I felt I had reached a saturation point as there were very few new themes identified. I continued to interview two more midwives and felt confident that this number was sufficient due to the repetition of themes.

The identifying of the sub themes was a slower process as I went back to the data repeatedly in order to clarify and distil the midwives comments into an accurate and precise representation of what was being said. The sub themes were categorised as having a specific relationship with the main themes and were situated within a broader contextual frame, similar to a hierarchal order of influence. An example of the process of identifying themes and sub themes can be described in terms of numbers. In simple terms, sub themes were less obvious and less frequently observed in the data than themes, in particular to the major theme, Desiring Normal. Within the transcripts, the word normal appeared over 300 times and often in relationship to the midwives role as a facilitator of normal birth. To this end it was easy to identify Desiring Normal as being the main theme. Sub-themes were categorised as they emerged, more subtlety from within the data. Similar words were clumped together

around one particular theme and were given a system of coding colours according to how many instances they were expressed by the midwives. Even though there was an overlap of certain sub themes being related to the main themes, for clarifying purposes sub themes were identified as being connected to one particular theme as illustrated on page 50 of this thesis.

The final section in this chapter will examine the ways in which I sought to maintain rigour throughout the research process.

MAINTAINING RIGOUR

> *As investigators, we are responsible for choosing topics that have practical value; our research should be both relevant and beneficial to those concerned* (Angen 2000, p. 392*).*

Within the literature there is much debate regarding the relevant factors that determine the validity of qualitative methods as, reliable, credible and rigourous (Angen 2000; Sandelowski 2000; Silverman 2000; Burns & Grove 2005; Hansen 2006). When considering rigour and reliability of findings, qualitative methods of inquiry are comprised of a different set of parameters compared to quantitative research (Angen 2000). Quantitative research often involves a specific measuring instrument that can be checked for consistency, reliability and validity by determining if the same results would be produced if the procedure were to be replicated (Beanland et al. 1999).

In this sense, it is easy to see the science in this research. Qualitative methods however, do not intrinsically lend themselves to the same tools for assessing rigour and reliability. Sandelowski (1986, p.29) claims that qualitative research is not able to replicate results in the same manner as quantitative research as *every human experience is viewed as unique and truth is viewed as relative*. Furthermore she states that :

> *...the artistic integrity rather than the scientific objectivity of the research is achieved when the researcher communicates the richness and diversity of human experience in an engaging and even poetic manner* (p.29).

In later work, Sandelwoski (1993, p3.) describes qualitative research as an art form, with particular reference to the *artfulness of qualitative inquiry* that has the potential to bridge the gap between science-based research and interpretive inquiry. In assessing the validity in qualitative research, Tesch (1990) asserts that no two qualitative researchers would approach the research with the same theoretical and philosophical underpinnings, and therefore replication is not useful. Burns and Grove (2005, p. 55) cite *openness and scrupulous*

adherence to a philosophical perspective as important aspects in maintaining rigour in qualitative research.

Whilst these principles are not specifically prescriptive, they guided my research. I took *openness* to be a quality with which to not only approach the interviews, but to also employ during the data analysis. It reminded me to remain as objective as possible when in dialogue with the midwives about their experiences of caring for women in labour. This was despite revealing some of my own experiences of being a practising midwife to the participants as the interviews progressed in a dynamic interactive way. At times I felt it was helpful to share some of my own thoughts as this enabled reciprocal revelations by the midwives being interviewed. This practice is supported by Oakley (1981) and Alvesson and Skoldberg (2000), who stress the importance of creating a level of mutuality and intimacy during the interviews. Being *open*, as opposed to *closed* in the process of the interviews, enabled a broad conversation that covered a wide variety of experiences to proceed. At times the midwives expressed their duty of care in a way that I found to be in conflict with my own personal views about childbirth. However I was mindful to practice a level of reflexivity within my own thinking so as to avoid possibly influencing the data. Burns and Grove (2005) describe reflexivity as a tool in research with which to critically examine ones thoughts in order to gain an objective lens when collecting and analysing data.

Bergum (1991) contends that reflexivity is not practised to arrive at an objective stance, rather it is used to chart the researchers changing or developing ideas about the topic and to value the contribution the researcher's own ideas have on the research. My own interpretation of reflexivity is guided by this quote from Seibold et al (1994):

> *The result* (of reflexivity) *is at every step, the constant questioning of our own assumptions and values, the research process, the initial question, the goals of the study and the process of inquiry* (p.399).

I was able to practice reflexivity during the research process by means of regular meetings and discussions with my supervisors about my thought processes, my understandings about the data content and the unfolding analysis. Additionally, I used reflexivity during the interview process by means of *checking.* This checking for clarification of what the midwives were expressing is also a means of ensuring a level of rigour and reliability when assessing the data. It provided an opportunity for me, the researcher, to separate any bias or misunderstanding of what the midwife was saying during the interview process. Sandelwoski

(1993) warns about the risk of contamination of data that may occur if the researcher becomes too close to the participant and is unable to distinguish between the opinions of the participants and their own experiences. To this end, I was conscious to remain a warm and welcoming presence to the midwives during the interview process, but was also mindful to limit my own responses. I usually found myself concurring with the midwives, without offering any personal opinion in order not to detract or derail what the midwife was telling me.

Hansen (2006) suggests the most adequate way to illustrate the dependability of qualitative research is to make transparent the methods undertaken by the researcher. I have detailed these methods in this chapter for this purpose.

CONCLUSION

This chapter has described the ways in which the research was conducted and outlined the method, methodology and data analysis technique with reference to the supporting literature. The theoretical underpinnings and the factors that influenced me as I collected the data have been discussed. The next chapter examines the findings from the data and uses direct quotes from the midwives in order to illustrate and justify the themes identified within the transcripts.

CHAPTER FOUR: FINDINGS

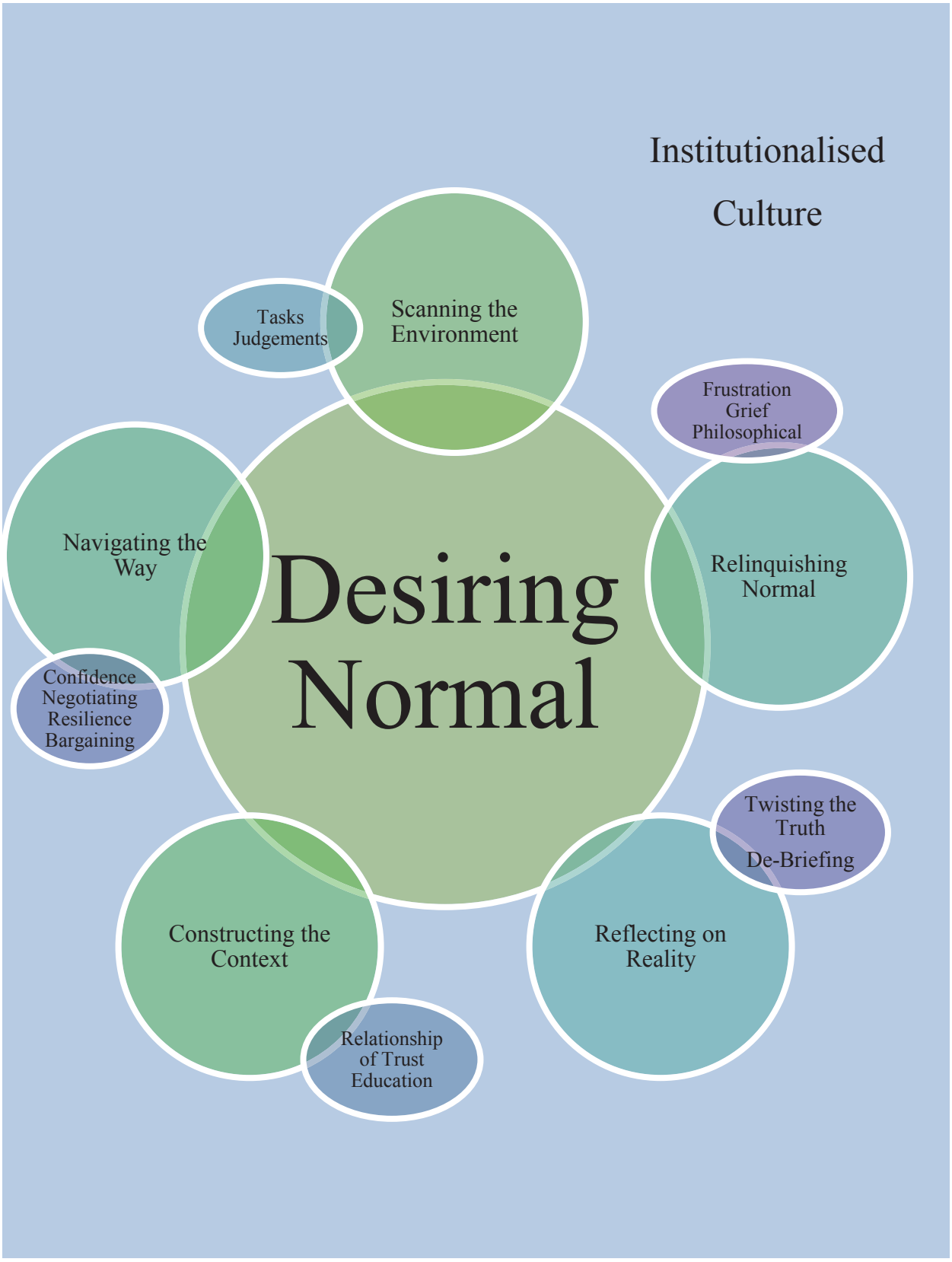
Chapter Four provides the demographic characteristics of the participating midwives and presents the findings from the research. The themes, sub themes and the over-riding concept that emerged from the data are discussed in relation to how midwives frame their beliefs about childbirth.

INTRODUCTION

The key theme, Desiring Normal, was identified as being a significant influence in the way midwives described how they cared for women in labour. Five other themes: Scanning the Environment, Constructing the Context, Navigating the Way, Relinquishing Normal and Reflecting on Reality were also identified. All these themes demonstrated strong relationships with the key theme, Desiring Normal. Sub-themes were identified from the data and clustered into six themes. Sub-themes were revealed to be less significant phenomena than themes and could be identified as being related to one specific theme. Occasionally the sub-themes could also relate to more than one theme, which demonstrates the close relationship that all themes and sub-themes share. For the purpose of the analysis I have grouped the sub-themes exclusively to one particular theme. Quotes from the participating midwives are provided to demonstrate both themes and sub-themes.

In addition to the themes and sub-themes, one overriding concept, Institutionalised Culture, was identified. Institutionalised Culture refers to the dominant medical model that was prevalent in these hospitals. This culture was shown to have a direct impact on the midwives' experience of caring for women during labour. Table 1 which is a diagram of the Theme Chart, illustrates the interactive association between the themes, sub themes and the concept.

TABLE 1: DIAGRAM OF THEME CHART



PARTICIPANTS

Table 1 illustrates the demographics of the participating midwives. The average age of the 12 participating midwives was 35 years with a mean of 12 years working experience working in hospitals. The midwives worked in a range of four different levels of hospitals in metropolitan Sydney. The *level* of a hospital refers to the level of medical facilities and their ability to provide the appropriate services for increasingly complex women and babies. The levels also relate to the specific needs of neonates who require intervention post birth. For example Level 6 is the most technologically equipped facility and thus receives many women and babies transferring their care when complications arise. Level 3 hospitals can only cater for women with relatively normal pregnancies and birth and have limited nursery facilities for premature babies, for example, not below 34 weeks gestational age. Levels 4 and 5 incrementally have more ability to cater for further levels of complications. These levels are defined by the NSW Health Delineation guidelines (NSW Health 2011).

MODELS OF CARE

The midwives interviewed represented a broad range of midwifery experience, maternity facilities and models of midwifery care in metropolitan Sydney. Midwifery Group Practice (MGP), Birth Centre and privately practising midwives all provide midwifery continuity of care where the midwives have a relationship with the women in their care throughout pregnancy, labour and birth. Midwives working on the traditional, usually fragmented models of care and those working in the private sector generally meet women for the first time once in labour. Whilst this is not significant to the findings, it does demonstrate diversity in the sample and was purposefully selected.

TRAINING

All but one midwife gained registration as a midwife in Australia and two were recent graduates from a Bachelor of Midwifery degree. This degree is a three-year university course that does not have a pre-requisite of a nursing degree. Midwives with a Graduate Diploma in Midwifery have undertaken a three-year nursing degree prior to the 14-month specific midwifery training, which takes place mainly in the hospital setting. The Bachelor of Midwifery degree is a recently offered course as outlined in Chapter Three, hence the smaller number in the sample.

TABLE 2. DEMOGRAPHIC CHARACTERISTICS

Age Range	Practice Setting	Qualifications	Years Of Midwifery Experience	Model Of Care
45-50	Level 6 Hospital	Bachelor Midwifery	1	MGP
25-30	Level 6 Hospital	RN Grad Dip Mid	5	MGP
40-45	Level 6 hospital	RN Grad Dip Mid	15	Birth centre
50-55	Private Level 4 Hospital	Hospital Trained	22	Traditional
50-55	Private Level 4 Hospital	Hospital trained	20	Traditional
50-55	Private Midwife Home	RN Grad Dip Mid	25	MGP
25-30	Level 6 Hospital	RN Grad Dip Mid	5	Traditional
25-30	Level 6 Hospital	RN Grad Dip Mid	6	Traditional
30-35	Level 6 Hospital	RN Grad Dip Mid	8	Traditional
30-35	Level 5 Hospital	Bachelor Midwifery	1	Traditional
50-55	Level 4 Hospital	RN Grad Dip Mid	30	Traditional
45-50	Level 6 Hospital	RN Grad Dip Mid	15	Traditional

Note: MGP and Birth Centre care are continuity of midwifery care models where midwives provide all aspects of pregnancy, labour and often the postnatal period. Traditional care refers to the standard model of midwifery care where midwives have generally not met with the woman prior to labour. The names of the midwives used in the following quotes are not cross referenced to this table and are pseudonyms to protect confidentiality.

CRITERIA

In recruiting midwives for this research, the only criteria were that the midwife had to be currently working in a birthing setting in a hospital in Sydney. This meant the midwife had to be caring for women during labour and birth. Having this minimal criteria meant I was able to canvass a broad range of ages, years of experience and also obtain a cross section of various hospital settings including one independent midwife who also currently attends home births as well as working in a hospital. This diversity was important, as the small sample size in this study is a limitation. However I feel I have been able to capture a wide variety of midwifery experience. Although this sample of midwives cannot be generalisable to the population of midwives in Australia, it is conceivable that these midwives reflect some important core beliefs of their colleagues.

THE MAJOR THEME: DESIRING NORMAL

The key theme, Desiring Normal, appeared early in the data and incorporated all other themes and sub-themes. Desiring Normal interacted with the five other themes and sub-themes as illustrated in Diagram A. Desiring normal is described through the midwives strong wish to facilitate normal birth for the women in their care. This desire for normal encapsulated the most significant thought process that influenced the midwives' description of childbirth and what it meant to them. The desire for normal was predominant in all 12 of the midwives minds as they discussed how they would care for women in labour as seen here in this quote from one of the midwives:

> *I think the birth will go beautifully and she is going to have a water birth. I feel that the (fetal) heart rate will be fine. Stay off the bed. Keep away from the monitor and you know, doing what she feels. Making sure she maintains her sense of self and what she wants, a great birth. (Kate).*

All of the participating midwives viewed childbirth through the lens of keeping it normal and expressed a strong commitment to promoting normal birth outcomes through their intended actions and philosophy of midwifery care as noted here by one of the midwives:

> *I think birth is normal until proven not, we have to keep to that path. (Sascha)*

The midwives described ways in which they practised in order to keep birth normal. At times this involved some degree of conflict about their own scope of practice. One midwife said:

I'm really conscious not to look at the (fetal) monitor, sometimes I really want to look at the monitor, but then I think, no, I'm not going to keep looking at the monitor. I want to keep this as normal as possible and not get caught up in the all of that monitoring stuff. (Annika)

In holding on to Desiring Normal, the midwives discussed ways to best facilitate normal birth and these often involved a degree of determination on their part to resist obstetric intervention. This was sometimes expressed in relationship to the conflict in collaborating with the medical practitioners about a woman's care. This is described by one of midwives during her interview:

We tend to keep the doctors out, we keep them out as much as possible, but you have to be strong, and say (to the doctors) "I don't need you at the moment, I will let you know if I do". (Renee)

Desiring Normal reflected the midwives knowledge and understanding about the benefits of normal birth outcomes for the women in their care. However they also expressed a far greater personal and professional satisfaction level for themselves when they were able to facilitate normal birth. It appeared to be important for their sense of professional esteem. Additionally the midwives described how much more pleasurable (for both themselves and the women) birth was, when not governed by interventions and obstetric complications. Interventions offered the midwives a level of anxiety and uncertainty that lowered their job satisfaction level.

The recognition of Desiring Normal as the major theme is significant for several reasons. Firstly it was central to the midwives' experience, both professionally and personally. It therefore reflected their basic interpretation of childbirth. Secondly, it differed considerably from the findings of Regan and Liaschenko (2007), which were discussed in Chapters Two and Three. These authors demonstrated that the midwives in their study viewed birth within the framework of risk, not at all similar to the framework of Desiring Normal. Whilst the midwives I interviewed did discuss risk, it was often expressed as fear, in particular the fear of the system interfering with the chance of achieving normal birth, as expressed by this midwife:

I get fearful that the system (and you know who I'm talking about here) is going to intervene and carry her into something that she won't want and that is not necessary. Possibly even harm her. (Annika)

The midwives identified this fear of the system as the biggest threat to the midwives desire for normal and their perceived chance of achieving it for the women in their care. Other examples of the fear of the system will be demonstrated later in this section when examining the concept of Institutionalised Culture.

SCANNING THE ENVIRONMENT

In their attempts to keep birth normal, midwives described how they performed a number of actions that influenced the ways in which they made clinical decisions during labour. The first of these was using their observation skills, which I have called Scanning the Environment. The midwives described their ability to form a rapid and acute awareness of not only the overall clinical situation, but also of the physical environment and atmosphere of the birth room and the wellbeing of birth partners, doulas, family and/or support people. The midwives' first observations were very important in creating an initial assessment of the labouring woman. They described how they assessed the physical environment of the room, the choice of equipment visible and the expression on the woman's face as clues to her progress in labour. One midwife describes the experience of scanning the environment:

> *I look at everything and especially when I'm writing my notes, I go from top to bottom. Comment on the CTG,* (fetal monitor) *the liquor* (amniotic fluid*). I just sort of go through everything that you need to think about. Have I done everything? Sort of like a systematic thing. You can always miss things, it's just human, but I guess you try not to. (Maeve*)

Scanning the Environment was vital to the midwives' ability to glean information that initiated the next step in the process of how they interpreted the progression of labour. Midwives also reported assessing the woman's emotional state by observing her facial expression for signs of labour. These comments by the midwives reflect this as they described the photograph*:*

> *Well she looks really happy, probably anticipating the birth of her baby, which is really lovely. (Sascha)*
>
> *My first impression is that it is early days (labour), I get a sense that she is possibly starting to get some contractions. (Dorita)*
>
> *She looks like she is in early labour at the moment, I just wasn't sure whether it was a little bit of pain-looking face. (Renee)*

Scanning the Environment involved multi tasking by the midwives as they described how they took stock of the birthing room atmosphere, performed the necessary clinical observations and began to establish a rapport with the labouring woman and her birth partner(s). The efficiency with which the midwives scanned the environment reflected the time constraints often experienced in a busy birthing unit. The midwives described the pressure of caring for more than one woman in labour on a shift and not being able to spend uninterrupted periods of time in one room. One midwife said:

> *I feel guilty about not being able to stay with the woman, I'm racing in and out of the room the whole time, too much going on in the ward and I know she misses out. (Madeline)*

The midwives described scanning the environment as something they did almost constantly throughout the processes of labour. Once the initial scanning had occurred, the midwives began to analyse their observations and in turn construct an understanding of what was happening during the process of labour. Whilst scanning the environment, midwives were often focused on the clinical tasks required. These they performed whilst making initial judgments of the progress of labour and being mindful of the need to utilise good time management skills. Comments such as these indicate the conflict midwives feel in prioritising tasks:

> *It's always such a rush and I often can't spend enough time in the room.* (*Madeline*)

> *I want to get all the initial palping and fetal hearts stuff done so I can have time to just sit with the woman.* (*Natalie*)

Other midwives reported that they enjoyed the clinical assessments as it gave them an opportunity to observe what was going on in the room at the beginning of their shift, as explained by this midwife:

> *I always take my time on my initial assessment, I like to have a bit of a chat and I can get a really good feel for what is going on with her, where she is at in her head, not just her body. (Dorita)*

CONSTRUCTING THE CONTEXT

Constructing the Context facilitated a more directive approach in the way the midwives discussed how they cared for woman during the course of labour. The midwives' use of language often indicated a more authoritative manner with the woman, which I have

interpreted as a way of holding onto their desire for normal. By actively guiding women in their choices, and educating women about birth choices, midwives were able to steer the course toward normal. One midwife said:

> *So I just have to explain to her why we do things.... tell her about fetal wellbeing and I guess you just have to negotiate if she refuses to have continuous monitoring, well that is her right but really we probably should be doing it. (Maeve).*

Constructing the Context and Scanning the Environment interacted with each other in a symbiotic relationship and were at times difficult to separate out as individual themes. The ability of the midwife to perform both functions simultaneously reflects the complex and multi-faceted nature of midwifery care as demonstrated in the following quote.

> *So this is what I see when I come in, so I see the mattress on the floor, so it's obvious that we are going to try and go natural...I would discuss if she had a birth plan or any preferences... She's still smiling so she is not in labour yet, so it's good to have a chat first, that sort of thing. (Marianna)*

This quote illustrates the observation skills of the midwife as she proceeds to elicit important information from the women in her care by communicating in a caring manner whilst beginning to construct her own perceptions of the woman's labour.

Constructing the Context of labour involved a sharing of information between the midwife and the woman and it was here that the foundations of a trusting relationship were built. This was particularly true for midwives who were working in fragmented model of care and had not met with the woman prior to labour. The midwives reported their ability to ask pertinent questions that related to both the clinical aspects of the woman's experience whilst also exploring her preferences for labour. These conversations enabled the midwives to gain an understanding of the progress of labour in addition to offering insights into the more personal aspects of the woman's journey through childbirth. One midwife expressed this as:

> I *think I would just be there in the room sitting in a chair and just allowing some time to see where she is up to, where she is at in herself. (Kara)*

The sub themes associated with Constructing the Context focused on a more interactive and communicative mode of midwifery care than the previous clinical skills approach. Midwives reflected on the importance of building a trusting and theraputic relationship once the initial stage of assessment had occured. This was particularly significant to the midwives who

worked in a fragmemted model of care and were meeting the woman and her family for the first time as described by this midwife:

> *I try really hard to make her trust me, I know you can't make any one trust you, but it's so much better when they do. So I do a lot of very fast work on communicating and reassuring them that I will be their advocate and will guide them to get the closest to their dream birth as possible. (Sascha)*

Midwives working within a continuity model of care spoke less of building relationships during labour and more about the joy of having done this work prior to labour. They referred to the women in their care as *my woman* and this reflected the close partnership they felt they had achieved during the antenatal period. It could be argued that this also reflected a sense of ownership on the midwives' behalf. The discussions around preparation for labour and the sharing of information for the MGP (midwifery group practice) midwives and the women in their care also had already taken place before the woman was in labour. This was quite evident when examing the contrasting comments that were made by the midwives working in delivery suites with no continuity of care. One MGP midwife said:

> *For me what makes everything so clear is the fact that I know her so well, there are no surprises in labour because we are all on the same page and have been working to that the whole pregnancy. (Katarina)*

The contrast in trying to build relationships whilst working in a fragmented model is noted here in one midwife's comment:

> *I often wonder what they (the women) think about it all. I mean it's so hard to know what is going on in their head when I only just introduce myself and then ask if I can examine them. I mean it must be pretty strange for them. (Polly)*

Another sub-theme that was identified within the main theme of constructing the context was related to the midwives' past experiences. In particular, if this had any impact on the way in which the midwife framed her beliefs about childbirth. Many midwives interviewed expressed some acknowledgement of the lasting impact a traumatic birth or poor outcome had on their experience of being a midwife. One midwife stated this very simply:

> *You are only as good as your last birth. I'm a bit burnt, I really need a good one. (Natalie)*

Another midwife described the anxiety she carried that related to a prior traumatic birth for a woman in her care. The midwife felt in some way it had interfered with her ability to trust the

process of labour and birth. Although she expressed good insight about this, the memory of this incident remained too powerful for her to regain her confidence.

> *I just will never trust that syntocinon again. It can make women totally lose it and I am sure that this was what made this baby distressed. I just hate looking after women being induced, it makes me too nervous.* (*Henrietta)*

NAVIGATING THE WAY

Navigating the Way was the process the midwives adopted in order to consult and negotiate their pathway within the institutionalised environment of the hospital whilst striving to maintain their desire for normal birth.

Once the midwives had constructed the context of the woman's labour, they began to negotiate with the woman and other staff members (that is, the doctors and other midwives) for plans of the expected progress of labour and birth. This negotiating process often involved a level of conflict as the midwives sought to enlist the support of their obstetric and midwifery colleagues. The decisions and plans put in place by the midwife and the woman during constructing of the context required an agreement from the obstetric practitioners in the hospital. Their support for the birthing plan was needed in order for the midwives to retain their sense of autonomy and their pursuit of normal birth outcomes. The midwives often experienced conflict when they attempted to deviate from set protocols in order to remain advocates for women. One midwife expressed this conflict in this quote:

> *Negotiating intermittent monitoring would not be a problem for me, but I am very low on the pecking order. I can say I'm the sludge on the bottom of the floor. Very junior and very well aware that everyone considers me to be quite junior, so there would be some rank pulling and the decision would be taken away from me. (Henrietta)*

I have called this process Navigating the Way as it symbolises a dynamic role on the midwife's part as she attempts to pursue normal birth for the woman in her care. Constructing and Navigating became an interactive process, one that involved much discussion and sharing of information between the labouring woman, the midwife and her colleagues. Midwives often described this stage of the labour to be the most professionally challenging for them. Most of the midwives expressed difficulty in negotiating their way through the institutionalised culture of the hospital. This often involved having to adhere to

protocols and policies that at times were perceived as not being optimal for creating opportunities to achieve normal birth. The midwives also spoke of the conflicts between personalities of staff and working within the medical model, which often undermined the philosophy of keeping birth normal as demonstrated here by one midwife:

> *You have to negotiate ...because whoever is in charge that day, you just know what your shift is going to be like and sometimes you can (negotiate), you know, depending who is in charge, you breathe a sigh of relief, but sometimes whoever is in charge, you go, oh gosh. Take a big deep breath and hold on. (Sarah)*

The midwives spoke of the contradictory philosophies often experienced whilst working in the hospital, in particular between the obstetric model of care and midwifery care. However it was also noted that there was conflict amongst the midwifery ranks, often relating to the level of experience, described as *senior and junior.* One midwife said:

> *It is very difficult to develop any kind of midwifery skills, it takes a long time as a junior person...it will be a combination of the senior midwives and the doctors. They will usually just come in and pull rank.* (*Henrietta)*

Navigating the way often involved a sense of disappointment expressed by the midwives as they felt they were coerced into practicing in ways that did not sit comfortably with their own personal philosophy of childbirth. Some of the midwives were able to hold onto their desire for normal birth outcomes in a more proactive manner than others. This appeared to be due to their personal resilience and (sometimes) their years of midwifery experience. Despite this, almost all midwives ultimately deferred major decisions during labour to the obstetricians and felt they had little influence. One midwife explained this by saying:

> *You've got to pick carefully who to approach when asking for more time, say for second stage. You know there is no point in even entering the conversation with some of the doctors, but you can manage to convince certain ones to give it a go. (Sarah)*

Alternatively midwives discussed the complexities of communicating and clinical decision making with their medical colleagues and at times were able to negotiate more successfully as expressed here by one midwife:

> *It's a bit of a pay off really, you play by the rules most of the time and then every so often you can push back and try to buy more time or get a little bit of control back. It's kind of a game*

but we know who really is in charge, and it's not us (the midwives) and it's certainly not the women. (Sarah)

Within the process of Navigating the Way, almost all midwives experienced challenges in negotiating with their obstetric colleagues. One midwife described negotiating as this:

*It can be tricky, it depends on how you sell your angle, you have to get the tone and all the facts right so that they (*the doctors*) feel you are on the same page as them. Even if you aren't. It's about winning them over and then seeing how far you can go. (Dorita)*

One midwife used her negotiation skills in a creative way, demonstrating an alternative to protect normal birth. She said:

Some of the policies in the unit can appear to be a bit restrictive, but I like to see it that they leave you open to interpret things the way you would like to. (Dorita)

This last comment indicates that confidence is a key element in the negotiation and navigating process. Having confidence and a strong belief in normal enabled some of the midwives to remain advocates for the women in their care despite opposition from other health care professionals.

REFLECTING ON REALITY

This theme was identified as the ability of the midwives to express their thoughts and feelings about the outcomes childbirth and their role as caregivers.

The midwives expressed a great deal of consciousness about how they cared for women during childbirth. They described the art of Reflecting on Reality and how they used this to examine the scope of their practice. Reflecting was a tool the midwives used in order to find meaning in their work and to gain an understanding of the events of labour. Although often expressed through storytelling or debriefing, reflecting was a necessary step in rationalising their role as a conduit for normality. By using reflection, the midwives were able to articulate their disappointments, frustration and fears. The midwives were honest about some of the techniques they used in order to achieve normal birth, which often involved withholding information or re framing it when negotiating with the doctors. Two midwives said:

Sometimes we have to fib (lie), because I feel a pressure (from the doctors) sometimes, as to how long she has been in established labour. I don't like that question at all. (Kate)

I think midwives lie, we should stop doing that. I mean we pretend that she is not fully, we don't really say what we do. (Sascha)

Another midwife described the ways in which midwives coerced women in their care into agreeing on a particular route to take during labour as expressed here by one midwife:

I think it's easy to manipulate women into doing something you want them to do. I think it's because they trust us. I'm not saying it's a bad thing all the time, but it's just we need to be aware and honest about what we do. (Sascha)

Reflecting on Reality was essential for the midwives to make sense of what had occurred during a birth and it also contributed to helping them to understand and resolve events. It appeared important that these midwives were able to reconcile their desire for normal with the reality of the outcomes, particularly when the birth did not proceed smoothly. By discussing the births that they had attended, the midwives revealed their own philosophy of practice and were able to articulate the rationale behind their thought processes whilst caring for women. Some midwives had clear boundaries about what defined their professional and personal midwifery beliefs. One midwife stated:

I am able to put my feelings aside about what I personally think, I would never let on. I work here so I am obliged to follow protocols etc. Having said that if they (the doctors*) asked me to do something I was not too happy with, I wouldn't do it, I just wouldn't. If I don't believe in it, I won't do it. (Polly*)

Other midwives expressed regret and powerlessness about what happened to women while in their care as demonstrated here:

Sometimes I get so sad, really sad that things don't go to plan, for whatever the reason. The system, the policies or just the way the baby seems to get its head stuck. I feel like I am just standing by and watching a drama unfold and can't stop it. Maybe if I had seen it sooner or did something differently, I don't know, sometimes it just gets to you that it can all go so wrong. (Natalie)

Most of the midwives appeared to value the ability to talk with their midwifery colleagues about their experiences of labour and birth. They often used humour as a way to let go of a less than perfect experience, described here by a midwife who had sutured a women's perineum.

She drove me crazy, she would ring me practically every day to tell me what it looked like, she was so body conscious, but really what am I supposed to do? I really wasn't that keen on the graphic visuals she was giving me over the phone. (Natalie)

Midwives also used reflecting as a tool to gain insights into complex situations. Sometimes reflection could be used as an opportunity to judge other practitioner's decisions as explained by this midwife:

Everything always gets discussed. A lot of time after the event people will say " oh I would have done it like this, or I would have don't it like that". But then you wonder if they actually would have. Too many people come in and comment on other's situations. You find people do judge, judge other's practice. We have to judge ourselves first. Everyone discusses. (Polly)

RELINQUISHING NORMAL

Relinquishing Normal relates to the midwives expressed dissatisfaction about having to compromise a portion of their desire for normal as labour progressed. Relinquishing Normal had a direct relationship with the Institutionalised Culture of the workplace and the conflict the midwives felt with their obstetric colleagues and the hospital environment as they strived to keep birth normal.

It became apparent, that during the navigation of childbirth, the midwives relinquished some of their original commitment to normal birth and engaged with other health care providers in a dialogue that resulted in a process of bargaining. The midwives felt they were coerced into trading a portion of their desire for a normal birth with an option that expedited the process of birth. This often involved the introduction of medical interventions that complied with hospital guidelines and the obstetrician's orders. A midwife, who was experiencing pressure from outside the birth room to continuously monitor a labouring woman's baby, described an example of this.

I wanted to intermittently monitor her, which is ok, but the midwife in charge says no, no, no, you need to monitor her continuously and you know it sort of tears at you because you really want to go by what the woman wants and you obviously can't. (*Sarah)*

Midwives commented on the conflict between their desire for normal and the reality of working in a tertiary referral hospital with high intervention rates. One midwife said:

It breaks my heart but I don't feel I have much faith in the normal because I see so much abnormal or so much intervention and that starts the whole cascade. (Sarah)

Relinquishing was often expressed with a sense of grief by the midwives who talked about the process of reflecting on their practice. It was often described as a very common trajectory, one that the midwives accepted with a certain degree of cynicism and one that they felt unable to change, typified by this midwife's comment:

I feel like I work in a sausage factory, just get the women in and the babies out and transfer them up onto the ward so we can get the room clean and be ready to go again. It's not woman centred at all. I think it's all about time, money and productivity and too bad if the woman takes a bit longer or dares to be different, god help that poor midwife. (Renee)

There were many examples evident in the transcripts that illustrated the midwives conflict in caring for women in an atmosphere that was not conducive to normal birth and how it created feelings of disempowerment and lack of autonomy within themselves. An example of this is this midwife's comment:

*It's really hard when the doctors want to come in and meet the women. They say it's "just in case". And I argue that "it's all normal and I will call you if I need them, thanks very much". But they still slip their way in and I reckon they put doubt in the woman's head that they probably will need to see them later. It makes them (*the women*) feel unconfident and it sort of undermines my practice. (Madeline)*

The concept of fear was identified during the interviews by the midwives but not usually in relation to the process of childbirth. It was more to do with the perception the midwives held in regard to their own practice seen through the eyes of their colleagues, in particular the medical staff as explained by this midwife:

I think midwives are fearful. They are fearful of getting into trouble by the more senior staff, particularly the obstetric team and we often make decisions because we also worry about what other midwives will think and say about us if we rock the boat. (Kara)

Relinquishing the Desire for Normal was often justified by the midwives as something they had to do in order to *keep the peace* within their working environment.

At the end of day it's all about a healthy mother and a healthy baby so I guess you just have to do what you can to get the baby born in the best possible way. There is not a lot of room for going against party politics in my unit. You just have to do what everyone expects you to. I

often think we are too conservative in our policies, but it's where I chose to work so I can't push too hard for change. It is frustrating though. (*Madeline*)

Another midwife explained relinquishing as:

It's your professional obligation, *it's not normal birth or bust, you just have to do whatever it takes to get the baby out, even if it means going down a whole different path that you don't really want or necessarily agree with. (Sascha)*

At times midwives were comfortable and philosophical about relinquishing the desire for normal as the reality of birth changed. However some felt enormously frustrated by the conflict and the process of bargaining between the health providers that often resulted in a birth becoming obstetrically managed.

INSTITUIONALISED CULTURE

Institutionalised Culture was identified in the data as the context in which the themes and sub themes were situated within, as demonstrated in Diagram A at the beginning of this chapter. Many of the previous quotes used in this chapter have a direct relationship with the reality of working in the hospital system within the culture that embodies a number of maternity care institutions. Many of these examples reflect the conflict and dissatisfaction midwives feel when constrained by this institutionalised culture. The following two quotes by midwives demonstrate the challenges midwives face in the hospital system in providing woman centred care that aims for normal birth outcomes.

Everything we do in an institution like this tells the woman that birth is dangerous and we as midwives have to keep counteracting this. What we want is to promote normal birth but it is very difficult in this hospital setting. (Sascha)

You get very narrow minded about the way you work. That's what I'm trying to say. You get in your box and that's just how you practice then, because you don't really think outside that, because you just get so used to this is the way it is here. (Maeve)

Several midwives discussed their anxiety around missing something significant by following the correct protocols of the hospital and how this impacted on the way they cared for women. One midwife described it in this way:

> *We are fearful of the institution, of getting into trouble, of making a mistake. I do think we make decisions based on what we think our colleagues would do and what the institution says, but it's the opposite of woman centred care, it's the complete opposite*. (Sascha)

Similarly a midwife had this to say about the culture of her workplace:

> *It all comes down to defensive practice. Any time we have a chance, we intervene. It's the culture, that's just what we do here and I think this has taken a lot away from being woman focused. (Henriettta)*

There was a general dissatisfaction with the hierarchical structures that defined institutionalised care and the midwives experienced great difficulty in practising with confidence because of this sense of surveillance. This is one midwife's experience:

> *Some of the doctors and even the senior midwives can get very intimidating and really question what I'm doing. Like when I say 'its normal" (the fetal heart rate pattern) they say: "Are you sure, let's just see about this". It makes me nervous and like I am being watched all the time. They never let a junior midwife make a decision either. (Madeline)*

However, there was a sense of teamwork and camaraderie between staff experienced by most midwives in their hospitals and instances where the obstetricians and midwives worked harmoniously within the hospital culture. One midwife expressed this as:

> *I think we have a really good thing happening here. Everyone is on the same page. We (*the midwives*) kind of run the show and call the doctors in when we think they are needed. They totally trust us. There is a general understanding that we know what we are doing. (Dorita)*

It appears that the institutionalised culture of hospitals governs many aspects of midwifery care and is enmeshed with the obstetric and medical hierarchies that impact upon the midwives' experience of caring for women during labour and birth.

CONCLUSION

In summary, midwives spoke about how they interpreted the process of childbirth and described ways in which they cared for women within the framework of desiring normal. which was a dynamic process. They discussed the ways in which they came to make decisions whilst caring for women in labour. These included the continual process of scanning the environment for clues in order to construct a context for their duty of care. Simultaneously the midwives had to negotiate and navigate their way through labour and

birth using their midwifery skills through the course of events. They often experienced conflict outside the birth room, which they stated was a result of the obstetric dominance prevalent within institutionalised care. Midwives used the art of reflection in order to gain an understanding of the process of childbirth and also to give meaning to their actions. Throughout these processes, midwives engaged in relinquishing their belief of achieving normal birth outcomes in order to navigate the challenges that arose whilst working in a maternity institution. The relinquishing was described as a *slow process of letting go of normal*. The data indicates midwives have a strong desire to achieve normal birth outcomes for women in their care and are frustrated by the polarised philosophies practised by midwives and obstetricians working in institutionalised maternity settings.

The next chapter, Chapter Five, is the final chapter in this thesis. This chapter will examine the findings of my study in a broader context by relating them to other relevant literature and discussing their implications for midwifery practice. The final chapter will also offer a concept known as *parrhesia* as a strategy for the midwifery profession to become a more powerful presence in order to challenge the concept of institutional culture in maternity care.

CHAPTER FIVE: DISCUSSION

INTRODUCTION

This chapter examines and discusses the findings of the study and examines them in relation to implications for contemporary midwifery practice and education. The chapter explores the themes identified in the data in order to interpret the experience of midwives caring for women during labour. These findings are then discussed further in relation to the existing body of literature, including Regan and Liaschenko's (2007) study, which informs this research.

In my study, the context of institutionalised culture and the conflict between obstetric and midwifery ideologies significantly influenced the practice of midwives in hospital settings. In this chapter the paradigms of fear, safety and risk are explored in relation to the difficulties midwives experience in challenging the established forms of authoritative obstetric knowledge that governs their workplace.

Finally the concept of parrhesia is offered as a potential tool for the education of future midwives. Parrhesia is the practice of speaking freely, without fear, often in the face of criticism. It is explored in this chapter as a means of shaping a new culture of articulate and forthright midwives who are well equipped to challenge the dominant obstetric rhetoric.

OVERVIEW OF THE FINDINGS

Six themes emerged from the in-depth analysis as detailed in the previous chapter. These themes illustrated factors that influenced the midwives' clinical decision-making and general experience of caring for women during labour and birth. Each midwife expressed a strong desire to facilitate a normal birth for the women in their care. The midwives articulated the frustration and conflict they felt whilst working in busy maternity units that were governed by obstetric authority that undermined their autonomy.

All midwives in this study described a strong belief in normal birth that became less achievable as the policies, politics and practices of the birth unit came to the fore. They described the act of scanning the environment for clues as to the progress of labour and then

the construction of the context of labour that followed. The ways in which the midwives had to negotiate and navigate the care of the labouring woman was often reported to be challenging as the midwives collaborated with their obstetric colleagues within the institutionalised culture of the hospital. The midwives often expressed this as *a process of relinquishing* when referring to this loss of autonomy. The midwives reflected on the reality of the rising rate of intervention during childbirth with a sense of powerlessness and disappointment. This chapter will explore the implications of these themes in relation to the current literature available and explore implications for midwifery education and practice.

COMPARISON WITH REGAN AND LIASCHENKO

My study is informed by Regan and Liachenko's (2007) research, and it is therefore fitting to revisit their study in relation to my findings. Their work is referred to in earlier chapters. Table 3 summarises the main components of the studies and how they compare.

TABLE 3: COMPARISON OF THE TWO STUDIES

	REGAN and LIASHENKO (2007)	**COPELAND (2011)**
NUMBER OF PARTICIPANTS	51 labour and delivery nurse-midwives	12 midwives
SETTINGS	2 low-moderate risk hospital based birthing units in North America	5 low-mod-high risk metropolitan maternity hospitals in Sydney, Australia and 1 homebirth model
METHOD	Participants were given a photograph of a labouring woman and written instructions. They were asked to speak into the tape recorder about what they thought was happening in the photograph and how the story continued. They did this alone. The researchers were not present.	Participants were interviewed in person by the researcher and a photograph was used as a starting point to construct a story about what the midwives believed was happening in the photograph and how it continued. This was an interactive process.
FINDINGS	The nurse-midwives viewed birth	The midwives unanimously viewed

	through the lens of risk, almost equally divided into 3 categories: Birth as a Natural Process Birth as a Lurking Risk Birth as a Risky Process	childbirth through the lens of normality and all expressed a strong desire for normal birth outcomes.
DISCUSSION	The authors reported that the data indicated that a nurse/midwife's beliefs about childbirth could influence their trajectories of care and these may well be associated with interventions and caesarean sections during labour.	This study found that the over-riding obstetric presence in the birth units had more bearing on they ways in which midwives cared for women in labour than their beliefs about childbirth.

Regan and Liaschenko (2007) used a photograph of a labouring woman and asked the participating midwives to individually record their thoughts on caring for this woman during labour. From these transcripts the authors found that a significant proportion of the midwives viewed birth within a cognitive framework of risk. They described this methodology as being based on a psychological testing tool, derived from the Thematic Apperception Test, which is designed to access the subconscious thought processes of the participants. Using a photograph to elicit responses from participants is described by Cramer (2004) as being a *projective technique,* one that aids in understanding one's belief systems and the motivating factors that initiate human behaviour. Photo elicitation is described in this thesis in an earlier chapter.

Projective methods (as in photo elicitation) are often used as clinical psychological assessment tools and are not widely utilised in nursing and midwifery research. Regan and Liaschenko (2007) suggest that this methodology could be applied as a useful device to predict a midwife's trajectory of care based on her subconscious beliefs about childbirth. I contend that this is unlikely, due to the multitude of influencing factors that are played out in maternity units and the often-conflicting contexts midwives find themselves in. Whilst it is

reasonable to assume that a midwife's beliefs about childbirth influences her clinical decision making process, my study indicated that the obstetric culture of the hospital has a greater impact on the ways in which midwives interpret childbirth.

The opinion of the midwives in Regan and Liaschenko's (2007, p. 616) study, were almost equally divided between the following cognitive frameworks of childbirth that the authors identified: *Birth as a Normal Process, Birth as a Lurking Risk* and *Birth as a Risky Process*. In more concrete terms, this indicated that only one third of the midwives they interviewed believed that birth was a normal process. This contrasts with my own findings, which indicated all of the midwives I interviewed expressed the same cognitive framework around childbirth, which was a strong belief in normal birth.

Regan and Liaschenko's (2007) hypothesis that midwives who perceive childbirth to be *a risky process* would engage more with interventions, does not take into consideration the influences that the hospital culture may have upon the way in which midwives care for women during labour. The reason why 2/3 of the midwives in their study viewed birth through the lens of risk, is unclear. It is possible that their midwifery training shaped their thought processes about childbirth or alternatively that their frameworks of childbirth have been reshaped by the dominant obstetric presence in the hospitals. It is also possible to consider that the litigious culture in the American medical system has influenced the ways in which these midwives perceive childbirth. These are important questions to explore as they have implications for the education of midwives but more significantly, how to develop strategies that counteracts the dominant obstetric culture.

The issue of hospital culture poses a more relevant challenge to my study as the midwives I interviewed all expressed a strong belief and desire for normal birth. They did not frame their labour care around levels of risk and safety in childbirth as in Regan and Liashencko's (2007) work. Instead, the midwives attempted to find ways to maintain their desire for normal birth whilst navigating the intrinsic nature of control within the medical hierarchy. These midwives viewed the concept of risk as closely aligned with the common medicalised interventions in childbirth and not specifically the process of childbirth itself.

It is possible that these contrasting findings are a result of the variable methods used by Regan and Liaschenko (2007) and my own study. The photograph we each used was dissimilar. The image I used, as detailed in Appendix 1 shows a distinct clinical scene with a variety of details from which the midwives could glean information. Regan and Liaschenko's

(2007) photograph showed an image of a woman on her hands and knees on a bed with a white sheet. Her head is central to the photograph and her face is visible, with an expression that suggests she may be in labour. She is dressed in a white gown with 2 bands, possibly hospital ID bands, on her wrist. A male's arm appears to be holding her wrist. No medical equipment is visible in this photograph. The midwives in this study were given no information and were asked to construct the story of her labour into the tape recorder provided. To the best of my knowledge there was no direct verbal interaction between the midwives and the authors of this study. Conversely, I conducted my own interviews personally, and was able to probe the interviews along particular paths that arose in our discussions. This gave me access to the midwives thought processes in a different way. This may have influenced what the midwives disclosed to me. However I have no reason to believe that their descriptions of how they interpreted childbirth were not a true and honest account of their views.

The following section examines the notion of risk and how maternity care providers engage with this concept whilst caring for women during labour. Although the midwives in my study spoke less about their concerns of risk during childbirth than those in Regan and Liaschenko's (2007) study, it still remained an overt presence, particularly in regard to working within an obstetric model of care.

RISK /SAFETY/FEAR PARADIGM

It is generally accepted amongst maternity care providers that pregnancy and childbirth can be categorised into either low risk or high risk, normal or abnormal. The notion of risk in childbirth has been documented as being much higher for obstetricians than for midwives, which may account for their more conservative and interventionist approach to managing labour (Morris 2005; Keating and Fleming 2007; Surtees 2010). The reasons behind obstetrician's perception of risk is complex and has been linked to their fear of litigation and a general distrust of women's bodies coupled with the urge to control the process of childbirth. The risk paradigm of childbirth is paradoxical in that obstetric surveillance and monitoring, whilst devised to reduce the risk of a poor outcome, has been shown to increase interventions whilst not decreasing perinatal morbidity. The Cochrane Database of Systematic Reviews found interventions such as the use of epidurals increased the assisted instrumental birth rates (Alfirevic et al. 2006) and fetal electronic monitoring had a direct link to an increasing caesarean section rate (Anim-Somuah et al. 2005).

The fear of litigation following a poor birth outcome has been cited as influencing the way in which obstetricians and midwives manage labour (Green 2005: Klein 2005: Lane 2001: Morris 2005). Bassett et al. (2000) argue that both the legal and medical discourses around litigation are symbiotic in so much as they reinforce the culture of defensive practice. This, they maintain is because both the legal and medical disciplines are deeply embedded in the social, economic and political expectations constructed around childbirth. These authors propose that defensive practice is the result of creating a system that allows medicine and the increasing technological approach to childbirth to *impose normative frameworks onto women during labour* (Bassett et al. 2000, p. 535). Furthermore, they argue that defensive practice will continue to influence obstetric clinical care unless a radical new approach to childbirth training is implemented. This would include changing the hospital environment to incorporate a less medical bias (Bassett et al. 2000).

Midwives, however, have their own unique discourses around risk, safety and defensive practice as noted by Surtees (2010). For example, a New Zealand study of 40 midwives' experiences on managing the perceived risks of childbirth, revealed the complexities involved in negotiating normal births within a culture of risk and defensive practices. Interestingly, these midwives described risk as being located not only within the labouring woman's body, but also within the spaces of the birthing unit itself. This suggests risk is also present at the points of negotiation with medical colleagues outside the birthing room (Surtees, 2010). Certainly, in the midwives I interviewed, there was often a level of conflict surrounding perceptions of risk between the doctors and their own perceptions. This was demonstrated as the midwives discussed how they navigated and negotiated their management of care outside the birthing room with both medical and midwifery colleagues. The midwives often commented that it depended *who was on*, as to how much intervention was used during a woman's labour. The conclusion here is that the higher ones perception is of childbirth risk, the more interventions will be used to alleviate those perceptions and the accompanying fear. This was a source of frustration for the midwives as they were concerned that this medically constructed context of defensive practice was the accepted norm, and that it subjugated midwifery care.

MIDWIFERY AUTONOMY VS OBSTETRIC CONTROL

Many of the findings reflect the lack of autonomy the midwives feel they have as they attend women in labour. This lack of autonomy is the effect of the authoritarian leadership that embodies most maternity care facilities where obstetric knowledge is valued above midwifery care (Downe 2006; Cheyney 2008; Lee & Kirkham 2008). It also expresses the midwives inability to circumvent the dominant obstetric authority and suggests a level of powerlessness in the midwive's ability to navigate women safely through the process of labour and birth. Downe (2006) calls for supportive governance and supervision of both midwives and obstetricians in order to support best practice in a culture of risk management. The dilemma for midwives, she states, is that they are caught in a paradox about what they believe midwifery to be, contrasted with the reality of how childbirth is managed in the risk-adverse maternity care facilities (Downe 2006). Midwives in my study certainly expressed this frustration, explaining how they were not able just to *sit and be with women* and to wait and observe the progress of labour. Rather they were encouraged to adhere to particular time frames and routine practices that they felt were unnecessary and even counterproductive for normal birth outcomes.

Davis-Floyd (2001) in her examination of contemporary global birth practices, described the predominately western technocratic model of childbirth as grounded in a fear-driven belief that the body is an unpredictable machine that physicians must manage and control. The need to control childbirth and women's bodies is also described by Harvey (1996) in her study of risk, uncertainty and medical technology. Since having power and control are pivotal to the ability to be able to wield influence, Harvey (1996) maintains that medicine is challenged by the uncertainty and variances often seen in childbirth. So whilst mortality in childbirth is uncommon in the western world, obstetricians argue that birth is unpredictable and risky, requiring stringent medical monitoring. It is alleged that obstetricians use this uncertainty in childbirth to implement interventions that will prevent worse case scenarios and limit the perceived risk of danger, however theoretically improbable they may be (Harvey 1996). This trajectory of obstetric management of labour has been called the *maximum approach to childbirth* (Brody & Thompson 1981, p.997). Harvey (1996) argues that this approach strengthens the ownership obstetricians seek to assert over women and their bodies.

SURVEILLANCE

When examining midwives and fear in the context of childbirth, midwives in my study and others (Keating & Fleming 2007; Blaaka & Schauer 2008; Surtees 2010) expressed a fear not of childbirth itself, but a fear of the system. This included the fear of reprimand by senior medical or midwifery colleagues as a result of challenging certain protocols in order to facilitate normal birth. The midwives in my study expressed this fear of the system as a sense of being watched and having their clinical decisions scrutinized, as expressed by this midwife:

> *... you really can't do anything without them (* the obstetric team*) breathing down your neck* , *it's as if they don't trust us. (Sascha)*

This subtle, yet ever present sense of being watched by their obstetric colleagues was often presented as a means of supporting the midwives and an example of positive collegial communication. However, the midwives interviewed expressed this surveillance as being overbearing and controlling. Foucault (1977) describes the medical establishment as creating a *panoptical gaze*. The panoptican (a central tower from which prisoners can be put under constant surveillance) operates as a metaphor for the means of maintaining the authoritative knowledge and power base required to assert control. Furthermore, once an individual becomes accustomed to the reality of being constantly observed, they themselves often unwittingly become complicit as observers and enforcers themselves, thus compounding the strength of the existing power structures (Foucault 1977).

Individuals subjected to an experience that restricts their freedom, such as surveillance, are in danger of then participating in the cycle of oppression. This cycle, detailed by Freire (1970) results in the victims of oppression becoming perpetrators upon lesser powerful individuals within their hierarchy. Although this was not a dominant theme in the data of my study, some of the comments made by the midwives about senior midwifery staff displaying domineering behaviours toward junior midwives were disturbing, such as this comment by a midwife:

> *The midwife in charge just came right in and tore strips off me, really put me down in front of the woman, I felt terrible and like I was a really bad midwife. (Henrietta)*

Interactions such as these between midwives reflect Freire's (1970) cycle of oppression.

The next three examples pertain to the discipline of nursing. However, issues raised around oppression and patriarchal governance remain relevant to midwifery. In an examination of abuse within the nursing profession, Rowe and Sherlock (2005) suggest that conflicts arise within the nursing ranks because expressing dissatisfaction directly to doctors, carrries a higher risk to nurses who are perceived as subordinate to doctors. The results from their study found that verbal abuse directed at nurses is more commonly expressed by their fellow nursing colleagues rather than by medical staff or patients (Rowe & Sherlock 2005). This illustrates the nature of an oppressed group who channel and deflect their subjugation in order to survive (Rowe & Sherlock, 2005). Pannowitz et al. (2009) in their study of gender bias in nursing, examined data that revealed the medical model remain an *unchallengeable sovereignty*. Exemplifying this sovereignty is the lack of authority nurses feel they possess in order to question a doctor's decision and the general lack of recognition they receive from doctors for their skills and knowledge (Pannowitz et al. 2009).

Walker and Holmes (2008) examined the hierarchy of nursing education in Australia. These authors found that in general, nurse educators legitimatised the unequal status quo between medicine and nursing. This, they surmise, is a result of the nurses being a product of a conservative and subservient approach to training and practice, one that suppressed reflective thought (Walker & Holmes 2008). This has resulted in nurses occupying a diminished professional capacity from which to claim recognition for their significant contribution to healthcare (Walker & Holmes 2008). Oppression within the midwifery profession is not well understood or documented and therefore there is much to be learnt by exploring studies related to oppression within the nursing profession.

In contrast to being constantly observed and becoming victims in the cycle of oppression, Cheney (2008) examines homebirth as a *systems-challenging praxis*. She contends that homebirth confronts and rejects the discourse constructed by the medical model that hospital birth (with its obstetric frameworks) is the safest and most socially acceptable mode of childbirth (Cheney 2008). By circumventing the hospital system, homebirth midwives are able to avoid the medical gaze, including the cycle of midwifery oppression and thus practice autonomously (Cheney 2008). Her hypothesis is that by removing birth from the constraints of obstetric governance, midwives can reclaim their ability to facilitate normal birth (Cheney 2008). This resonates with my findings, as the midwives I interviewed felt constrained by the overt obstetric presence in their work place and found this restricted their practice. However the midwives I interviewed who worked primarily in a birth centre, where there was less

medical presence than in the traditional birthing suite, felt less observed and felt they were more able more able to practice midwifery according to their philosophy.

POWERLESSNESS

When speaking with the midwives in this study, it became obvious that embedded within their strong desire for normal, was a sense of powerlessness about the inevitable act of having to relinquish normal. The midwives expressed this as a feeling of hopelessness in regards to their negotiating with medical colleagues about the women in their care. These two statements from the midwives exemplify this:

> *There is no point arguing with them (*the doctors*) as it's just the way it is. (Polly)*

> *What's the point really, you know they will pin you against the wall with scare tactics if for example, you haven't done an admission trace or an ARM (*artificial rupture of membranes*) after a certain time. There is just no way around it. You just learn to go with the flow or it becomes too much of a battle. (Sascha)*

Keating and Fleming's (2008) study of Irish midwives experience of working in an obstetric-led unit reiterates this lack of midwifery voice. She reports that the midwives felt disempowered by the patriarchal hierarchy of obstetric dominance and felt they were unable to utilise their midwifery skills in order to promote normal birth (Keating & Fleming 2008). She concluded that strong midwifery leadership and educational practices were required to foster midwives confidence in facilitating normal birth (Keating & Fleming 2008). It was evident in some of the comments from the midwives in my study, that having strong midwifery leadership was crucial in promoting normal birth within an obstetric-led birth unit. Some of the midwives reported that it depended on which *senior* midwife was in charge of the shift as to how much negotiating needed to be done with the obstetric team. A supportive senior midwife was able to assist in the navigation process that the midwives described, at times as challenging.

The significance of the need for strong midwifery leadership is echoed by other feminist midwifery academics such as Davis-Floyd (2001), Kirkham (2005) and Downe (2008). They are critical of the current culture of medical dominance in the maternal health sphere and champion in favour of progressive changes to empower midwives. Hyde and Roche-Reid (2004) suggest *communicative action* between obstetricians and midwives is the most effective strategy in building more equitable relationships in the maternity care setting.

Communicative action is described by critical theorist Habermas (1984), as an interaction that is governed by the participant's mutual agreement to reach an understanding that is not driven or contaminated by personal agendas or ego. It is this mutual agreement that is often elusive in the obstetrician and midwife relationship as illustrated in my findings.

Despite this lack of reciprocation, some midwives in my study expressed certain levels of satisfaction in working alongside their obstetric colleagues. Some midwives reported finding the doctors supportive and respective of midwifery practice and indicated that they enjoyed an equal collaborative relationship. This suggests that reciprocity is important in building professional relationships as Hunter (2003) and Fahy and Hastie (2011) also note. It also indicates that having a level of personal resilience is an important factor in being able to negotiate effectively for one's beliefs when working in an environment such as maternity facilities. There was evidence from the interviews in my study that some midwives were able to assert their opinions in a more direct way when negotiating with colleagues than other midwives. Having personal resilience is essential to health care workers as they negotiate the *increasing industrial and organizational challenges* that are often associated with workplace adversity (Jackson et al. 2007, p. 2).

Resilience can be described as an individual's ability to effectively cope with setbacks, adverse environments and stressful or hostile situations (Jackson et al. 2007). The Penguin Dictionary of Psychology states that one may acquire personal resilience by equipping themselves with a specific skill set, by surrounding themselves in an environment that fosters support or by simply having a hardy temperament (Reber et al. 2009). In a review of the literature regarding personal resilience in healthcare settings, Australian nursing academics recommended that staff be encouraged through mentorship and training to foster emotional intelligence in order to reduce their sense of vulnerability (Jackson et al. 2007). Amongst the data of my study, there were comments from the midwives illustrating that positive working relationships with their fellow workers contributed significantly to their experience of caring for woman during labour. One midwife expressed it as this:

> *I love when we are all on the same page. No conflict or having to push for anything. Just everyone thinking and working the same way, it can be a lot of fun as well.* (Katarina*)*

However, this was not the general opinion expressed by midwives in my study as most midwives felt they were working within differing ideologies than their obstetric colleagues.

Hunter (2001) explores the differing ideologies that midwives negotiate when working within the institutionalised maternity setting and asserts that this creates emotional stress for midwives. She argues that parties such as obstetricians and midwives require a fundamental change in addressing their polarised beliefs about childbirth. However as it is unlikely that medicine will shift towards a less technocratic model of care, midwives must find a more pragmatic approach to managing this conflict of ideologies (Hunter 2001). A more pragmatic approach may well lie in adopting the concept of parrhesia as a means to find our *midwifery voice.* An exploration of this concept, parrhesia, now follows.

PARRHESIA

> *Parrhesia is a verbal activity in which a speaker expresses his personal relationship to truth through frankness instead of persuasion, truth instead of flattery, and moral duty instead of self-interest and moral apathy. (*Foucault 1983, p. 13*)*

In this discussion I propose that there needs to be a more structured and concrete pathway to be implemented within midwifery education and clinical institutions to better equip midwives to address the imbalance of power between midwifery care and obstetric management. In the current climate of increased interventions in childbirth it is paramount to nurture a generation of articulate midwives who are confident to question the status quo and to challenge the accepted norm of medicine as the authoritative knowledge. In order to effect change and reform the obstetric midwifery power struggle, we must become creative in the ways in which we educate future midwives. This thesis suggests that the risk of remaining silent about the conflict between medical and midwifery ideologies is potentially more dangerous than speaking out, hence the need for midwives to adopt the practice of parrhesia.

Parrhesia is a teaching that originated in Ancient Greece, and literally translated means "free speech" or speech without fear. Elements of this concept maybe a way forward for midwifery education and practice that addresses some of the issues highlighted in this thesis. Parrhesia provides a pathway for midwifery students to speak not only on behalf of themselves, but of their profession, the women in their care, the community and both the public and political arenas. In discussing the use of parrhesia as a potential tool for the education of midwives I draw mainly on the following work:

- Foucault (1980; 1983) who was critical of the ways in which medical science positioned itself as being the authoritative knowledge.

- Ewen (2010) who proposes the introduction of parrhesia for the mentoring of Australian indigenous medical students.
- Papidermos and Murray (2008) who suggest that parrhesia is the answer to the American Medical Associations reform of the education of medical students.
- Huckaby (2007; 2008) who challenges hegemony in education by means of exploring the qualities of parrhesiaic scholars.
- Zembylas & Fendler (2007) who support the *reframing of emotion in education through the lens of parrhesia.*

To date there is no midwifery literature that links midwifery scholarship to parrhesia and to this end I will draw from the afore mentioned literature to advocate an argument for midwifery education and clinical practice that is grounded in parrhesia. I contend that the use of parrhesia in midwifery has the ability to make transparent the complexities that exist between freedom, truth telling and politico-institutional power that underpin the conflicts between midwifery, medicine and government. Parrhesia is a discipline that involves the following principles of speaking freely as outlined by Foucault (1983):

> **Truthfulness:** The speaker (the parrhesiastes) will speak the truth, free of ego and self-interest.
>
> **Frankness:** The speaker will give a full and accurate account of what is on her mind in order for her audience to have an understanding of the situation
>
> **Danger**: Using parrhesia will often involve speaking in a dangerous climate, that is, there is a risk in speaking the truth to those who are unwilling to hear it or who oppose it.
>
> **Respect:** As parrhesia is often a form of criticism towards another or toward a system in situ, the speaker must always use respect when challenging those in power.
>
> **Duty:** Speaking one's truth is considered to be a duty to one's self, the profession and those who you serve.

The French theorist, Michel Foucault, explored the concept of parrhesia and likened it to Socrates commitment to living the true life by virtue of speaking one's truth at all times. Foucault (1983) described parrhesia as the relationship between what one does and how one acts. He asserts that this concept offers an opportunity to truly know oneself. Foucault

further claims that parrhesia is a means of *self-care* and refers to *the technologies of the self* which Ewen (2010) states are:

> *...the tools and methods that individuals use to define and constitute themselves and also to look after themselves*. (p.1)

This concept of self care is defined by Foucault (1983) as self discipline and the art of examining and transforming oneself by analysing ones thoughts, judgements and actions in order to know oneself more intimately. In his critique of Foucaudian theory and ethics, Pignatelli (2002) describes self care or care of self as:

> *... taking up the challenge of creatively and courageously authoring one's ethical self* (p.57).

Self-care, he proposes, is an important element in teaching and supporting pedagogical practices that challenge normative frameworks of an institution (Pignatelli 2002).

To build a culture of parrhesia in the academic institutions that provide midwifery education would be to not only instruct and encourage these principles of self-care, but to mentor students by means of mirroring this behaviour back to them. Educators would be wise to imbue in their students a strong belief in the value of nurturing truth telling. The challenge for midwifery leaders and teachers of midwifery who embrace the concept of parrhesia is to resist the urge to defer to the predominant popular belief that science, technology and the medical profession hold the authoritative knowledge. Parrhesia has the potential to foster a culture for students, teachers and midwives to challenge and debate the current discourses of midwifery and obstetrics and the problematisation of maternity care, with critical intelligence. This, as Papadimos and Murray (2008) suggest, not only creates able practitioners, but also able citizens who are equipped to embrace the increasing ethical and moral dilemmas facing healthcare today.

The other challenge for midwives, in using parrhesia, is that their actions and thought processes must become more visible. Here is an example in the data, which illustrates how midwives, in order to hold fast to their desire for normal, become somewhat covert in their practice. This reflective comment from a midwife in the study reveals the strategies they employ in resisting obstetric power and involvement:

> *I think midwives lie. We lie about what is normal. We have to stop doing that. I mean we pretend that she is not fully (dilated) when she really is. We don't really say what we do.*

> *Doctors have such a narrow view of normal and we know that normal is so much broader, so we lie about things so that they won't come in and intervene. (Sarah)*

It is easy to see the rationale behind this comment. This midwife feels that by telling the truth, she risks having input from the doctors that may introduce conflicting opinions about how to care for women in labour. She lies about the progress of the woman's dilation in order to buy more time for her body to give birth. It could be argued that the midwife feels she is protecting the woman from unnecessary medical intervention and that her actions are justified. Foucault (1980) argues that there is different discourses constructed for different truths and that resistance can be used as a form of truth telling. The biomedical model produces a different set of truths than the discourse of midwifery knowledge. In this case it could be said that midwives are finding their own way to subvert the dominant medical discourse.

However I wish to argue that covert and concealed midwifery practice does much harm in the long term and undermines the dynamics between midwives, obstetricians and the women in their care. Furthermore, it does not confront the oppressive culture in the hospitals that the midwives in my study found so restrictive.

Stewart (2006) comments that when midwives alter the findings of cervical dilation, it is at the expense of the woman, as the midwife is using her power to construct an experience of the woman's labour. Furthermore, Stewart (2006) found that the midwives did not always share this altered finding with the women in their care and therefore exercised a matriarchal assumption of knowledge that indicates superiority over the woman's body. Although matriarchal power is woman focused, the dynamics of the power relationship between midwives and the women remain unequal. If midwives do not tell the truth and do not speak out in the face of *danger,* then the medical fraternity remains not only dominant, but also ignorant to the wealth of midwifery knowledge that midwives keep hidden (Stewart 2006). As Foucault, in Papadimos and Murray ((2008) states:

> *Truth is not out there waiting to be discovered, it is created in the interest of those who exert the most power.* (p3)

Parrhesia is a courageous act in this instance, because the perceived risks are that the medical practitioner will wish to expedite birth if the woman does not give birth in a certain time frame. However, the more midwives practice parrhesia, the more the truth of the wide

variances of normal birth, which midwives are well aware of, become visible and validated within the obstetric realm. Huckaby (2007) describes the significance of parrhesia:

> *Parrhesiastes work to influence and change the status quo so that more people may participate in and enjoy the rights of democracy*. (p.521)

In other words, the more we encourage the speaking of the truth, the more it becomes acceptable to challenge and debate issues that midwives hold as important aspects of their duty of care. Implicit in this vision, is the possibility that midwifery and obstetrics build their own discourses around birth and professional relationships that incorporate more equitable forms of communication and supports a healthy culture of debate.

In order to enable a shift in the culture of the hospital setting, this study suggests we embrace the parrhesiastic verbalisation of emotion. This will require midwives to confront the accustomed norms of obstetric rationale and express their feelings about alternate practices. It is in this expression of emotion that the possibility to question and scrutinise routine hospital practices arises, thus enabling an opportunity to create new ways of thinking about and approaching maternity care. The freedom in speaking the truth can make space for transforming the way in which the midwifery and obstetric discourses are constructed and make explicit the ways in which these discourses are expressed. It is interesting to note that the midwives in this study expressed their frustrations and sense of powerlessness articulately and honestly. This is reflective of the very concept of parrhesia that is required to challenge the power imbalance between midwifery and obstetrics. I suggest that the ease with which they expressed themselves was a reflection of the safety they felt in the context of the interviewee (myself) being a midwife. I am not convinced that they would have disclosed their dissatisfaction quite so easily had I been a medical practitioner, a non-midwife or a consumer. Whilst this is only a hypothesis, it indicates the barriers that may potentially be present that prevent frankness between these two disciplines. I believe engaging in parrhesia will challenge the masculine hegemony prevalent in our clinical settings and create the possibility of enhancing collaborative consultations amongst midwives and their medical colleagues.

Hastie and Fahy (2011) in their research regarding inter-professional collaborative practice in the maternity setting, found that although midwives were intrinsically submissive to medical authority, there were many examples of rewarding and enriching collaborations between the two disciplines. Their findings highlighted the capacity of both doctors and midwives to

interact with emotional and social intelligence. However, the prevailing difficulties lie in the organisational and cultural structures of the institution that limit and dictate the discourses in which both parties engage (Hastie & Fahy 2010). Using parrhesia in collaborative practice is an act of emotional and social intelligence and is able to transcend the cultural norms of organisation because by speaking the truth in the face of adversity, one begins to construct a new and different discourse.

This ethos of *speaking truth to power* (Foucault 1983) requires courage, courage from the students, from registered midwives and courage from our midwifery leaders. If we are to create a new more equal power relationship with our medical colleagues then we must support, mentor and lead by example for our student midwives, both in the universities and in the clinical settings. We must help them build the capacity to challenge the status quo, to expose the flaws in obstetric dominance and to facilitate the right to self-determination by speaking the truth in a culture that has historically undervalued midwifery knowledge. To speak fearlessly on behalf of themselves, their profession, society, and for the women in their care is the foundation of becoming not only an able practitioner but also an able citizen (Papadimos & Murray 2008). As Foucault states, cited in Papadimos and Murray (2008):

> *When you accept the parrhesiastic game in which your own life is exposed, you are taking up a specific relationship to yourself: you risk death to tell the truth instead of reposing in the security of a life where the truth goes unspoken* (p.3).

We can apply this philosophical practice to midwifery teaching, to mentoring midwives at the clinical coalface and to our capacity as role models for the future of the midwifery profession in order to effect change in the current culture of medical dominance.

LIMITATIONS OF THE RESEARCH

This research has demonstrated the interpretation process that midwives experience as they care for women during labor. It has also revealed their belief systems about childbirth by describing their thought processes during an interview using a photographic image as the starting point. Whilst all attempts have been made to maintain rigour in the validity of the findings, the nature of qualitative interpretive research lends itself to a certain level of subjectivity. Despite regular meetings and guidance from my academic supervisors, ultimately the interpretation of the data is mine alone.

The choice of the photographic image could be seen as a limitation of the study as it was purposefully chosen for its content. It could be argued that a different photo, perhaps one more clinical in nature, may have resulted in the identification of different themes emerging from a different data set. As images have the potential to manipulate responses, I recognise the choice of the photograph to be a possible limitation of the study in its ability to influence the findings.

Although the study was designed to maximize the variety of hospitals, models of care and midwives experience, the sample size is small and thus cannot be generalised to the broader population. The study was conducted in one city of one state of one country and therefore represents only a glimpse of the broader maternity context of Australia. The limitations of this being a Masters Degree undertaken over a course of four years has also restricted the size and strength of this study.

CONCLUSION

> *This is a challenge for all of us, nationally and internationally, not only for our sakes, but for our daughters, and their daughters after them. If, through fear and ignorance, we neglect our heritage and allow technocracy to take over, woman-centred childbirth may be lost forever* (Kitzinger, 2000 p.250).

This study sought to examine the thought processes and belief systems that midwives held around childbirth with a view to identifying links that personal beliefs may have to the use of interventions during labour. Originally the intention of this research was to ascertain whether midwifery practice was implicated in the rising use of childbirth technologies and if their cognitive frameworks about childbirth influenced midwifery care during labour.

However, as the data were collected and analysed it became clear that what dictated midwifery care and clinical decision-making in my study was the overriding influence of the culture of the workplace, that is, the institutionalised environment of hospitals. The midwives in this study all had a strong belief and desire for normal birth outcomes for the women in their care. They expressed frustration, powerlessness and a sense of disillusionment that they were often unable to carry out this philosophy. The midwives described the experience of relinquishing their desire for normal birth as they negotiated and navigated their way in an environment that was governed by medical authoritative knowledge that dominated midwifery care. Additionally the midwives spoke of their ability to reflect on the reality of childbirth in maternity facilities and were mostly philosophical about the relinquishing of

normal birth outcomes. At times however, the midwives did express a sense of grief at this loss of normality.

It would appear from this research that the institutionalised culture overrode the midwives' ability to promote and facilitate normal childbirth in a way that they believed was to the best of their capabilities. Throughout the transcripts there were examples of the positive experiences of effective collaboration between medical and midwifery staff, and these were expressed by the midwives as being very important to their personal and professional satisfaction levels.

This research has highlighted the need for an effective way in which midwives can practice their philosophical beliefs in facilitating normal childbirth. The midwives in this study reported feeling unable to promote normal birth as effectively as they wished to because of the over-riding obstetric influence in their hospitals. This thesis has offered and explored the concept of parrhesia, to speak without fear, as a means for midwives to express themselves in an articulate and unified form to challenge obstetric governance.

This study has identified a gap in our understanding of how midwives interpret the birthing process within an Australian context. It has illuminated the discord and disconnect that midwives feel when working in a hospital environment that is predominately obstetrically orientated. Further research is required to identify factors that may facilitate a more equitable and collaborative approach between the midwifery and obstetric professions, so that labouring women can have every opportunity of achieving normal birth outcomes.

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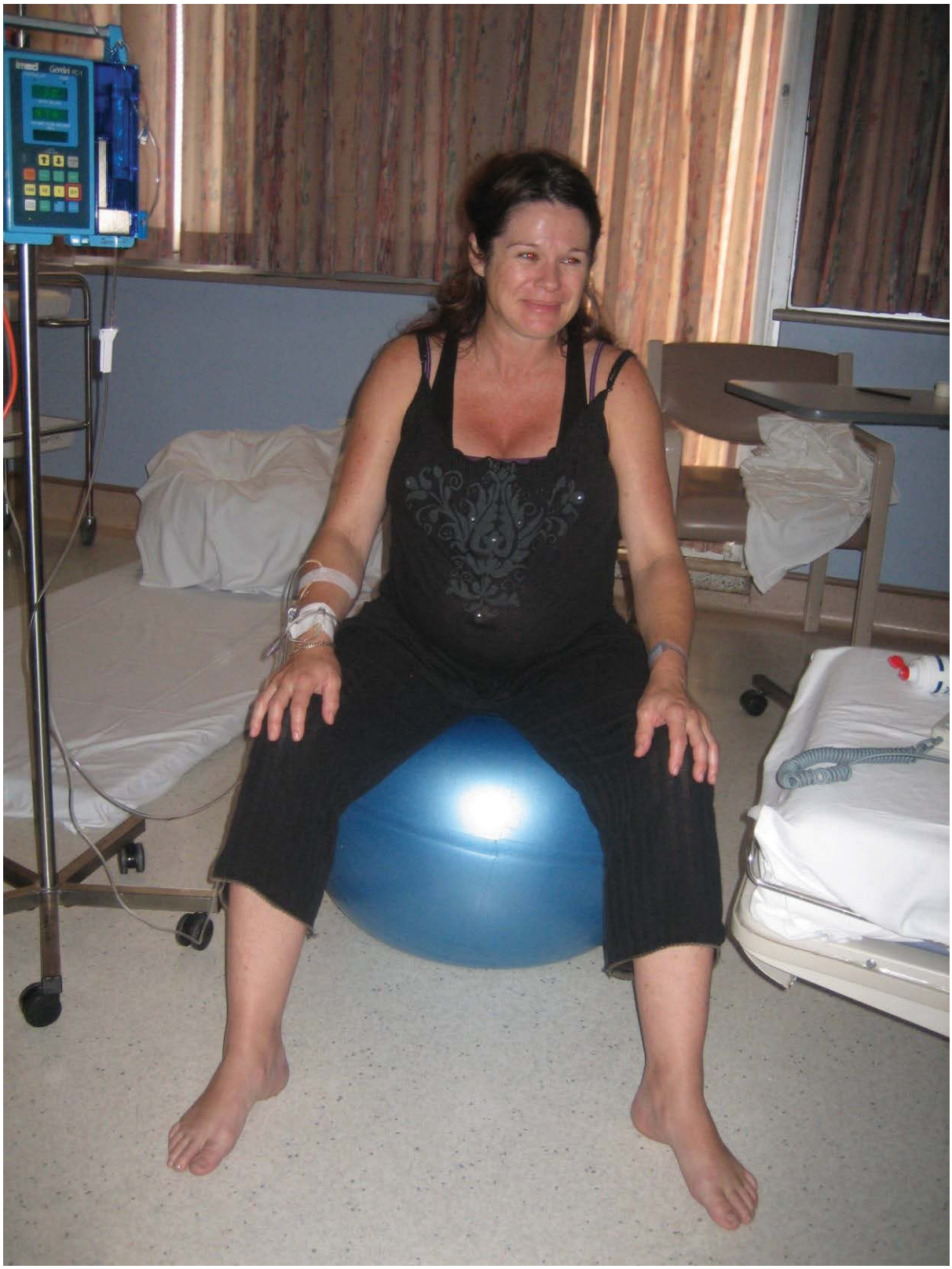
APPENDICES

APPENDIX 1: PHOTOGRAPH USED IN STUDY



APPENDIX 2: ETHICS CLEARANCE LETTER

16 March 2009

Professor Caroline Homer

Faculty of Nursing, Midwifery and Health

CB10.07.211

UNIVERSITY OF TECHNOLOGY, SYDNEY

Dear Caroline,

UTS HREC 2009-010 – HOMER, Professor Caroline, DAHLEN, Associate Professor Hannah (for COPELAND, Ms Felicity, Masters Student) – "What role do midwives' beliefs have on their interpretation of childbirth?"

Thank you for your response to my email dated 18/02/09. Your response satisfactorily addresses the concerns and questions raised by the Committee, and I am pleased to inform you that ethics clearance is now granted.

Your clearance number is UTS HREC REF NO. 2009-010A

Please note that the ethical conduct of research is an on-going process. The *National Statement on Ethical Conduct in Research Involving Humans* requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

If you have any queries about your ethics clearance, or require any amendments to your research in the future, please do not hesitate to contact the Ethics Secretariat at the Research and Innovation Office, on xxxxxxxxxxx.

Yours sincerely,

Professor Jane Stein-Parbury
Chairperson
UTS Human Research Ethics Committee

APPENDIX 3: ADVERTISEMENT

ATTENTION MIDWIVES

HOW DO YOU INTERPRET CHILDBIRTH WHEN SHOWN A PHOTOGRAPH?

My name is Felicity Copeland and I am a student at UTS enrolled in a Masters (Hons) Midwifery research degree. My supervisors are xxxxxxxxxxx and xxxxxxxxxxxx

I am conducting research into how midwives interpret labour and birth when shown a photograph of a labouring woman. Participating in the project would involve one face to face interview that would take no more than one hour. Confidentiality is assured.

I welcome all levels of experience and any midwives who live in the metropolitan Sydney area who care for women during labour.

If you are interested in participating and would like to hear more about the research please contact me on xxxxxxxxxxx. My email address is xxxxxxxxxxxxx

Appendix 4: Research Process Letter

Thank your for your interest in participating in the research project

Here is some information about the research process.

The interview will consist of semi-structured questions that aim to facilitate a conversation around how midwives interpret the process of labour. A photograph will be used to help stimulate conversations about how you care for women in labour. I am interested in how midwives make clinical decisions and their thought processes behind this. The interview will be tape recorded and later transcribed. These tapes will be de-identified and confidential and in no way will be recognisable in the final thesis. The tapes will be stored in a secure facility according to the UTS research data protocol.

Please find attached a copy of the consent form for you to look at. If you feel you would like to participate I would be happy to arrange a time that suits you for the interview in the next few weeks. It will take no more than one hour and I am happy to meet you either in a quiet spare room at work or anywhere else you feel is appropriate. Please feel free to email me with any questions about the research.

APPENDIX 5: CONSENT FORM

Removed form this publication to protect confidentiality