Towards an understanding of midwifery practice in relation to managing the risk of severe perineal trauma for women of Asian ethnicity in the Australian setting: An ethnography

Submitted by

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A Professional Doctorate submitted in partial fulfilment of the requirements for the degree of Doctor of Midwifery

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January, 2014

CERTIFICATE OF ORIGINAL AUTHORSHIP

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

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

Signature of Student:

Date:

ACKNOWLEDGEMENTS

To the midwives who can be heard in this ethnography, thank you for so generously opening the door to your complex professional world. There was a great deal to learn and understand.

To the gracious, gentle antenatal women who invited a stranger into the midst of one of their most sensitive life experiences, thank you. My hope is that this ethnography may (in some way) help improve your childbirth experience by reframing midwifery care.

Without the support of the midwives, midwifery students, antenatal women, managers of the selected site and my place of work, this ethnographic research could not have been undertaken.

Special thanks go to my supervisors, Professor Deborah Davis, Professor Caroline Homer, Professor Margaret Fry and, previous supervisor, Professor Pat Brodie. Their continued guidance and support throughout this research helped shape my foundational understanding of ethnography.

Ethnography has taught me to step back and look at alternative realities, broadened my perspectives and changed the way I see things.

To my family, your love, support and broad shoulders have kept me afloat.

To the many people not mentioned here, who made a difference - thank you.

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PUBLICATIONS AND PRESENTATIONS ARISING FROM THE THESIS

Wheeler, J.L., Davis, D., Fry, M., Brodie, P. & Homer, C.S.E. 2012, 'Is Asian ethnicity an independent risk factor for severe perineal trauma in childbirth? A systematic review of the literature', *Women and Birth,* vol. 25, no. 3, pp. 103-13 (Appendix 1).

Wheeler, J.L. 2011. Midwifery clinical practice and perineal trauma in women experiencing spontaneous vaginal birth: What do midwives do? Conference presentation at the *International Confederation of Midwives, 29th Triennial Congress,* Durban, South Africa.

GLOSSARY AND ABBREVIATIONS

Accoucheur	Birth attendant
Active second stage of labour	The woman's cervix is fully dilated and she is actively pushing
ANC	Antenatal Clinic
Asian	People originating from Malaysia, Burma, East Timor, Thailand, Philippines, South Korea, North Korea, Cambodia, Taiwan, Laos, China, Vietnam, Hong Kong, Japan or Indonesia (Dahlen, Ryan, et al. 2007)
Crowned	The baby's occiput births under the symphysis pubis and the head does not retract
CTG	Cardiotocograph : An electronic monitor as a method of listening to the FHS, or recording the FHS and maternal uterine contractions
Delivery Suite	A place located in a hospital, where women in labour are cared for
EAS	External anal sphincter
Episiotomy	Scissors are used to make a cut into the vagina and perineum to make the opening of the vagina larger to allow the baby's head to be born
Ethnicity	Refers to "a person's origins rather than their present nationality" (Waite & Hawker 2009) and includes the social group a person relates to, including physical features (Bhopal 2004)
FHS	Fetal heart sounds
Follow through experience	Provides a midwifery student with opportunities to follow women during pregnancy, birth and the postnatal period. In

	this way, the midwifery student is exposed to a midwifery continuity of care experience (Gray et al. 2013).
IAS	Internal anal sphincter
Instrumental birth	Where instruments such as, a vacuum extractor or forceps are used to deliver the baby
MUM	Midwifery Unit Manager
O&G	Obstetrics and Gynaecology
Origin	Defined as "…a person's background or ancestry" (Waite & Hawker 2009)
RPG	Reflective Practice Group
Spontaneous vaginal birth	Labour occurring at term, with spontaneous onset and the baby's head presenting. Birth is completed, with no complications or medical interventions
SWSLHD	South West Sydney Local Health District
Term	Gestation between 37 and 42 completed weeks of pregnancy
Vacuum	An instrument applied to the fetal head to assist vaginal birth
VE	Vaginal examination

ABSTRACT

Introduction: Asian ethnicity is a significant risk factor for severe perineal trauma during vaginal birth. Some Australian hospitals care for a high proportion of women of Asian ethnicity, yet little is known about the practices of midwives in relation to managing this risk.

Aim: To explore midwifery clinical practice used to minimise perineal trauma for Asian women anticipating a normal labour and spontaneous vaginal birth, within one hospital-based Delivery Suite in New South Wales (NSW), Australia.

Methodology: The research design selected for the study was ethnography.

Method: The ethnographic techniques used for the study included observations, interviews and focus groups. The total sample for the study consisted of 22 midwives, six midwifery students and 18 women of Asian ethnicity having their first baby. Ethnographic data included 13 interviews, four focus groups and 18 observations of midwives caring for women of Asian ethnicity during the second stage of labour and birth. An ethnographic framework was used for the analysis and interpretation of data.

Findings: A Delivery Suite midwifery culture of care was identified in the following six key themes: The geography of care, midwifery cultural beliefs and Asian women, the midwife-woman relationship, a communication link, protecting the perineum: rituals and patterns of practice and the right to influence and control.

Midwifery practice and the woman's childbirth experiences are shaped by the physical environment, midwifery cultural beliefs and shared patterns of care, which set the potential for reducing or increasing the incidence of maternal perineal

trauma. The midwife-woman trust and communication link is recognised as underpinning the effectiveness of all clinical practice strategies in reducing perineal trauma for Asian woman. A relationship of trust is known to reduce maternal fear and lower the incidence and severity of perineal trauma. Attempting to minimise perineal trauma for Asian women is associated with an ongoing clinical practice evolution embedded in the power and control dynamics within the midwifery cultural group in the Delivery Suite.

Conclusion: The evidence for changing maternity systems towards a more democratic, collaborative, midwifery-led focus is compelling. A strong midwifery social identity can support transformation of practice, promote the quality and safety of care, improve childbirth outcomes and reduce the likelihood of severe perineal trauma for all women.

CHAPTER 1

INTRODUCTION

In a maternity unit south west of Sydney, New South Wales (NSW), Australia, four women experienced severe perineal trauma following a vaginal birth and required colorectal surgery in 2004. In response, a 12 month retrospective audit of health care records was conducted (unpublished). Data were gathered retrospectively from the Delivery Suite birth register and the women's health care records. In approaching this audit, the decision was made that the term 'Asian' would be used to describe any woman born in South East Asia, China, India or Fiji. This audit identified that of 2,403 vaginal births, 61(2.5%) women experienced severe perineal trauma, with 64% (n=39) experiencing a normal vaginal birth, 31% (n=19) a vacuum and 5% (n=3) forceps. Twenty-five percent of the women experiencing severe perineal trauma were born in Australia, almost half were born in an Asian country and the rest were from other countries. Women born in Asian countries were over-represented in the findings. It was possible that local labour and birthing practices may be partly responsible for the high incidence of severe perineal trauma in this group of women.

Having qualified as a midwife in the 1980s, I worked for several years in this maternity unit providing care for women of many ethnic minority groups, including women of Asian ethnicity. I had initiated the severe perineal trauma audit in an attempt to identify practice issues. The finding of increased severe perineal trauma vulnerability for women of Asian ethnicity was surprising. It was this audit that led to this doctoral study.

STATEMENT OF THE PROBLEM

The experience of childbirth can have significant psychological and physical effects on women (Andrews et al. 2013; Hansen et al. 2012; Soderquist et al. 2009; Sultan & Thakar 2002; Torrisi et al. 2012; Williams et al. 2005). Severe perineal trauma (Table 1) has possible short and long term implications for quality of life and wellbeing, therefore, it is essential to minimise this adverse outcome (Bols et al. 2010; Dahlen & Homer 2008; Laine et al. 2011; Marsh et al. 2011; Nordenstam et al. 2009; Samarasekera et al. 2009; Sultan et al. 1994). Consequently, there is strong international interest in reducing the severity and incidence of perineal trauma for women following vaginal birth, as well as a general assumption that midwives attempt to minimise perineal trauma when providing intrapartum care.

Studies continue to identify Asian ethnicity as a significant risk factor for severe perineal trauma (Baghestan et al. 2010; Dahlen, Ryan, et al. 2007; Goldberg et al. 2003; Green & Soohoo 1989; Groutz et al. 2011; Handa, Danielsen & Gilbert 2001; Hopkins et al. 2005; Landy et al. 2011). No studies focus on midwifery clinical practice in relation to Asian ethnicity and perineal integrity for normal labour and vaginal birth. This ethnographic study aims to bridge this knowledge gap by providing an in-depth understanding of midwifery clinical practices used to minimise perineal trauma in Asian women experiencing normal labour and spontaneous vaginal birth.

For the purposes of parsimony, the terms ‘Asian women’ and ‘Asian midwives’ will be used throughout the thesis. These terms are not meant to be disrespectful in any way and are used only when necessary.

The following classification of perineal tears after vaginal birth is becoming internationally recognised. Thus the term 'severe perineal trauma' refers to 3rd and 4th degree perineal tears (Table 1).

Table 1: Classification of perineal tears

First degree	Injury to perineal skin only
Second degree	Injury to perineum involving perineal muscles but not involving the anal sphincter
Third degree	Injury to the anal sphincter involving the anal sphincter complex: • 3a: Less than 50% of External Anal Sphincter (EAS) thickness torn • 3b: More than 50% of EAS thickness torn • 3c: Both EAS and Internal Anal Sphincter (IAS) torn
Fourth degree	Injury to perineum involving the anal sphincter complex (EAS and IAS) and anal epithelium.

(Royal College of Obstetricians and Gynaecologists 2007)

Ethnicity tends not to be considered by the majority of studies investigating perineal trauma, or the results are frequently inconclusive due to insufficient numbers in ethnic groups (Dandolu et al. 2005; Goldberg et al. 2003; Groutz et al. 2011; Handa, Danielsen & Gilbert 2001). In some studies, the lack of understanding regarding birth outcomes for various ethnicities effectively builds flaws into the research design for example, combining Pacific Islander and Asian women into one group (Hopkins et al. 2005; Landy et al. 2011). Some Asian women, such as those from Vietnam, may have an ethnic origin that could increase their risk of severe perineal

trauma compared with women of a different Asian ethnic origin. It is difficult, however, to compare studies on this topic as there are no standard international definitions for the terms *ethnicity*, *race* or *Asian* (Bhopal 2004).

Midwifery practice should, as far as is possible, be evidence-based and yet this clearly does not always occur. Sanders, Peters and Campbell (2005) identified techniques (which are essentially not supported by research) that were used by midwives to control perineal tearing and pain during labour and birth. Some clinical practice techniques may undermine or support perineal integrity for example, the use of episiotomy or perineal massage (Beckmann & Stock 2013; Carroli & Mignini 2009). These techniques will be expanded on later in this document. The incidence of perineal trauma appears to be dependent on numerous factors, such as usual practice within the maternity unit, expertise, personal experience and philosophy of the individual birth attendant (Eason et al. 2000; Graham et al. 2005; Parsons & Griffiths 2007).

PURPOSE OF THIS STUDY

The purpose of this study was:

- To explore what midwives do to minimise perineal trauma when caring for Asian women during the second stage of normal labour and spontaneous birth.

AIM

The aim of the study was:

- To explore midwifery practice used to minimise perineal trauma for Asian women anticipating a normal labour and spontaneous vaginal birth, within one hospital-based Delivery Suite in NSW, Australia.

RESEARCH QUESTION

The research question was:

- What practices are used by midwives to minimise perineal trauma for Asian women during the second stage of normal labour and spontaneous birth?

SIGNIFICANCE

For specific ethnic groups there is a dearth of research regarding practice interventions during labour and birth related to reducing perineal trauma. It is unknown if midwives take into account the ethnicity of the woman when attempting to reduce perineal trauma during childbirth. It is also not known what influences midwifery practice in these circumstances. This ethnographic study aims to fill a gap in midwifery practice literature.

STRUCTURE OF THE THESIS

This thesis is structured in a series of eight chapters. Chapter 1 has presented an outline of the events that led to this study as well as the purpose, aim and research question. Chapter 2 presents a literature review that was undertaken to inform the study. The chapter is divided into three main sections: the importance of reducing perineal trauma for women, what can be done to reduce the incidence of perineal

trauma and the impact of ethnicity. Chapter 3 then describes the ethnographic methodology and methods applied in this study. The processes of selection and recruitment of participants, data collection and data analysis are explained in detail as are the ethical considerations.

A description and explanation of the results is provided in four chapters. Chapter 4 provides demographic information on participants and describes the influence of the physical environment, and midwifery beliefs on practice culture. Chapter 5 illustrates the shaping of midwifery relationships with Asian women and support people, within a Delivery Suite culture of care, while chapter 6 portrays the cultural dimensions of midwifery intrapartum practice. The final results chapter, Chapter 7 highlights the power and control factors influencing and surrounding the midwifery culture in Delivery Suite.

Chapter 8 discusses the results in relation to other research in this field. The limitations and strengths of the study are presented. The chapter concludes with a section on the implications of the study and recommendations for the future. New ways of thinking are presented to enable reframing of midwifery intrapartum practice culture within an acute hospital setting.

Information and supporting documents are included in the Appendices. The appendices consist of: a publication, participant study information and consent forms, research participation notification, observational template, an interview guide and copies of the approval letters from the relevant Human Research Ethics Committees.

SUMMARY

Severe perineal trauma following vaginal birth holds numerous negative health and social connotations for women. Women of Asian ethnicity are known to have an increased vulnerability to this adverse childbirth outcome. It is unknown what midwives do to minimise perineal trauma for Asian women during childbirth. This ethnographic study intends to explore what midwives do to minimise perineal trauma when caring for Asian women during the second stage of normal labour and spontaneous birth. The structure of the thesis is briefly described.

The next chapter provides a literature review that; considers why it is important to attempt to reduce the incidence of severe perineal trauma for women, describes practice techniques that may support a reduction in the incidence and severity of perineal trauma, examines the impact of Asian ethnicity on perineal integrity during childbirth and reveals the gaps in the midwifery practice body of knowledge.

CHAPTER 2

LITERATURE REVIEW

The previous chapter introduced the problem, significance and purpose of the ethnographic research. This chapter provides a review of the literature related to; why reducing the incidence and severity of perineal trauma during childbirth is important for women, specific intrapartum practice techniques that may support a reduction in the incidence and severity of perineal trauma and the effect of Asian ethnicity on perineal integrity during childbirth. Finally, gaps in the midwifery practice body of knowledge are disclosed. Part of this literature review has been published in a peer reviewed midwifery journal (Wheeler et al. 2012).

A literature review was conducted searching Ovid Medline, CINAHL, Cochrane and MIDIRS databases in English, using the terms “perineum”, “perineal trauma”, “perineal tears”, “severe perineal trauma”, “perineal laceration”, “perineal management”, “genital tract trauma”, “anal sphincter”, “anal sphincter laceration”, “anal sphincter trauma”, “ethnicity”, “Asian”, “race”, “Vietnamese”, “clinical practice”, “midwifery”, “episiotomy”, “second stage of labour” and “childbirth”. A hand search of current relevant journals also occurred. A broad review of the literature was conducted and an extensive number of articles were found on the topic of perineal trauma following vaginal birth. Specific issues on the topic were identified and have been divided into headings for this review under ‘Why is it important to reduce perineal trauma?’, ‘What can be done to impact on the incidence of perineal trauma?’ and ‘What is the impact of ethnicity?’

WHY IS IT IMPORTANT TO REDUCE PERINEAL TRAUMA?

A national report on pregnancy, childbirth and babies of Australian women revealed that out of 201,613 vaginal births in 2010, 1.8% (n=2,713) of women experienced a 3rd or 4th degree perineal tear (Li et al. 2012). During the same year in in NSW, the rate of 3rd and 4th degree perineal tears was 1.7% (n=1,129) (Centre for Epidemiology and Evidence 2012), whereas throughout Australia, incidence ranged from 1.1% (n=46) in Tasmania to 2.2% (n=61) in the Northern Territory (Li et al. 2012). Dahlen et al. (2013) describe a 36% increase (1.4% to 1.9%) between the years 2000 to 2008, in the incidence of severe perineal trauma in NSW. In 2010, the incidence of 3rd and 4th degree perineal tears for women giving birth in the South Western Sydney Local Health District (SWSLHD), NSW, was 1.4% (n=115) (Centre for Epidemiology and Evidence 2012). Located in the SWSLHD, the selected research site for this ethnographic study had a 0.7% (n=11) incidence of 3rd or 4th degree perineal tears, which was significantly lower than the NSW state average.

A number of studies have highlighted that any perineal trauma after childbirth can often lead to short or long-term morbidity (Brown & Lumley 1998; Dietz et al. 2012; Glazener 1997; Herron-Marx, Williams & Hicks 2007; Ismail et al. 2013; Rathfisch et al. 2010; Williams, Herron-Marx & Hicks 2007). For example, symptoms may include pain, sexual problems, pelvic floor muscle weakness, wound infection, urinary urge or stress incontinence and faecal or flatus incontinence. Sultan, et al. (1994) revealed inadequacy of anal sphincter repair technique and highlighted significant under reporting of anal incontinence symptoms by women with 3rd degree perineal tears following vaginal birth. The study was conducted in a

large maternity hospital in the United Kingdom (UK). The aim was to determine risk factors associated with the incidence of 3rd degree tears and the success of primary sphincter repair. Third degree tear was defined as involvement of the anal sphincter, with or without involvement of the rectal mucosa. This is a variation in definition (the term 4th degree tear was not used), which limits comparison with other studies.

The research design was a retrospective analysis of 50 women experiencing a 3rd degree tear compared with 8,553 women experiencing vaginal births over the same time period (Sultan et al. 1994). A control group was matched to the case group for parity, age and ethnic origin and proximity to time of birth. Significant risk factors for a 3rd degree tear were identified as nulliparity (no previous births), forceps birth, occipitoposterior position and increased birth weight. Sphincter defects were found in 29 cases and 29 controls and anal incontinence or urgency was present in 16 cases and 11 controls.

Every woman describing anal incontinence symptoms was found to have both internal and external anal sphincter damage and lower anal pressures (Sultan et al. 1994). It was suggested that the initial anal sphincter repair was inadequate, with approximately half the women experiencing anal incontinence caused by sphincter defects. The authors recommend asking all women if they have anal incontinence symptoms regardless of whether they had experienced perineal trauma or not. It was noted that after childbirth, none of the symptomatic women had sought medical attention. It is suggested there may be significant under reporting and lack of recognition of 3rd degree tears following birth.

These findings were supported in a prospective interventional study conducted at a hospital in the UK (Andrews et al. 2006). This study aimed to identify the incidence of recognised and occult anal sphincter laceration following vaginal birth. Over 12 months, 241 women were recruited (4% had a previous caesarean section, 96% were nulliparous). During the study, midwives provided care for 173 (72%) births and medical officers 68 (28%). Immediately following a vaginal birth, the accoucheur (birth attendant) assessed the perineal trauma (if the accoucheur was a medical officer, the midwife caring for the woman also completed an assessment). A trained researcher (medical officer) attended a vaginal and rectal examination immediately after the accoucheur, and an endoanal ultrasound scan was performed if an anal sphincter laceration was diagnosed (prior to suturing).

Two experts (blinded to the outcome) reviewed the video recording of the scans independently (Andrews et al. 2006). When the researcher examined women, the incidence of anal laceration increased from 11% to 24.5%. Midwives only diagnosed four women with an anal sphincter laceration out of a total of 30 cases and medical officers diagnosed 22 out of 36 cases. This study identified that the majority of midwives and medical officers were not able to accurately diagnose an anal sphincter laceration. Training to improve clinical practice was recommended.

The study by Andrews et al. (2006) highlighted the significant need for a broad systematic approach towards evidence-based, multi-professional training in perineal assessment and care for maternity services in the UK. A national quality improvement project was subsequently established, with the aim of improving outcomes for women experiencing perineal trauma following childbirth (Bick et al. 2010; Ismail et al. 2013). This training programme was conducted in 22 matched

maternity units. Units were allocated into 11 pairs and randomised as to when they would receive the training (either an early or late intervention). Women (n=3,681) experiencing a second degree perineal tear were recruited to the study. Results confirmed that women experienced improved outcomes such as, a reduction in the incidence of perineal suture material removal and wound infections. Following the training intervention, a significant increase in the use of evidence-based practice for perineal care was identified in the participating maternity units.

Australia does not have a national standardised, multi-professional approach towards perineal care training for maternity unit staff. Education on this topic is usually ad hoc, uncoordinated and offered by a variety of professional groups or maternity services. Therefore, quality and safety of practice standards on perineal care may fluctuate between and within maternity unit settings. This places birthing women in Australia in a vulnerable position as the quality of perineal management during childbirth cannot be confirmed.

Research is limited on the experiences of women with severe perineal trauma (Priddis, Dahlen & Schmied 2013). One study explored the experiences of postpartum women with a 3rd degree perineal tear (Williams et al. 2005). Purposive sampling occurred of ten (10) Caucasian postpartum women attending a perineal clinic at a hospital in the UK. A grounded theory approach influenced sample size and data collection, and participant recruitment ceased when data saturation was achieved.

The results identified that participants had unrecognised and unresolved psychological distress from experiencing a 3rd degree perineal tear at birth (Williams et al. 2005). The main themes generated were information/communication,

apprehension, physical impact, support, sexual relationships and emotional impact. Information/communication was identified as a significant unmet need. Health professionals did not provide accurate information and the way information was provided was considered inappropriate. Anxiety was also a significant finding and was linked to several concerns expressed by the women, for example, commencement of sexual relations, the potential physical effect of the 3rd degree tear and implications for a future birth. Recommendations included ensuring health professionals provide accurate verbal, visual and written information on 3rd degree tears in an insightful manner. It was acknowledged the sample size was small, however this exploratory study revealed previously unknown information regarding the psychological impact of severe perineal trauma.

The maternal psychological and physical effects of severe perineal trauma identified by Williams et al. (2005) have since been confirmed (O'Reilly et al. 2009; Priddis, Dahlen & Schmied 2013). Severe perineal trauma experienced during childbirth has the potential to be an adverse life changing event, with social isolation, a reluctance to seek help due to the nature of the symptoms, provision of insensitive care by health care professionals and inadequate health care support compounding the situation. Practices to reduce the incidence of severe perineal trauma during vaginal birth require consideration.

WHAT CAN BE DONE TO IMPACT ON THE INCIDENCE OF PERINEAL TRAUMA?

It is hypothesised that midwives employ a number of clinical practices to minimise perineal trauma during the second stage of normal labour and spontaneous birth. In this section the evidence for the following clinical practices will be discussed:

- Restricting the use of episiotomy
- Antenatal perineal massage
- Maternal pushing techniques
- Maternal position during second stage of labour and birth
- Clinical practice techniques

Midwives may vary considerably as to when, how and if they apply these various practices in the clinical setting.

RESTRICTING THE USE OF EPISIOTOMY

Episiotomy is a common procedure in maternity care. A systematic review examined outcomes of restrictive versus routine episiotomy (mediolateral and midline) during vaginal birth (Carroli & Mignini 2009). Eight randomised controlled trials (RCT) were included in the review and it was found that while a policy of restrictive episiotomy increased anterior genital trauma, it reduced posterior perineal trauma, the need for suturing and healing complications. No differences were found in the incidence of severe perineal and vaginal lacerations. The authors concluded a policy of restrictive episiotomy was more beneficial for women.

More than a decade previously, an extensive systematic review was conducted by Renfrew, et al. (1998) to examine evidence for reducing genital tract trauma at birth. Avoiding routine use of episiotomy was found to increase the rate of an intact perineum, although the rate of vaginal and labial tears increased (a lower impact on morbidity). The rate of an intact perineum was considered to be influenced by a number of factors such as: place of birth, birth attendant, instrumental birth, nulliparity, long or rapid second stage of labour, maternal position at birth, episiotomy, fetal malposition and macrosomia (large baby). The influence of ethnicity was unable to be clarified. Significantly, some clinical decisions such as, episiotomy were found to increase the likelihood of 3rd or 4th degree tears, whereas, a slow, unrushed labour increased the chance of an intact perineum. The evidence supported restricting the use of episiotomy at birth to reduce perineal trauma unless there are clear indications for its use. However, there is currently no universal wide agreement on what is an acceptable episiotomy rate (Graham et al. 2005).

Numerous studies (particularly over the last 20 years) have provided evidence for restrictive rather than routine use of episiotomy (Graham et al. 2005). The incidence of episiotomy is known to vary between, and within, countries and professional groups. Between 1995 and 2003, Graham, et al, (2005) confirmed that a number of European and English speaking countries experienced a trend of reducing rates for episiotomy. For example, Australia's episiotomy rate ranged from 9.9% in the Northern Territory to 20.9% in Victoria and the incidence in Canada ranged from 3% to 31%. The highest rate of episiotomy was found in Asia, South Africa and South America. Data were limited from Asia as it only included Nepal, China and Taiwan. Graham (2005) deliberated on why the practice of restrictive use of

episiotomy does not occur in a larger number of countries (particularly developing countries) and mentioned cultural beliefs or attitudes towards childbirth as possible reasons.

Thirteen years ago, Eason, et al. (2000) conducted a systematic review to examine evidence of the use of techniques and practices to minimise perineal trauma during birth. A clear, detailed description was provided of the literature search and study selection for the systematic review. RCTs and quasi-randomised studies were included and results from non-randomised studies were used to describe practices that were not evidence-based. The results confirmed that routine use of episiotomy does not prevent anal sphincter lacerations. However, midline episiotomy significantly increased the risk of anal sphincter trauma compared with mediolateral. A policy of restrictive episiotomy use was found to reduce the risk of perineal trauma, whereas a forceps birth was identified as causing more anal sphincter trauma than a vacuum or spontaneous birth. Women having their first baby, who used perineal massage for a few weeks prior to birth, were found to experience less perineal trauma.

The practice of restrictive episiotomy has gradually gained acceptance (Graham et al. 2005). The UK National Institute for Health and Clinical Excellence (2007) clinical guidelines confirm a policy of restrictive episiotomy as best practice for uncomplicated vaginal births. Use of an episiotomy is advocated only when clinically indicated such as, instrumental birth or fetal distress. Furthermore, the NSW Clinical Excellence Commission (Clinical Excellence Commission (CEC) 2012) advised that in 2009 the Area Health Service in which the selected site for this ethnographic study is situated, had the highest incidence of episiotomy rate (32.6%)

in the state. The CEC questions why NSW episiotomy rates continue to rise despite strong research evidence that restrictive use is best practice.

Apparent alternative views on the use of episiotomy continue to filter through the clinical practice literature in contrast to the above high level research evidence recommendations (Stedenfeldt et al. 2012). In particular, the last few years have seen a growing emphasis on the need for clinicians to increase their episiotomy rate in response to a number of population-based studies (Eskandar & Shet 2009; Räisänen et al. 2011; Räisänen et al. 2012). These studies may create uncertainty for some clinicians on best practice related to episiotomy initiation.

ANTENATAL PERINEAL MASSAGE

Antenatal perineal massage has been a practice advocated by midwives to reduce perineal trauma. Beckmann and Stock (2013) conducted a systematic review to assess the effect of antenatal perineal massage on the incidence of perineal trauma at birth and subsequent morbidity. A total of four, good quality RCTs were included, with a total sample size of 2,497 women. The results indicated that antenatal digital perineal massage from approximately 35 weeks gestation reduces the incidence of perineal trauma requiring suturing (mainly episiotomies). The 9% reduction was significant for nulliparous women only, who massaged, on average, once or twice a week. A 16% reduction in episiotomies was observed in nulliparous women attending perineal massage.

Perineal massage was also found to reduce the incidence of perineal pain at three months postpartum for women with a previous birth (Beckmann & Stock 2013). There was no difference in the incidence of perineal tears. No differences were

identified in either the control or experimental groups regarding occurrence of incontinence of faeces, urine, sexual satisfaction or instrumental birth. Flatus incontinence (at least daily) was described by women in one study. The sample size was small, however, and implications uncertain.

Beckmann and Stock (2013) suggest that improved outcomes from perineal massage may be due to a combination of increased motivation of the women and positive effects of massage. Further research is required on this topic. The authors recommend that women should be made aware of the potential benefits and technique of perineal massage. There was no mention of ethnicity in this review, hence, it is unknown if perineal massage would have a positive outcome for specific ethnic groups.

MATERNAL PUSHING TECHNIQUES

The conventional method of assisting women to give birth involves the accoucheur actively encouraging the woman to hold her breath and push when the cervix is fully dilated. The alternative method is to allow passive decent of the fetal head and wait until the woman feels an involuntary urge to push. Different types of maternal pushing during the active second stage of labour may cause an increase in perineal trauma as well as having an adverse effect on the fetus (Bloom et al. 2006; Simpson & James 2005; Yildirim & Kizilkaya 2008).

Simpson and James (2005) conducted an RCT in a hospital in the United States of America (USA) and included women with epidural analgesia during the second stage of labour. The main purpose of the study was to assess the impact on the fetal condition comparing two methods of maternal pushing during the second stage of

labour. The study included healthy nulliparous women with effective epidural anaesthesia. The dependent and independent variables were defined and included both methods of pushing in second stage of labour, assessment of fetal wellbeing and birth outcomes such as, perineal status. The power analysis (to reach a power of 0.90 to identify a difference of at least 5% in fetal oxygenation between the two types of maternal pushing) determined a sample size of 42 (21 randomised to each group) and 45 women were recruited to the study.

Active pushing was found to significantly compromise the fetus (increased fetal oxygen desaturation and fetal heart rate decelerations), prolong the second stage of labour and increase the incidence of perineal lacerations when compared to involuntary pushing (Simpson & James 2005). Consequently, support of the involuntary pushing method rather than active pushing during the second stage of labour was recommended.

Walsh (2008) considers the extensive evidence on involuntary pushing for well women experiencing an uncomplicated vaginal birth, as indisputable. This view, related to involuntary pushing, is supported by the National Institute for Clinical Excellence (2007) and the World Health Organization (2006) intrapartum guidelines. Nevertheless, the evidence on involuntary versus directed pushing continues to be considered controversial in some areas (Tuuli et al. 2012). A Cochrane systematic review is currently being conducted to examine the effects of different methods of pushing during the second stage of labour and subsequent maternal, and fetal outcomes (Lemos et al. 2011). Results will assist clarification and strengthen evidence on maternal pushing techniques.

MATERNAL POSITION DURING SECOND STAGE OF LABOUR AND BIRTH

Maternal position in second stage is also an important consideration due to the likelihood that some positions may reduce the risk of perineal trauma. A systematic review examined 22 randomised or quasi-randomised trials, with a combined sample size of 7,280 women, to review the effect of maternal position during the second stage of labour at full dilatation (Gupta, Hofmeyr & Shehmar 2012). The quality of the trials was inconsistent and the authors suggest caution when reviewing the results. Compared with the supine or lithotomy positions, women adopting upright positions were found to experience less episiotomies, more second degree perineal tears, fewer instrumental births, an increased blood loss (>500mLs), a reduction in abnormal fetal heart rate patterns and a non-significant reduction in the length of second stage of labour. The authors recommend that, until further results of good quality trials are available, women should be made aware of the potential benefits of upright positions but be encouraged to adopt whatever position is most comfortable for them.

Soong and Barnes (2005) examined the association between maternal position at birth and perineal outcome, with a midwife-attended spontaneous vaginal birth for women experiencing an uncomplicated pregnancy at term. Data were collected prospectively for 3,756 births using a piloted data collection form. The results identified that with first vaginal birth of babies greater than 3,500 grams, the risk for perineal trauma was significantly increased in the semi-recumbent birth position and significantly reduced with women in the ‘all-fours’ position. With regional anaesthesia, a semi-recumbent position was significantly associated with a higher

incidence of perineal trauma, whereas lateral position was associated with a significant decrease.

Most women gave birth in the semi-recumbent position. Identified limitations were small numbers in some birth position groups (Soong & Barnes 2005). Why women choose the semi-recumbent birth position is unknown but it is likely that it is heavily influenced by the preference of the care providers. The midwife-woman relationship may influence maternal positioning during labour and birth, particularly if poor communication, fear and lack of understanding of cultural norms are involved.

More than half (56% n=1,619) of 2,891 women recruited to a retrospective study in an Australian hospital, gave birth in the semi-recumbent position (Shorten, Donsante & Shorten 2002). This study examined the effect of maternal birth position (all fours, semi-recumbent, upright kneeling, squatting, standing and lateral) and of different accoucheur types on perineal trauma for women experiencing a normal vaginal birth. The main findings were that women who gave birth in the lateral position had an increased chance of an intact perineum (66.6%), compared to other positions.

Shorten, Donsante and Shorten (2002) highlighted that perineal outcomes related to accoucheur type found that women cared for by midwives (including midwifery students) had an intact perineum rate of between 56% to 61%, their episiotomy rate was 3.2% to 5.4% and tears requiring suturing were 36.1% to 39.4%. Women cared for by midwifery students, however, had the highest rate of 3rd degree tears (2.3%). Lack of expertise may be the reason midwifery students had this increased rate. Women cared for by obstetricians were found to have an intact perineum rate of

31%, their episiotomy rate (26%) was five time higher than midwives, rate for tears requiring suturing was 42% and there was a higher than average 3rd degree tear rate (1.3%) compared to the overall rate of 0.9%. An RCT was recommended to confirm the study results and it was suggested that, although not recorded, accoucheur attitudes and management techniques at birth may have influenced perineal outcomes.

Midwife-attended births were found to increase the probability of women experiencing no perineal trauma in a retrospective study conducted in Belgium (Meyvis et al. 2012). This retrospective study reviewed 557 hospital birth records to examine the effects of women (between 37 and 42 weeks gestation) adopting a lithotomy compared with a lateral position during a normal vaginal birth. Women experiencing an instrumental or preterm birth were excluded from the study. A lateral position during birth was found to reduce the incidence of episiotomy (6.7% versus 38.2%) and increase the likelihood of an intact perineum by 47% (OR: 0.53; 95% CI: 0.36-0.78) when compared with a lithotomy position.

Numerous studies continue to confirm that a reduction in the incidence and severity of perineal trauma tends to be related to maternal positions other than semi-recumbent or lithotomy. There is also a noticeable trend in the literature towards midwifery care being related to a decreased rate of maternal perineal trauma during birth, when compared with other birth attendants. Exploring midwifery practice for supporting a woman's choice to adopt the most comfortable position during the second stage of labour and birth may reveal cultural influences in the practice environment (Nieuwenhuijze1 et al. 2012).

CLINICAL PRACTICE TECHNIQUES

Various clinical practice techniques may be used by midwives when attempting to minimise perineal trauma during the second stage of labour and birth. Eason et al. (2000) addressed the significant differences in rates of perineal trauma between accoucheurs and deliberated on the possibility of unrecognised techniques that decrease trauma. Future RCTs were suggested for the following interventions: examining application of perineal compresses, flexion of the fetal head, preventing rapid expulsion of the head, manual stretching of the perineum during labour, maternal pushing with a tense perineum and maternal position during the second stage and at birth. Some of these studies have been undertaken and are outlined in this literature review.

An RCT was conducted at a teaching hospital in Albuquerque, USA, from 2001 to 2005, with the aim of comparing the effect of three clinical practice techniques on perineal integrity, late in the second stage of labour during vaginal birth (Albers et al. 2005). The three techniques were described in detail: (1) hands off the perineum until crowning, (2) massaging the perineum with lubricant and (3) using warm compresses on the perineum. Independent and dependent variables are defined with the main dependent variable being an absence of genital tract trauma. Twelve midwives were involved in the study and the ethnic backgrounds of the labouring women were primarily White, Hispanic and Native American.

Albers et al. (2005) randomised all women (who had previously provided consent), with a singleton cephalic presentation at term, with no medical complications, to one of three groups. A sample size of 1,200 (400 in each group) was calculated using a rise in the rate of an intact genital tract (baseline of 20% increasing to 30%)

and 1,211 women were randomised. None of the three practice techniques reduced or increased genital tract trauma. Primiparity and birth weight ≥ 4,000 grams were most commonly linked to genital tract trauma, with higher level of education and race/ethnicity (non-Hispanic white) having a small but significant negative effect. Birth of the fetal head between contractions and a sitting position were found to help safeguard the genital tract against trauma. Sitting upright was the predominant position when giving birth for four out of five women. This position is considered to be most appropriate by the authors, although it is suggested that reliable comparisons could not be made with alternative positions due to small or insignificant numbers.

All participating midwives were experienced and were able to offer one to one care (Albers et al. 2005). However, other facilities may not have similar resources of expertise or staff to women ratio. Clinicians are encouraged to reflect on their current practice and to offer labouring women individualised care. Unfortunately, one to one care is not an option available for most women giving birth in Australia.

An RCT investigated the influence of accoucheur 'hands-on' versus the 'hands-poised' method on the risk of perineal trauma during vaginal birth (Mayerhofer et al. 2002). Both 'hands-poised' and 'hands-on' methods were described in detail. Inclusion and exclusion criteria were clearly specified and internal validity was strengthened by involving only midwives who agreed with the study goals. Power analysis confirmed a sample size of 502 in each group (based on the ability to detect a reduction in the rate of perineal tears from 33% to 25%) and 1,076 women were randomised. No significant difference was found in the overall rate of perineal trauma in either group, however, women receiving 'hands-on' had a significantly

higher rate of 3rd degree tears than those in the 'hands-poised' group. The episiotomy rate was significantly higher in the 'hands-on' group than the 'hands-poised' group (17.9% versus 10.1%), which suggests an 'interventionist' approach may create more interventions.

Mayerhofer et al. (2002) advise the 'hands-poised' method is superior to 'hands-on' concerning overall perineal trauma rates. The influences of ethnicity or other midwifery clinical practice techniques on perineal trauma were not considered. The authors felt a significant change in clinician practice to the 'hands-poised' method may be difficult to achieve, which suggests practice change is not readily accepted by health professionals. Midwifery culture surrounding knowledge acquisition and acceptance of practice change requires further exploration.

The above practice technique of 'hands-on' versus 'hands-off' on the effect on perineal trauma described by Mayerhofer et al. (2002), was preceded by a similar RCT conducted by McCandlish et al. (1998) in the UK. Results in this study identified a significantly reduced incidence of episiotomy (RR 0.79, 99% CI 0.65 to 0.96 P = 0.008) in the 'hands-poised' group compared to the 'hands-on' group. Increased postnatal pain, however, was experienced by women ten days postpartum in the 'hands-poised' group (910 (34.1%) versus 823 (31.1%)). Furthermore, manual removal of the placenta was significantly increased in the 'hands-poised' compared to the 'hands-on' group (RR 1.69, 99% CI 1.02 to 2.78; P = 0.008). Both findings were statistically significant.

Da Costa and Riesco (2006) conducted a subsequent small RCT of 'hands-on' 'hands-off' practice techniques on nulliparous women in Brazil. Description of the techniques differed between studies examining this practice. Results identified no

difference in the incidence or extent of perineal trauma between the 'hands-off' versus the 'hands-on' group ($P > 0.5$) and babies suffered no ill effects. Episiotomy occurred more frequently in the 'hands-on' group, although the authors provide no specific data related to this outcome. As there was no difference found between the groups related to perineal trauma (except episiotomy), it was proposed that unknown factors occurring within the birthing room may be influencing the incidence and severity of perineal trauma such as, the presence of a support person.

Sanders, Peters and Campbell (2005) conducted a national postal survey of midwifery practice, with the aim of describing techniques used by midwives to reduce perineal pain during spontaneous vaginal birth, episiotomy and perineal repair. Surveys received from individuals in charge of 210 (90%) maternity units in the UK, reported a variety of non-pharmacological methods of perineal pain reduction during the second stage of labour. Fluids (hot or cold) and lubricants were either poured over or rubbed into the perineum during the second stage of labour to minimise pain associated with perineal stretching. Alternatively, hot or cold packs were used with the aim of reducing perineal tearing. In 62% of maternity units midwives reported injecting the perineum with local anaesthetic (from 50mg to 300mg) to control perineal pain during advancement of the fetal head. This unusual clinical practice is not supported by any research and frequency of use by midwives in Australia is not known. The authors suggest midwives practice a variety of mostly unknown methods to control perineal tearing and pain, and recommended RCTs to establish effectiveness of second stage interventions.

Clinical practice techniques are described as being many and varied by Aasheim, et al. (2011) in a systematic review conducted to examine the impact of practice

techniques on reducing the incidence and severity of perineal trauma during vaginal birth. Eight RCTs were included, with a sample total of 11,651 women. It is noted that some of these RCTs are described in this literature review. Application of warm compresses to the perineum, massage of the perineum and the 'hands-on' 'hands-off' techniques were found to decrease the severity and incidence of perineal trauma. Use of warm compresses applied to the perineum is recommended as the practice appears safe, cost is limited, midwives and women are accepting of the practice and incidence of perineal trauma is reduced.

One of the RCTs reviewed by Aasheim, et al. (2011) was Australian-based (Dahlen, Homer, et al. 2007). This study identified that warm packs placed on the perineum of nulliparous women (n=360) during the late second stage of labour would significantly reduce postnatal morbidity when compared to women (n=357) receiving standard care. Women of Asian ethnicity made up approximately one third of each group and the definition of Asian ethnicity corresponds with this ethnographic study. The incidence of 3rd and 4th degree perineal tears in the warm pack group compared to the standard care group was found to be significantly reduced (15/360 vs 31/375, OR = 2.16, 95% CI = 1.1-4.3, p = 0.02). Otherwise, no difference was identified in perineal trauma between groups. A significant reduction in early postnatal mean pain scores (mean 3.86 [SD 2.3] vs 4.67 [SD 2.3]) and urinary incontinence at three months (26/277 vs 59/262, p = 0.0001) occurred in the warm pack group compared to standard care. The incidence of severe perineal trauma practically doubled in the standard care group compared to the warm pack group. It was recognised that the study was underpowered for severe perineal trauma and further studies on the use of warm packs was recommended. The

eventual incidence of severe perineal trauma in this study was calculated at 6.4%, with nulliparity and Asian ethnicity considered influential factors.

As some midwives practice unproven techniques during the second stage of labour (Sanders, Peters & Campbell 2005), this raises the question as to what does the midwife take into account when deciding which specific clinical practice techniques to use, when attempting to minimise perineal trauma? Does a woman's ethnicity influence the midwife's practice? No studies have been found that consider this aspect of midwifery clinical practice.

The next section in the literature review examines the potential influence of ethnicity on the incidence and severity of perineal trauma.

WHAT IS THE IMPACT OF ETHNICITY?

Green and Soohoo (1989) were one of the first researchers to suggest that ethnicity may increase the risk of anal sphincter laceration during vaginal birth. This retrospective study attempted to estimate the risk of rectal injury during spontaneous cephalic birth for women with risk factors (combined and alone) identified in the literature. The gaps in knowledge are identified (ethnicity) and internal and external validity was strengthened by the authors explaining how information on ethnicity was obtained and how classification of each woman occurred.

From a total of 2,706 cephalic births over a two year period, 351 (13%) women experienced anal sphincter tears (Green & Soohoo 1989). Data were obtained from a database where information was entered for all births occurring in one hospital in the USA. The results identified 90% of anal sphincter lacerations occurred with midline episiotomy. Other identified risk factors were nulliparity, delivery by

physicians compared with midwives, fetal weight and ethnicity. Chinese and Filipino women were significantly more likely to have anal sphincter lacerations compared with White women. Language barriers and possible anatomical variation (short perineal bodies) were thought to be the cause of increased risk for anal sphincter lacerations in Chinese and Filipino women. The authors could not explain why women cared for by midwives had significantly lower rates of anal sphincter tears. Recommendations included the need for research to investigate the variety of management techniques used during birth by accoucheurs.

Handa, et al. (2001) conducted a retrospective study to estimate the incidence of anal sphincter laceration and identify risk factors. The sample included 2,101,843 vaginal births from 1992 to 1997 at hospitals in California. Stillbirth, breech, multiple and preterm births were excluded. Age and other factors were controlled for using logistic regression. The results indicated that incidence of anal sphincter laceration decreased significantly from 6.35% in 1992, to 5.43% in 1997, at the same time use of episiotomy significantly reduced (41.6% to 35.3%). The risk for severe perineal lacerations was increased in women with an Indian (OR 2.5; 95% CI 2.23-2.79), Filipina (OR 1.63; 95% CI 1.50-1.77) and Other Asian (OR 1.37; 95% CI 1.29-1.45) ethnic or racial background. Ethnicity was not differentiated within the Other Asian group even though this group made up 6.5% (129,220) of the total sample, which is significantly higher than the Indian (0.7%) and Filipina (2.3%) groups. It was mentioned that it was not possible to control for the experience, training or techniques used by accoucheurs, or maternal position at birth.

In the USA, Goldberg, et al. (2003) examined the association between maternal race, the incidence of 3rd and 4th degree perineal tears and the rate of perineal trauma

(with and without instrumental birth or episiotomy) in one hospital. It was hypothesised that the incidence of perineal trauma would increase in Asian women, and in women experiencing episiotomy during vaginal birth. A retrospective, electronic audit of 34,048 vaginal births from 1983 to 2000, identified that 3,487 (10%) women had experienced a 3rd or 4th degree perineal tear. There were 833 Asian women in this group.

Asian race was identified as an independent risk factor for 3rd or 4th degree perineal tears (OR 2.04; 95% CI 1.43-2.92) compared to White race, whereas Black race (OR 0.42; 95% CI 0.35-0.52) was protective (Goldberg et al. 2003). Asian women were found to be particularly at risk for anal sphincter injury if they experienced an instrumental birth and an episiotomy. The terms *race* or *Asian* were not defined and the Asian group was described as being mainly Chinese, although there were other ethnicities for example, Laotian and Vietnamese. It is suggested that results related to this heterogeneous group could not be generalised and further exploration is required.

Hopkins, et al. (2005) advise there is still a lack of clarity regarding the effect of ethnicity on perineal integrity. Understanding if, and why, ethnicity affects the incidence of perineal trauma may provide the clinician with relevant information to enable adaptation of clinical practice techniques to minimise perineal trauma. This retrospective study aimed to identify variations in ethnicity in perineal, vaginal and cervical tears following vaginal birth in nulliparous women. Data were extracted from a database at the University of California from 1976 to 2001. Ethnicity was self-reported and was grouped as Other Asian (South East Asian, Indian and Pacific Islander), Native American, Japanese, Philippino, Chinese, Latina, African

American, White and Unknown. From a sample of 17,216 births, 2,645 (15.4%) women experienced a 3rd or 4th degree tear. Other Asian (19.3%), Chinese (23.3%) and Philippino (21.9%) groups had the highest number of 3rd and 4th degree tears. The Other Asian group was a combination of South East Asian, Indian and Pacific Islander women.

A comparative study investigated experiences of childbirth in women born in Vietnam, Turkey and Australia, who gave birth in Australia (McLachlan & Waldenstrom 2005). A sample of 100 Vietnamese and 100 Turkish women were compared with 100 Australian born women, following a normal vaginal birth of a well, term baby. All women were interviewed 24 hours after birth and prior to going home. Vietnamese women viewed childbirth significantly more negatively, reported more pain and used significantly less pain relief. However, they felt less anxiety, less panic and more confidence than the other groups. Vietnamese women experienced significantly more episiotomies (29%) compared to the Turkish (18%) and Australian (16%) groups. Cultural background, lack of cultural awareness by staff and communication barriers are suggested as influencing women's responses to childbirth.

A two year prospective cohort study of all vaginal births (1998 to 2000) was conducted at a maternity unit in NSW, with the objective of identifying risk factors for 3rd and 4th degree tears (Dahlen, Ryan, et al. 2007). This hospital had one of the highest, severe perineal trauma rates in NSW, which was thought to be caused by the large number of Asian women attending the facility. Data from 6,595 women was entered into an electronic database following birth. If women experienced a 3rd or 4th degree perineal tear during birth, midwives were asked to document on a

survey form (when completing the health record following birth) any risk factors and reasons why they felt the trauma had occurred. Survey form comments were explored in discussion groups attended by a total of 25 Delivery Suite midwives. The results identified a 2% (n=134) severe perineal trauma rate over the two year period, with 91% (n=122) 3rd degree and 9% (n=12) 4th degree tears.

Severe perineal trauma was found to occur more often if women were of Asian background, had no health insurance and when interpreters were needed (Dahlen, Ryan, et al. 2007). The majority of women in this group were having their first baby (OR 4.6; 95% CI 2.9-7.2). Severe perineal trauma was experienced by nearly twice as many Asian than non-Asian women (OR 1.9: 95% CI 1.3-2.8). The term 'Asian' was classified as the woman's country of birth. Classifying Asian women by country of birth, however, is a study limitation, with individual ethnic background being misrepresented, for example ethnicity could be Chinese and country of birth could be Australia. This is the first study identified that directly asks midwives their opinion as to why 3rd or 4th degree tears occur during birth. Analysis of the data from survey forms and discussion groups identified that poor communication during birth, a short perineum and Asian ethnicity were thought to be risk factors for severe perineal trauma.

Secondary analysis of data from an RCT conducted in Australia, examined postpartum perineal morbidity following vaginal birth for primiparous Asian and non-Asian women (Dahlen & Homer 2008; Dahlen, Homer, et al. 2007). Data were collected from two maternity units in NSW, during 1997 to 2004. One third of women were classified as from an Asian background, from a sample of 717 nulliparous women. Asian women were more likely to experience an episiotomy

(18% vs. 8%, OR 2.4, 95% CI 1.5-0.38) and a 3rd or 4th degree perineal tear (11% vs. 4.5%, OR 2.6, 95% CI 1.4-4.7) compared with non-Asian women. Asian women were least likely to adopt an upright position for birth and postnatal morbidity was increased. Midwives provided the intrapartum care for all women. The need for further studies to explore maternal fear and communication barriers between birth attendants and Asian women was highlighted.

Studies examining perineal integrity following vaginal birth tend to apply specific clinical practices and identify outcomes on techniques such as, 'hands on' or 'hands off' the perineum during birth or applying warm compresses (Albers et al. 2005; Da Costa & Riesco 2006; Dahlen, Homer, et al. 2007) , which limits understanding. These studies 'apply' practice techniques to the birthing process rather than looking at what is actually happening in the context of the birthing room setting.

Significant ethnic group disparities were identified for hospital maternal childbirth morbidities in a retrospective cohort study conducted in Wisconsin, USA, during 2005-2007 (Cabacungan, McGinley & Ngui 2012). Data were accessed via the state dataset and a sample of 206,428 women aged 13 to 53 years of age, belonging to six ethnic groups (African-Americans (9.5%), Whites (72.2%), Hispanics (8.2%), Asian/Pacific Islander (2.8%), Native Americans (1.1%) and Other Race (1.8%)) were extracted. Incomplete data was excluded from the sample (4.4%). Definition of ethnic groups was not provided and ethnicity was self-reported. A number of morbidities were examined using multi-variable logistic regressions after adjustments for covariates. Ethnic minority groups were found to experience more health related morbidities. Amongst a number of increased health related morbidities, the incidence of 3rd and 4th degree tears (OR = 1.53; 1.34-1.75) was

significantly higher in the Asian/Pacific Islander group compared to other groups. The African-American group was least likely to experience 3rd and 4th degree perineal tears. Clearly, ethnicity does impact on health related disorders during pregnancy and childbirth. Why women from an Asian background have significant health vulnerabilities such as, a high incidence of severe perineal trauma requires further exploration.

SUMMARY: WHAT ARE THE GAPS IN THE LITERATURE?

Asian ethnicity has been identified as a significant risk factor for severe perineal trauma during childbirth by numerous studies (Dahlen & Homer 2008; Dahlen, Ryan, et al. 2007; Goldberg et al. 2003; Green & Soohoo 1989; Handa, Danielsen & Gilbert 2001; Hopkins et al. 2005; McLachlan & Waldenstrom 2005). The lack of an international definition for Asian ethnicity, however, limits the generalisability of research findings (Wheeler et al. 2012). When attempting to determine whether Asian ethnicity was an independent risk factor for severe perineal trauma, a systematic review (Wheeler et al. 2012) identified that reviewed studies were relying on indirect data collection. No observational data of birth attendants providing intrapartum care for Asian women was provided. Current research on this topic was found to be confusing and conflicting. Moreover, a definitive answer as to why Asian women have a significant risk factor for severe perineal trauma was not available.

It is not known if midwifery intrapartum care differs for Asian women compared with women of other ethnic backgrounds. It is also unknown what influences midwifery practice in these circumstances. No studies have been found that explore midwifery intrapartum practice for women of Asian ethnicity, with a focus on

perineal care during the second stage of labour and vaginal birth. Midwifery practice when caring for Asian women during labour and birth may be so instinctive and subtle that possibly midwives themselves are unaware they are applying a particular practice approach, or specific techniques, during care provision. Specific cultural factors or the context of care may be indirectly influencing intrapartum practice.

This ethnographic research aims to close the gap in the national and international midwifery body of knowledge. The findings of this ethnographic research will provide an in-depth understanding of a midwifery practice culture in context, when midwives attempt to reduce perineal trauma for Asian women during childbirth. The new knowledge gained from this study will have significant implications for the midwifery profession and may lead to changes in practice in similar situations or settings.

CONCLUSION

This chapter has reviewed the literature on the implications of perineal trauma during childbirth for women. Practices that may minimise perineal trauma during pregnancy, labour and birth have been considered. The significance of Asian ethnicity on maternal childbirth perineal outcomes has been examined and gaps in practice knowledge have been disclosed. The following chapter outlines the methodology and method applied in this study to explore a Delivery Suite midwifery practice culture when providing Asian women with intrapartum care during the second stage of labour and vaginal birth.

CHAPTER 3

METHODOLOGY AND METHOD

The previous chapter provided a review of the literature and discussed the potential maternal implications for sustaining severe perineal trauma during childbirth. A number of well-known practice techniques and the effect of ethnicity on the incidence and extent of perineal trauma were considered. Gaps in the midwifery practice literature were identified.

This chapter describes the methodological framework and method that underpins this study. Wheeler, et al. (2012) recognised that quantitative studies did not have the capacity to fully explain why Asian women had an increased vulnerability for severe perineal trauma in some childbirth settings. A qualitative research strategy was required that would allow the researcher to explore and uncover unknown aspects of midwifery intrapartum practice culture related to the study topic. Ethnography provided the most appropriate methodological framework to better understand midwifery practice when providing intrapartum care for Asian women during the second stage of labour and birth. The ethnographic method processes of sampling techniques, fieldwork, data collection and analysis are detailed. Strengths of applying an ethnographic methodology, within a Delivery Suite context, are considered.

An ethnographic approach was required to provide an in-depth understanding of the complex practice world of midwives within an acute hospital Delivery Suite setting in Australia. The ethnographic approach provided for a rich and deep understanding

of the meaning behind what midwives do and why, when attempting to minimise perineal trauma for Asian women during the second stage of labour and birth.

ETHNOGRAPHY AS METHODOLOGY

As a research methodology, ethnography enables the researcher to step into and explore the cultural world of midwives, in order to learn and develop an understanding of the clinical role and social reality underpinning midwifery practice (Fetterman 2010; Hammersley & Atkinson 2007). The shared knowledge of embedded practices, behaviours and processes influencing participants are able to be considered contextually within the ethnographic framework (Van Maanen 2011). Ethnography provides the application of a cultural lens, which enables insight and interpretation of the meaning behind midwifery intrapartum practice behaviour and consideration of the possible implications. Analysis of experiences during fieldwork, therefore, will generate an account of a culture of care from this ethnographic perspective (Van Maanen 2011). Ethnography provides the opportunity for research participants to describe their culture and to explain why they do what they do (Van Maanen 2011; Wolcott 2008). Consequently, the voices of midwives can be heard in this ethnography, through detailed, rich description and direct quotations on practice and behaviour when attempting to reduce perineal trauma for Asian women during childbirth. Ethnography provides for an authentic, detailed narrative of midwifery practice culture from the perspective of midwives.

Ethnography originated within the discipline of anthropology and has a long history as a mode of inquiry (Hammersley & Atkinson 2007; Van Maanen 2011). While in the late 19th and early 20th centuries, ethnographic methodology was considered erratic and ad hoc (Van Maanen 2011), ethnographers have sought to better

standardise the way data was collected, documented and analysed. For many ethnographers, and to address the criticisms from the late 1920s, the theoretical framework of functionalism was widely adopted. This anthropological theoretical stance viewed social systems as being reliant on behavioural patterns and customs for ongoing stability and existence (The Columbia Electronic Encyclopedia 2012). Functionalism provided credibility and was widely used to underpin ethnographic research (MacDonald 2008). This strengthened and supported ethnographic methodology and the research process. Functionalism was credited to Bronislaw Malinowski (1884-1942) in the UK (Vincent 2001) who emphasised the need to enter the field to better understand the contextual setting. Hence, functionalism influenced cultural change within anthropology and fieldwork practice, which gradually redirected ethnographers towards exploring and trying to understand the 'how' and 'why' of group culture from the perspective of the individual (MacDonald 2008; Van Maanen 2011). Fieldwork (observation and interaction with the people within the group) was now considered key to being able to understand how people see, behave and function within their own world.

A functionalist approach believes that cultural factors intersect with social, psychological and physical needs of people within a group (Islam 2013). Group culture was seen as tightly controlling and influencing the way people related and behaved towards each other (Munch 2001). Cultural groups were thought to share similar patterns of social interaction, knowledge and behaviour. The concept of functionalism embraces holism and social praxis, which facilitate openness to the exploration of cultural groups (Krzysztof 1992; MacDonald 2008). Hence, ethnography is ideally suited to exploring and understanding clinical environments.

As a qualitative methodology, ethnography opens up the world of clinical practice and more specifically the culture of care of midwives working within one Delivery Suite in Australia. Underpinned by functionalism, an ethnographically informed study could demonstrate the value and strength of undertaking clinical research and immersion in practice when attempting to understand the everyday experiences of a midwifery group in context. More specifically, ethnography assists in uncovering the meaning behind what midwifery groups do during childbirth to reduce severe perineal trauma in Asian women, within a clinical setting.

The use of ethnography as a research methodology and approach has increasingly been adopted by a variety of disciplines throughout the world (Atkinson et al. 2008; Hammersley & Atkinson 2007). Ethnography usually consists of a study being conducted with one cultural sharing group in their natural setting. A hospital Delivery Suite is a most suitable example. Midwives share knowledge, understanding and meanings within their cultural contexts. Ethnography facilitates holistic, in-depth description and understanding of a group through a cultural lens.

Ethnography enables various data collection methods to be utilised and triangulated to reach understanding and insight into the cultural phenomenon. Generally there is no pre-arranged rigid data collection design to enable categories to emerge. Instead, during data collection and subsequent analysis, understanding and insights undergo an iterative process which yields insights and patterns of the cultural group. Ethnography enables comparison of multiple data sources (triangulation) and broadens the context to inform findings. Within ethnography, this is recognised as triangulation of data.

Triangulation of ethnographic data usually involves direct observation, interviews and focus groups thereby strengthening data credibility and validity (Bryman 2004; Burns & Grove 2005; Fetterman 2010; Hammersley & Atkinson 2007; Rock 2008; Stewart 1998; Van Maanen 2011; Wolcott 2008). It is in this way that the ethnographic researcher can obtain a view of individual and group practice. Some ethnographic techniques include: fieldwork, participant observation and interviews. For the purposes of this thesis, the researcher was able to capture glimpses of multiple layers of midwifery practice coexisting and operating to influence practice.

Ethnographic data analysis supports interpretation of the meaning behind what people do, why they do it and the implications of behaviour. However, ethnography acknowledges the researcher within the research process and seeks to minimise the impact on the study findings. Nonetheless, the final ethnographic product would resonate with the cultural group under study (Hammersley & Atkinson 2007; O'Reilly 2005; Stewart 1998).

Ethnography was, therefore, chosen as the methodology to explore midwifery practice in an acute hospital Delivery Suite setting. Ethnography provided a way to explore the practice world of midwives and, as a cultural group, how they undertake everyday work. A strength of ethnography is in the detailed and rich description of the context of practice, which arises from fieldwork. This is achieved only through prolonged fieldwork which is necessary to provide sufficient exposure to experience, learn and understand a group's culture. Prolonged ethnographic fieldwork also enables the development of positive field relationships thereby, enhancing the rigour and validity of the study.

Ethnography as a methodology is strengthened through the credibility of prolonged fieldwork, interviews and focus groups. The voices of the cultural group can be heard as a result of the iterative analysis process and triangulation of data. The reliability and validity of ethnography is further enhanced as a result of prolonged fieldwork, which provides time to gain knowledge, maintain accuracy and strengthen understanding of a cultural group (Silverman 2006). Ethnography was therefore considered as a most suitable methodology to explore and understand the practice of midwives within a hospital Delivery Suite.

REALISM - ETHNOGRAPHY AS TEXT

Ethnographic realism was selected as a framework, a style of writing, to capture ethnography as text (Marcus & Cushman 1982). Realism claims that only by being in the field can a researcher truly understand, interpret and more specifically, convey a group's cultural context. Realism provides researchers with a framework to capture participant voices in a way that pushes the researcher intentionally into the background. In this way the readers of an ethnography are able to believe that the presentation of data is a real and accurate reflection of what took place within the cultural context (Van Maanen 2011).

Within ethnography, realism provides the framework for detailing and describing a culture of care through participants' thoughts, behaviours and actions. The researcher, in presenting a realist tale, seeks to convey objective data in a scholarly, considered style that minimises researcher bias, political imperatives or moral beliefs. In this way, a realist framework presents an objective, holistic portrayal of a cultural group (Marcus & Cushman 1982).

Realism provides a researcher with a framework that ensures the voices of participants are heard. This is achieved through the rich detailing and in depth descriptions provided within text. Only through this thick and rich description are participant voices appropriately and accurately contextualised. Hence, realism ethnographies, as presented in this thesis, ensure that the textual accounts of participants are provided from the viewpoint of participants. For this reason, a realist lens was chosen to provide an authentic cultural description of contemporary midwifery practice.

Realist ethnographies enable the researcher to directly observe, hear and feel what is going on in everyday practice in order to learn and understand how and why midwives do what they do (Fetterman 2010; Van Maanen 2011). For the purposes of this thesis, the realist style of writing is seen to align with anthropological functionalism to convey the world as it really is, permitting an objective account of the multi-layered realities of participants and the group as a whole (Emerson, Fretz & Shaw 2008). Shared midwifery practices and customs are detailed. The ethnographic findings give voice to this midwifery group, within the context of their everyday working environment.

METHOD

Ethnographic methods enabled the researcher to enter the cultural context of midwifery practice, within one Australasian Delivery Suite. The ethnographic methods provided an opportunity to collect in-depth data from prolonged immersion in the field to obtain a detailed understanding of the complex practice world of midwives, within an acute hospital Delivery Suite setting in Australia. The methods and processes of site selection, sampling techniques, data collection (observation,

interviews and focus groups) and analysis are detailed below. The ethnography has been based on two years fieldwork so as to provide sufficient exposure to experience, learn and understand about the midwifery role of caring for Asian women and reducing perineal trauma during childbirth.

SITE SELECTION

The purposely selected maternity unit was situated within a small, level three acute hospital located in the suburbs south west of Sydney, NSW, Australia (Figure1). The hospital Delivery Suite selected for the study provided health services for one of the most ethnically diverse health areas in Australia, with 60% of the local population being born overseas and 80% of families speaking a language other than English at home (Australian Bureau of Statistics 2006). Moreover, the Area Health Service, in which this Delivery Suite was situated, had a significant Asian population of approximately 20% (Centre for Epidemiology and Research 2010).

Consequently, the site selected for the study increased the opportunity to be able to recruit pregnant women with an Asian background and supported the generation of insights that may be pertinent to other Delivery Suite settings. The large Asian population accessing this maternity unit ensured significant midwifery practice exposure in caring for women from this ethnic background and strengthened quality of data.

Figure 1: A small level three metropolitan public hospital in NSW

The definition of a level three hospital for maternity services at the commencement of this study was described as: country, district and smaller metropolitan services, caring for mothers and infants at normal-selected, moderate-risk pregnancies and births, full resuscitation and theatre facilities available, rostered obstetricians, resident medical staff and midwives, accredited general practitioners and specialist anaesthetist on call (Centre for Epidemiology and Research 2010). In the state of NSW, role delineation level is dependent on the range of available maternity hospital on-site services and support services available (Centre for Epidemiology and Evidence 2012). Along with maternity care, service provision in this hospital also included an emergency department and a variety of inpatient and outpatient specialties such as, a small intensive care unit and a surgical ward.

A mainly hospital-based, traditional, institutional model of maternity care (Hodnett, Downe & Walsh 2012; NSW Health 2003) was provided by the hospital maternity unit. A large proportion of the women attending this maternity unit were low risk for maternity complications due to limited onsite resources. Any woman presenting to this level three maternity unit, assessed as requiring a higher level of care, would be

transferred to the local level six tertiary hospital, which provided care and support services for women and babies considered at high risk for complications.

The maternity unit was identified as an appropriate location to conduct this ethnographic research due to the high local Asian population accessing maternity services and the high proportion of midwives providing intrapartum care. The maternity unit and hospital insiders were supportive of this study being conducted in their Delivery Suite and the hospital. Hammersley and Atkinson (2007) describe the importance of considering these practical implications when considering possible research sites.

Wolcott (2008) emphasises the importance of site selection and how the research question and site must match to ensure the integrity of the findings. The research question for this study was developed prior to site selection. Given Wolcott's view point, the location of the research site was investigated and determined as appropriate for exploring and understanding the research question. The site needed to have exposure to and provide care for a large Asian population. Only one maternity unit was selected for the ethnography to ensure deep immersion within the field and thereby, enable rich exposure to midwifery practice and provision of intrapartum care for Asian women during the second stage of labour and birth. By focusing a study on one site, the researcher is able to obtain in-depth exploration of the research topic (Hammersley & Atkinson 2007; Wolcott 2008).

SAMPLING FOR THE ETHNOGRAPHY

Purposive sampling was used to recruit midwives and midwifery students working in the Delivery Suite, and antenatal women. At the beginning of the research there

was no pre-determined sample size, although a sample of ten midwives, five midwifery students and twenty antenatal women was considered sufficient to enable understanding of the shared meanings behind practice culture (Burns & Grove 2005). This approach provided flexibility, allowing the researcher to purposely recruit selected midwives and midwifery students who were prepared to share their opinions and experiences around the topic of this study, and were supportive of a researcher observing them caring for Asian women during the second stage of normal labour and birth (Burns & Grove 2005; Fry 2004; Polit & Hungler 1999; Wolcott 2008). Purposive sampling would support the ethnographic aim of capturing a broad scope of practice and looking for confirming and disconfirming evidence within midwifery culture for reducing severe perineal trauma for Asian women during childbirth (Stewart 1998).

The study required midwives with extensive knowledge and expertise in Delivery Suite who were willing and able to share their experiences and understanding of the meaning behind practice (Burns & Grove 2005). As the study progressed, midwives could join the study at any time. Midwifery students could join the study if they were undertaking a rotation within the Delivery Suite, or had recent experience, within the previous three months. Ongoing recruitment was intentionally continued as staff regularly commenced their Delivery Suite rotation. Ongoing sampling also increased the potential of exposure to a broad range of practice behaviours (Stewart 1998). This sampling strategy helped to establish a strong midwifery commitment towards study participation, which translated into all midwives working in Delivery Suite consenting to participate in the research.

A purposive approach was also used to recruit women attending the hospital Antenatal Clinic (ANC) who met the study inclusion criteria. Women of Asian descent were invited, by the researcher, to participate in the study when they were approximately 32 to 36 weeks gestation. Occasionally the gestation was earlier as some women were receiving antenatal care from a General Practitioner in the community and therefore rarely attended the ANC. Women were also recruited in the Delivery Suite when they presented in early labour at term. The strategy of a purposive, homogeneous (focused) sampling approach strengthened the ethnography and assured that the emerging understanding of data focused on the cultural phenomenon under investigation (Burns & Grove 2005; Wolcott 2008).

The inclusion criteria for enrolment of women of Asian ethnicity (born in an Asian country or one, or both parents were born in an Asian country, or the woman self-identifies as of Asian origin) in the study included: 18 years of age or over, no identified antenatal or intrapartum risk factors, a singleton pregnancy and anticipating a spontaneous vaginal birth at term (more than 37 completed weeks gestation), with the baby's head presenting. The exclusion criteria included: antenatal risk factors, premature labour, planned induction of labour, augmentation or malpresentation, significant morbidity such as severe pre-eclampsia, multiple pregnancy, significant drug allergy, no labour and women not of Asian ethnicity. Enrolment of women progressed throughout the two year fieldwork study.

RECRUITMENT PROCESS FOR ANTENATAL WOMEN

Study information for antenatal women was placed in the ANC to enable women to become aware of, and consider participating in, the study. The study information (Appendix 2) and consent forms (Appendix 3) were available in three Asian

languages (Vietnamese, Chinese and Khmer) as well as English. As the researcher, I undertook the recruitment of all antenatal women. Prior to meeting with potential participants, their health records were reviewed to ensure they met inclusion criteria. While women were sitting in the ANC waiting for their antenatal care appointment, they were individually approached if they met the study inclusion criteria and, if they were able to speak fluent English, would be offered study information in a language they were most comfortable reading. The woman was left alone to read the information and then approached to identify if they would be interested in learning more about the study. If they wanted to know more, this discussion was conducted in a private room in the ANC, usually with a hospital interpreter present as, for the majority of women, English was a second language.

Occasionally, a partner or relative accompanied the woman to the ANC and the interpreter would confirm whether or not the woman was supportive of the presence of this person during the study discussion. At the beginning of the discussion, all women were made aware that participation in the study was voluntary and they were free to decline, or could withdraw from the study at any time without any repercussions. They were also advised that the study would not influence their midwifery or medical care in any way, their confidentiality would be maintained, personal details would be known only to myself, all identifying features of the woman would be coded to ensure privacy and confidentiality and, any information (including records of observations and discussions) would be kept in a secure place and be destroyed seven years after completion of the study. If the woman decided to participate in the study, this information was reinforced prior to signing the study consent form.

If the woman was not fluent in English but able to read in her first language, she was offered the study information, left to read this and prior to attending the ANC appointment, would be approached by myself and a hospital interpreter to ask if she was interested in learning more about the study. If a woman was unable to read in her first language or in English and was not able to speak fluent English, or language needs were different to those available, then myself and a hospital interpreter would talk to the woman and ask if she was interested in learning more about the study.

If a woman expressed an interest in learning more about the study, then following introductions (supported by the interpreter), the woman, the hospital interpreter and I would sit together in a private room and respond to the woman's study information requirements. For example, the interpreter may need to initially read out aloud (in the desired language) the study information for the woman. Queries or concerns from the woman would be relayed through the interpreter and I would respond. The interpreter would translate this response to the woman and then translate back the woman's response to me in English. If requested, copies of the study information and consent forms were given to the woman to take home to provide more time to consider study participation. Researcher contact details were made available.

If a woman decided to participate in the study, a consent form in the preferred language would be provided. If required, the interpreter would read out aloud the information on the consent form prior to the woman agreeing to sign the form. The woman was always provided with a consent form in the language she felt most comfortable using. For women who were unable to read in their first language or in

English, or whose language needs were different to those available, the hospital interpreter would verbally translate the English version of the consent form.

If there was a problem accessing a face-to-face hospital interpreter in the ANC, then I invited the woman into a private room and contacted the hospital telephone interpreter service to ask the woman whether she felt comfortable using a telephone interpreter to discuss the study, as this discussion could always be delayed until the next ANC visit. However, during the study no women experiencing this situation expressed a concern and requested to continue the telephone interpreter discussion.

Study information for antenatal women was displayed in a prominent position in the Delivery Suite as well as the ANC. This was to ensure pregnant women, of Asian origin who were unaware of the study, also had an opportunity to participate in the study when they presented to the Delivery Suite in early labour. The midwife would contact me to advise of a potential participant in early labour in Delivery Suite. I would confirm with the Delivery Suite team leader and midwife caring for the woman, that the condition of the women was appropriate to be considered for the study (labour was early, there was no maternal distress and the study inclusion criteria were met) and she was able to speak fluent English. If this was confirmed, I would ask if the woman could be given the study information. If the woman requested further discussion, I would attend.

On arrival, only after reconfirming with the team leader and midwife that the woman still wanted to be a part of the study was it then appropriate to enter the birthing room. I would enter the room, introduce myself to the woman and any support people, and discuss the study. Only women who were able to speak English fluently would be offered the opportunity to participate in the study in this way as it

was not common practice to access telephone or face-to-face interpreters in Delivery Suite.

BUILDING FIELD RELATIONS AND GAINING ENTRY TO THE FIELD

The ethnographic fieldwork was conducted over two years (April, 2008 to March, 2010), which assisted in building good field relations. To build good field relationships and gain entry into the field the researcher contacted the Delivery Suite and ANC Midwifery Unit Managers of the selected site, provided information about the study and advised of ethics approval. The Delivery Suite and ANC Midwifery Unit Managers (MUM) fully supported the undertaking of an ethnographic study within the Delivery Suite. The Delivery Suite MUM advised that the Obstetrics and Gynaecology (O&G) Staff Specialist was also aware and supportive of the study. Having obtained the support of both managers, I forwarded an email to the hospital's Director of Nursing and provided details of the study. The Director of Nursing supported and endorsed the study.

Meeting the participants is an important stage of building relationships and gaining entry to the field. The use of an intuitive, natural approach is suggested by Wolcott (2008) when first meeting potential participants. Fetterman (2010) describes the need to initially take a broad view of the group under study. As I had not worked in this hospital maternity unit, meeting and gradually getting to know the participants within this cultural context provided insight into the everyday functioning of the Delivery Suite and helped to identify those who could be informative participants. At all times during fieldwork I was respectful and grateful that, as an outsider in this

setting, I was privileged in being allowed to step into this particular midwifery practice environment.

To establish fieldwork relations and build rapport with staff, meetings were arranged (through the Delivery Suite MUM) for midwives to be invited to discuss the proposed study. On arrival, I found that Delivery Suite was very busy and so it was not possible to meet with all Delivery Suite midwives. I managed to quickly introduce myself to the midwifery team leader and left copies of the midwifery study information (Appendix 4) and poster in the MUMs office (she was out of the department at a meeting).

The next time I went to the Delivery Suite the study poster and information had been placed on the notice board in the staff tea room. The poster included my photograph, contact details and an explanation of the study aims and methodology. This information helped to raise staff awareness of the study and built rapport between the midwives and myself. The recruitment strategy was similar to one successfully used in previous clinically based health care research (Fenwick 2001). The ANC did not have a staff tearoom and there was no appropriate space to place a study poster.

To enhance recruitment of women of Asian ethnicity, access to interpreters (either by telephone or in person) was arranged in consultation with the Area Director of the Area Health Interpreter Service. For the purposes of the study, the interpreter access within the health facility was available 24 hours a day, seven days a week.

On that first day, as I was already in the hospital, I contacted the ANC MUM and then walked to the ANC to meet her. A meeting was arranged for the following day

to which the ANC midwives were invited to discuss the study. Five ANC midwives attended the one hour meeting, which provided an opportunity to discuss the purpose of the study, explain the research techniques of participant observation, interviews and focus groups and the need to recruit antenatal women of Asian descent. Some of the midwives also worked part time in the Delivery Suite, which facilitated discussion regarding the data collection techniques and the ethnographic approach of wanting to present the midwives point of view. It was emphasised at the time (and to all participant midwives throughout the length of study), the importance of not allowing the presence of a researcher to influence individual intrapartum practice in any way. All midwives expressed an interest in supporting the study and study information and consent forms (Appendix 5) were provided to read at a convenient time.

In seeking to be respectful and sensitive of this clinical context, I reassured and advised the ANC midwives that I would appreciate advice as to the best way to locate, approach and offer antenatal Asian women the opportunity to participate in the research. Over the course of the study, informal meetings with other ANC staff and hospital interpreters occurred (as workload allowed and as staff rotated through), which provided further opportunities to discuss the study. Throughout the study I was guided and supported by midwives, and the ANC administrative staff, and hospital interpreters in the recruitment of antenatal Asian women.

Regular information sessions for Delivery Suite midwives were organised, at least weekly at the beginning of the study, through the MUM. As a consequence, I managed to meet every Delivery Suite midwife and provide them with study information. The Delivery Suite MUM confirmed with midwives that they were

interested in learning about the study and were happy for me to contact them at work to arrange a convenient time for a meeting. Midwives could be working part-time and shifts were diverse (daytime, evening or night time). For example, two midwives were working together on one night shift so, I contacted them and they advised that the best time for me to meet with them in Delivery Suite was 0500hrs the following morning. I arranged for them to contact me at 0330hrs to advise if it was convenient for me to attend. They did ring and I met with them at the appointed time. Both were interested in, and supportive of, the study.

Whenever the study information meetings occurred, it was important to confirm the workload status with the midwives prior to arriving in Delivery Suite. It always had to be kept in mind that the status of the workload could change from speaking to the midwives on the telephone and arriving in Delivery Suite. This was something that could not be predicted and was part of the process of establishing access for the study in the field.

The study information meetings usually occurred in the Delivery Suite staff tearoom. This provided an opportunity to discuss the study in a non-threatening environment. At the beginning of the discussion, the purpose of the study was always explained. It was also explained that participation in the study was voluntary and they were free to decline or withdraw at any time without any repercussions. All participants were also assured that their confidentiality would be maintained, personal details would be known only to myself, all identifying features of the midwife or midwifery student would be coded to ensure privacy and confidentiality, any information (including records of observations, interviews, focus groups and

discussions) would be kept in a secure place and destroyed seven years after completion of the study.

The processes of building expert field relations, gaining approval to enter the field and the prolonged field immersion, enabled for a richer and more detailed study. Prolonged ethnographic fieldwork enables development of positive field relationships thereby, enhancing the rigour and validity of the study.

INSIDER – OUTSIDER

Being a midwife enabled me to understand the orientations of participant midwives during observations in the birthing room and Delivery Suite. (Hammersley & Atkinson 2007). As a midwife, I had background knowledge, could understand the language, had experienced a similar work environment and could ask questions when attempting to understand the meaning behind practice behaviour or language.

To ensure openness and transparency, consideration was given to how I would dress in the field. A decision was made not to wear a hospital midwifery uniform (comprising of blue slacks and blue and white printed blouse) so that I would not blend in with the midwives, as I was there as a researcher. I discussed this decision with the Delivery Suite midwives and although they thought a hospital uniform would be fine, they really were not concerned what I wore. The decision to wear everyday, smart, casual clothes was to ensure that I did not distance myself from the woman and support people. I also did not want to appear as though I was a member of staff. At all times I wore a researcher identity card.

Prior to commencement of data collection, a respectful process had to be worked out that would facilitate midwifery identification of women study participants arriving

in Delivery Suite. Working together with both ANC and Delivery Suite midwives, a process was developed that became the preferred way for the Delivery Suite midwives. The process consisted of a blue coloured A4 sheet of paper being placed in the front cover of the woman's health record (Appendix 6), which advised of the woman's participation in the study and for Delivery Suite midwives to call the researcher as soon as possible (24 hours a day, seven days a week). A copy of the original study consent form was also placed in the health record. Midwives also had a list of the participant's health record numbers and estimated date of birth dates, which was regularly updated as women were recruited to the study or gave birth.

All health records of antenatal women were held in Delivery Suite and were easily accessible. Consequently, it did not take long for the midwives to recognise a woman as a study participant. I would receive a telephone call from the midwife providing care, or the team leader, advising of the woman's presence, status and progress of labour. I liaised with the midwives via telephone until it was considered appropriate for me to travel to the Delivery Suite. If the woman's situation in labour was uncertain or unknown, with midwifery support, I would sometimes drive to the Delivery Suite. By the time I arrived the woman would have often progressed in labour, therefore, with the support of the team leader and midwife, I would wait close by (usually in the tearoom depending on the time of day, evening or night) until the midwife advised the woman was close to the second stage of labour. Occasionally I would be contacted by the midwife prior to arrival and advised that the woman had just given birth. This occurred during day and night time hours and was not related to any specific midwife.

On arrival in the Delivery Suite, and prior to entering the birthing room, I would ensure the midwife providing intrapartum care was still supportive of being in the study and that the woman had recently confirmed she wanted to continue participating in the study. Unless I was entering the birthing room accompanied by the midwife, I would knock on the birthing room door, as similarly described in previous midwifery ethnographic research (Hunt & Symonds 1995).

DATA COLLECTION

The ethnographic techniques of observation, interviews and focus groups were used to collect data for this study.

BIRTHING ROOM OBSERVATION

Non-participant observation was the main data collection technique used in this ethnographic research. Participant observation enabled direct experience of the shared behaviour and knowledge underpinning midwifery practice. This supported development of understanding and interpretation of the complex nature of the culture (Van Maanen 2011) of midwifery located within the birthing room and Delivery Suite settings. From the beginning, participants were aware that I was an observer, with the participant part being limited to such activities as handing a bed sheet to the midwife.

As a non-participant observer, my aim was to listen, and watch what the midwife was doing and saying, and observe the social interaction within the room. Asking the midwife questions was also important, but this had to occur at an appropriate time when the midwife was available. When the workload was busy (which was often the case), the midwife did not have much time to talk as she was running from

room to room. On entering the birthing room, I would look first at the midwife and midwifery student (if present) and would receive a nod or smile to enter the room. I also looked at the woman and, unless her eyes were closed, or she was facing away from the door, she invariably looked at me. There was always a small positive (usually non-verbal) response provided as I was a known face, we had met once before in the ANC. Some support people, however, did not know me. In this situation, the woman would talk to her support people and they would smile and nod at me and I would smile and nod back. If appropriate, I would confirm with the woman verbally, or by body language, that she wanted to continue being a study participant and felt comfortable with me being in the room.

I was always conscious of trying to remain as inconspicuous as possible given the nature and sensitivity of events unfolding in the room. I usually positioned myself as peripherally in the room as possible. I could see and hear everything and everyone from this position. The aim was to keep the midwife in full view at all times.

During some observations, midwives would encourage me to sit on a chair in full view of the woman. I felt very uncomfortable doing this as the woman and support people would look at me to provide care, but I could not step in. As a result I advised I was much more comfortable in the corner of the room. This was soon the standard positioning, when in the room, and soon became seen as normal behaviour on my part.

At the beginning of the study, the midwives were conscious of me being in the room. We would talk about how they felt about this and why and I would attempt to respond sensitively and respectfully to their thoughts. However, due to the prolonged fieldwork, midwives soon became familiar and comfortable with my

presence. During the study there was no perceived change in practice behaviours when comparing earlier observations with later ones.

Direct observation may alter participant behaviour thereby, potentially undermining credibility of data (Burns & Grove 2005; Gray 2004). Efforts were made, therefore, to observe passively, build trust in order to minimise this effect and observe the true realities of midwifery practice culture (Hammersley 2006; Polit & Hungler 1999; Schatzman & Strauss 1973). However, Wolcott (2008) describes this alteration in behaviour as of benefit to the researcher, as members of the group reflect more on processes and interactions during periods of observation. This potentially increases midwifery reflection on clinical practices within the birthing room. Participants could be enacting what is thought to be ideal practice rather than their usual practice as discussed by Wolcott (2008). This information supports the identification of what participants think they should do or say in practice, rather than what they actually do.

Behaviours and processes are more easily understood when participants are directly observed in their natural setting (Gray 2004; Schatzman & Strauss 1973; Van Maanen 2011; Wolcott 2008). This data collection method enabled the researcher to observe and listen to activities and interactions between the midwife, woman and support people in the birthing room. Talking to people within the birthing room helped me to be aware of slight changes in individual perceptions and meanings (Robson 1993; Schatzman & Strauss 1973). During all observations I continued to write field notes.

Field notes included documentation, interpretation and analysis of processes, behaviour, and conversations (Gray 2004; Hammersley & Atkinson 2007). During

the first few observations there was so much to see, hear and sense, that I was concerned I would miss something as I looked down to quickly write in the fieldwork notebook. It felt almost overwhelming – there was so much happening. How was I going to manage to see, hear and write everything down? I could not, of course. During the last few observations I found I was writing much less because social and practice patterns had become very familiar due to immersion within the field.

After leaving the birthing room I would sit out of the way in the Delivery Suite and document observations, thoughts and feelings in an observational template (Appendix 7) and fieldwork notebook. I walked to the hospital car park, sat in the car and dictated into a digital audio recorder my reflections and interpretation of events in the birthing room and Delivery Suite. Field notes were expanded and summaries documented in the margins to help clarify thoughts about the data.

Observations enabled the gathering of information about individual midwifery clinical practices and interactions that may not have been identified through interviews or focus groups. Robson (1993) suggests that taking field notes about what is being said during direct observation could be a problem if participants come from a non-English speaking background. However, difficulties with communication between the midwife and woman may affect the incidence of severe perineal trauma (Dahlen, Ryan, et al. 2007) and these difficulties needed to be observed.

When midwives did communicate with women in an Asian language, I would ask about the content of the conversations. Observing the midwife and woman's behaviours and reactions during childbirth provided detailed and rich information,

even though I was unable to understand what was being said at the time. This was compared with other observations where only English was spoken by the midwife and the woman had limited English. A great deal of knowledge was gained from this related to communication, relationships and emotions.

INTERVIEWS

Semi-structured interviews were chosen as a second method of data collection in order to triangulate with the observational data to gain further insight into midwives and midwifery students concerns, thoughts and opinions (Fetterman 2010; Minichiello et al. 1999). Semi-structured interviews enabled participants to have some control over the flow of conversation, with the researcher guiding and shaping the interview as it progresses. Open ended questions facilitated natural conversation and helped midwives to consider and express their thoughts. For example, one of the first questions was usually "Could you please tell me what it is like for you working as a midwife (or midwifery student) in Delivery Suite?" supported reflection and stimulated conversation. Comfortable silences also provided time for the participant to organize thoughts and consider responses.

An interview guide was developed which contained three topic areas that related to the study (Appendix 8) (Bryman 2004; Minichiello et al. 1999; Polit & Hungler 1999). The guide provided assistance to the interviewer to focus on the phenomenon of interest while maintaining consistency between interviews. However, the interview process was flexible and techniques such as, funnelling (starting the interview with broad, general questions, narrowing down to specific areas) and questioning that encouraged either clarification of points or descriptive explanations were used (Minichiello et al. 1999).

The aim of the study was to interview each midwife as soon as possible after a birthing room observation. Midwives were invited to attend a semi-structured interview, at their convenience. On occasions this did not happen due to workload or the midwife taking holiday leave, sick leave, or other factors. Interviewees would organise with the team leader or MUM when they were able available to attend. The interview took place near or in Delivery Suite, within a relaxed room in a venue that ensured privacy and confidentiality. All interviews were recorded to enable the free flow of conversation without the distraction of the researcher writing. The digital audio recorder would be placed on a low table in front of the participant and we sat facing each other. Reflections of the interview were written into a fieldwork notebook or spoken into the recorder after the interview.

Two interviews were interrupted by midwives knocking on the door and asking the interviewee if they had the keys to the medication cupboard and the other was for a query about a woman in labour. These events did not interrupt the flow of discussion and interviewee picked up the conversation from where they had left off.

All interviewees were open to discussing midwifery practice. No-one appeared uncomfortable or defensive in being interviewed. All participants were interested and seemed to appreciate that someone wanted to know their opinion on practice.

FOCUS GROUPS

Focus groups were chosen as a third method of data collection to gain additional insight into the phenomenon under study and to triangulate with observational and interview data. Focus groups were conducted towards the end of the second year of fieldwork. Three midwifery focus groups and one midwifery student focus group

were scheduled and advertised in the maternity unit tearoom in Delivery Suite and the ANC. All Delivery Suite midwives and students, currently working or having worked in the Delivery Suite in the last three months, were invited to attend, including midwives and students who had participated in birthing room observations and individual interviews. Attendance was voluntary and information and consent forms were made available for attendees who had not already completed one.

The venues varied from the education room situated in Delivery Suite, a large ANC assessment room and a room located outside the clinical area for midwifery students. All venues supported privacy and confidentiality except the education room, where midwives were advised that there might be interruptions by staff wanting to access maternal health records. This only happened on one occasion and participants paused as the health record was located and the person left the room and then the discussion spontaneously continued.

Between three to four midwives attended each of the three focus groups. One focus group was organised for midwifery students and three students attended. Each focus group was timed to be a maximum of 50 minutes in length and midwives were advised of this prior to commencement.

Chairs were placed in a circle for participants and the digital audio recorder was placed on a low table in the middle of the circle. All participants were aware and supportive of the focus group discussion being recorded. Privacy and confidentiality were emphasised and everyone was aware that data would not be discussed with workplace colleagues or managers.

Rules to guide focus group behaviour were discussed. For example, participants were advised that everyone in the group had an equal voice, if they wanted to say something it was important to wait until the other person had finished speaking before starting to talk and they could raise a hand if they had something to say. It was explained that no one would be identified on the transcribed information.

The purpose of the focus group was explained to participants. The aim of the focus group was to explore their knowledge on the research topic. Collaborative discussion and critical reflection were part of the dialogue processes to better enable the exploration of experiences, knowledge and opinions on factors that may affect perineal integrity in women of Asian ethnicity during childbirth. Focus groups could uncover aspects of midwifery practice culture that may remain otherwise unknown (Hammersley & Atkinson 2007).

Data involving such things as group dynamics were documented in the study journal after the event (Burns & Grove 2005). A neutral rather than a leading approach was conducted to attempt to stimulate participant interaction and interest. Participants were respectful of each other and individuals rarely attempted to dominate the discussion. When this did occur in one focus group, the direction of the discussion was redirected to ensure everyone had an equal voice within the group.

Questions were used to guide the discussion within the focus group only when the group wandered off the area of interest. Four focus groups were found to be sufficient for data saturation as information already collected in other data collection methods was being reinforced. It showed that triangulation of data collection is worthwhile to enhance the understanding of cultural groups. Each method of data

collection strengthened and deepened understanding and enhanced the rigour, reliability and validity of the findings.

SECONDARY DATA SOURCES, JOURNALING, MEMOS

Examination of various formal and informal documents within the cultural context assisted and supported data collection and analysis. Access to maternal and neonatal health records, the Delivery Suite birth register, departmental and hospital policy folders, noticeboards and communication notices all formed part of data collection in understanding midwifery practice culture in context.

A separate fieldwork journal provided opportunity to express personal feelings, events and thoughts on the research at the end of each day in the field. As journal documentation was updated, previous journal entries were reviewed and considered as research ideas, learning and knowledge accumulated. This is a reflective technique recommended by Hammersley and Atkinson (2007). The additional documentation also provided an ongoing description of conducting this ethnographic research from a personal, researcher and midwifery perspective. These reflections explored the research processes and progress, ideas, thoughts and queries about what was being learnt from data collection, which formed the beginning of data analysis.

Other reflective analytical practices involved in fieldwork notes included writing observational and casual conversational data on the right hand page of the fieldwork notebook and writing reflections, statements and questions on the left hand page as the observation or conversation progressed. This could also be completed later during a quiet time, or by digital audio recording when travelling home. These

reflections were transposed separately onto individual transcriptions as separate data.

Writing analytical thoughts about identified practice or social processes ensured points of interest would be pursued in the field (Hammersley & Atkinson 2007). Data collection was influenced by the need to understand the meaning behind these particular aspects and it was recognised this was ongoing, reflexive practice and the beginning process of data analysis and theme development.

LEAVING THE FIELD

In preparing to leave the field I had ensured that midwives and students were regularly updated about how the study was progressing. The start of the focus groups signaled to the participants that the fieldwork was drawing to a close. Data saturation provided the timing for leaving the field (Burns & Grove 2005). When birthing room observation data collection no longer brought to the surface new data or new patterns of midwifery practice behaviour and dialogue it was time to leave the field.

Observations lasted two years while interviews began four months after the observations started and ceased 14 months later. Focus groups were conducted around the last four months of the second year of the study. All methods of data collection were discontinued as they had reached the point of data saturation. It was time to leave the field.

After two years of stoically supporting the study, I felt the midwives were looking forward to getting back to not having to contact me when they saw the blue coloured research participant notification at the front of a health record. The positive field

relationships and feeling at ease with the midwives working in the Delivery Suite and ANC was found to facilitate this event. There was no apparent distress for the midwives when it was time for me to leave the field. A professional distance had always been maintained in the research setting to ensure that the ethnographic analysis would not be compromised. If a researcher over-identifies with study participants and gets too close, this can interfere with the analytical process (Hammersley & Atkinson 2007).

I was aware that the midwifery workplace culture would continue as it was prior to the study being conducted. However, for some midwives and students there may have been raised awareness or reflection on practice related to care of the woman's perineum during intrapartum care. Leaving the field was a gradual affair and I confirmed with the midwives, students and MUM how supportive they had been. Since leaving the field some midwives have made contact to hear about the study results.

When leaving the field I realised the extent of how much I had learnt and enjoyed the experience of being in their world – a researcher exploring midwifery practice culture. I experienced feelings of appreciation, sadness and awareness of the fact that it had been a privilege to be allowed to view the world of midwifery practice in a Delivery Suite setting.

RESEARCHER BIAS

While I am the researcher, I am familiar with the clinical context as I am also a midwife. However, I was not an employee within the maternity unit nor had I ever worked within the facility in which the research was being conducted. My

familiarity with the clinical context strengthened the study findings as the nuances of practice could be better understood if I was an outsider. An appreciation of the clinical context and sensitivity for the activities taking place enabled me to minimise researcher bias and ensure the voices of this context would be heard in a way that would resonate with participants. However, there was a constant awareness that researcher bias could influence understanding.

As a midwife, exposure to practice experience will have formed personal opinions related to caring for birthing women from a variety of ethnic backgrounds, including Asian ethnicity. Preference for specific methods of practice to minimise perineal trauma for birthing Asian women may have formed biases in relation to what should or should not occur when providing care. However, personal awareness of the possibility of this type of research bias and a decision to avoid accessing literature on the topic of perineal trauma related care during childbirth, prior to and throughout the duration of the study, may have gone some way to limit this bias. In addition, to ensure the voices of the field were heard any thoughts, hunches and themes were explored and discussed within the study context to minimise bias.

I found there were three midwives in Delivery Suite I had met before. These midwives had previously been a midwifery student and a Delivery Suite midwife (working mainly night shift) at the hospital where I worked. The other midwife I had met briefly one day at a local peripheral hospital maternity unit when she was a student. These previous relationships may have affected how the midwives responded during birthing room observations and discussions, although this was not apparent at the time. Nevertheless, it was expected that my presence in the birthing rooms or Delivery Suite, would have impacted on the practice environment in some

way on all participants and others in the field, whether or not we had previously met (Hammersley & Atkinson 2007; Stewart 1998). However, the prolonged fieldwork should have minimised this bias. Further, awareness of bias allows for accommodation within the research method during data collection, interpretation and analysis. In this way, researcher bias is minimised and the findings of the study strengthened.

DATA ANALYSIS

Ethnographic studies have used observations, focus groups and semi-structured interviews to enable comparison of data and deepen interpretations (Gray 2004; Hammersley & Atkinson 2007; Polit & Hungler 1999). Triangulation involves using a variety of data collection methods (Fetterman 2010; Hammersley & Atkinson 2007). This approach enables comparison of data from a variety of contexts, which reduces the likelihood of multiple biases within the data (including researcher bias) and strengthens the possibility of veracity (Fetterman 2010; Hammersley & Atkinson 2007; Stewart 1998). Within ethnographic studies, data analysis begins with data collection and intensifies on completion. Triangulation of data brings to the surface meaning and understanding of the cultural group. The directness of observation for data collection can complement and be augmented by other methods of data collection.

Participants within ethnography contribute towards data analysis and interpretation. Midwives become aware that the credibility of their comments to the researcher and colleagues may be reflected against direct observations of their practices in the birthing room settings (Polit & Hungler 1999; Schatzman & Strauss 1973). This factor helps to increase credibility of data by providing a basis for confirming the

truth of information collected from a variety of methods (Fetterman 2010; Polit & Hungler 1999).

Ethnographic use of detailed field notes offered insight into conversations between midwives, women, support people and others (inside and outside the birthing room setting), which strengthened veracity of findings.

Within ethnography, to strengthen credibility of data, all interviews and focus groups were recorded by digital audio recorder and transcribed by the researcher. This increased immersion in the field and deepened understanding of the research topic. Direct observations were written by hand and expanded on as soon as possible after the event, by hand or via digital audio recorder, and transcribed by the researcher. This ensured and maintained the integrity of the data analytical process.

To enhance the integrity of data and the analysis process, copies of interview and observational transcripts were provided to midwifery participants as soon as possible after the event in order to confirm accuracy. A study journal provided a detailed record of thoughts and background information as the study progressed. This ethnographic analytical framework increased data reliability and validity, providing time to gain knowledge, maintain accuracy, and strengthen understanding of midwifery culture in Delivery Suite (Silverman 2006). In this way data analysis, interpretation and (eventually) theory construction would be enhanced (Bryman 2004; Fetterman 2010).

Interpretation of data occurred throughout data collection, analysis and writing. A systematic process was applied to analysis that involved transcription, theme building and interpretation of data. This facilitated immersion and in-depth

knowledge of the data, which supported data analysis. The analytical, iterative processes provided structure for the large amount of data, together with reflection, participant feedback, fieldwork and primary literature sources.

Ethnographic analysis provides for intense consideration of the data (Fetterman 2010; Silverman 2006; Stewart 1998). To this end, contemporaneous data collection and transcription offered opportunities for learning, reflection, and building understanding of cultural norms and differences in the everyday milieu surrounding practice culture. Immersion in the data (in and out of the field) facilitated ongoing analytical reasoning, comparing and contrasting within the data and gaining of insights and theorising.

All birthing room observations, interviews and focus groups (written and recorded) were transcribed as soon as possible after the event. To maximize immersion, familiarity and understanding, I decided to transcribed all data (Stewart 1998). This supported identification of variations, patterns and events within the data.

TRANSCRIPTION AND FEEDBACK

A word document was compiled for each recorded or written data collection event (observations, interviews, focus groups). Each document contained page numbers in the footer and consecutive numbering (starting from the number one (1)) was situated to the left on each line of the transcript throughout the document to provide a quick reference point when referring back to the transcript during analysis. Coded numbers (instead of the participant name) were placed at the beginning of the transcription along with the date the event took place. At the top of the document was the event (Observation, Interview, Focus Group), the time and the following

key: M=Midwife, MS=Midwifery Student, W=Woman, P=Partner, SP=Support Person. The relevant abbreviation was placed at the beginning of text relating to that person. The abbreviation for my voice was JW.

During transcription a small amount of editing occurred to support understanding and readability, although this did not alter the meaning. Editing included; noting emotions such as, [laugh] to indicate when a person laughed, three dots … indicated a long pause, '……' indicated the name of a person or place - ensuring confidentiality, words would be placed within brackets [ ] to indicate what the person was referring to, if required and an exclamation mark would denote an emphasis. A slight pause or sound was not transcribed and indistinct speech due to background noise or other voices was labeled as such in brackets ( ). This editing maintained the quality, readability and dependability of the transcriptions (Fetterman 2010; Hammersley & Atkinson 2007).

For observational transcriptions, the black coloured text was related to the written documentation on the right hand page of the fieldwork notebook. The blue coloured text in the document related to my reflections, ideas and thoughts written on the left hand page, or audio recorded, that were expanded on later. Attached to each final observational transcript was information from the observational template completed immediately after leaving the birthing room. Interview and focus group transcriptions looked similar, with black text relating to what was recorded and the blue text being my words.

For observations, where a midwife handed over the care of a woman during a change of shift, the transcripts were separated. The first midwife received a transcript up to the handover event and the second midwife received a transcript

from the handover onwards. This was done to maintain individual midwifery confidentiality. If two midwives, or a midwife and a student, had worked together providing care for one woman, then both would receive a copy of the same transcript as they had observed each other's practices. If several midwives had entered the birthing room throughout the observation during one shift, then only the midwife providing the main portion of intrapartum care would receive a copy of the transcript.

Following discussion with the individual midwife or student, a paper copy of the transcript (black text only) would be placed in a sealed envelope, with the person's name and the word 'confidential' in large letters underlined. For the majority, I handed the envelope directly to the person. Occasionally, the midwife would ask for the transcript to be left in the correspondence folder in the Delivery Suite, to be picked up. I would confirm the person was comfortable with this process and offer to wait until they were present in Delivery Suite, but they declined.

The observational transcripts were returned to the midwives within two weeks of the event (except for one midwife who received the transcript after returning from four weeks holiday), with a request for confirmation or correction and to return the document to the researcher. Interview transcripts were returned to midwives within one to two weeks unless two interviews occurred within a two week period, which subsequently increased the return time. The same request for return of the transcription, with feedback, was made to interview participants. Participants of focus groups were advised prior to commencement that no transcript would be provided.

The request for participant validation on transcript content was aimed at increasing transparency of the study processes for participants and strengthening reliability and objectivity of data (Silverman 2006; Stewart 1998). This may have placed some limitations on researcher bias. All observational and interview transcripts were returned except for one where the midwife misplaced the copy, but verbally confirmed the contents of the interview transcript were accurate. The content of the majority of transcripts was confirmed as accurate, with no changes made. Two transcriptions were received with very minor changes to the text, which did not alter the meaning of events and required limited conversation with participants.

INTERPRETATION

Data interpretation was ongoing as transcripts were taken through a systematic process, allowing intense consideration of the data. A paper copy of each transcript was initially read and reread line by line. During this process, individual key words (potential conceptual codes/ index words) were circled in pen, with short analytical comments being noted, if appropriate. Writing of analytical memos was found to be a mental release of thoughts and ideas, which continued throughout data collection and interpretation.

To enhance the rigour of the findings a process for checking coded data and theme development was adopted. Interrater reliability enhances the trustworthiness of ethnographic coding and indexing (Silverman 2006). This process involved an experienced researcher in ethnographic analysis reviewing the coding and subsequent themes independently of the researcher.

An ongoing process of decontextualizing, memoing and recontextualizing of the data began within the software programme (NVivo) (Bazeley 2007; Stewart 1998). This helped to organize the data and to facilitate a systematic process of building categories and themes inductively. Reading through the imported transcripts and comparing this with the paper copy key words, allowed intense consideration of the data and further confirmation or disconfirmation of index words (initial concepts).

Theorising about the data continued as each computer transcript was reread, with the paper copy alongside, to support reflection and development of ideas. Audio recordings were also accessed to increase exposure to original participant conversations. Data interpretation began with recognisable patterns of behaviours, practice, opinions, relationships and other cultural features. Within ethnography, this is recognised as a significant experience in the analysis process (Bazeley 2007; Fetterman 2010).

Access to the software analytical memos provided a strategy to further deepen theoretical consideration. Brazeley (2007) warns against developing firm ideas too early on foundational themes and argues for the need to question findings and compare and contrast possible alternatives. The process of identifying concepts within the data and placing manageable segments of data (ensuring the meaning is retained) into codes (concepts/index words) assists to build interpretation. Same segment data may often relate to multiple codes (concepts/ index words) and were coded as such (Bazeley 2007; Stewart 1998).

This framework for data interpretation is recognised as decontextualising and recontextualising data and is achieved through an iterative process, accessing the

words and phrases within text (individual transcriptions) and building patterns from the data (Stewart 1998).

Data interpretation clarifies the processes involved in the clinical practices during the second stage of normal labour and birth, and the circumstances in which the processes occur (Bryman 2004; Polit & Hungler 1999).

DATA MANAGEMENT AND STORAGE

All transcriptions and original audio recordings were imported into an NVivo8^{TM} computer software programme to better manage and retrieve the data. Within NVivo8, segments of data were identified and coded (concept names) to begin to develop patterns and explore hunches. Throughout the analytical process, concept names were altered and some were merged, and tree nodes (files) were developed to place concepts under categories. When assigned to a category, an event or text should remain within its context for example, birthing room observation data will be identifiable as such (O'Reilly 2005). Categories can overlap and may change over time, and the same data can be placed under several categories (Bazeley 2007; Hammersley & Atkinson 2007; O'Reilly 2005). Themes or inconsistencies within the data may be identified as sorting into categories continues. Identification of concepts helped to explain what was happening and could lead to the development of best practice principles, which may help understanding (O'Reilly 2005).

Themes and sometimes inconsistencies within the data began to be identified as the sorting into categories continued. NVivo8 enabled the management of data and provided a mechanism to sift, sort and triangulate data. Thus, the software programme was used to systematically organise and retrieve data, so facilitating the

analytical process of data analysis and thematic interpretation (Bryman 2004; Fetterman 2010).

ETHICAL CONSIDERATIONS

Ethical approval was obtained from the Area Health Service (AHS) Human Research Ethics Committee (2007/140) in which the selected hospital site was situated (Appendix 9). Ethics clearance to undertake the study was also ratified by the University Of Technology, Sydney (UTS), Human Research Ethics Committee (HREC REF NO. 2008-72R) (Appendix 10).

Information and a study outline were forwarded to all stakeholders in order to request hospital and departmental approval. Written confirmation of hospital support to conduct the ethnographic study at the selected site was obtained from the Director of Nursing of the hospital, the General Manager, the Area Clinical Manager, the ANC MUM and the Delivery Suite MUM. This study met the *National Statement of Ethical Conduct in Research Involving Humans* (The National Health and Medical Research Council 2013) principles and the ethical guidelines that were relevant at the time for the hospital selected for the study. These guidelines have not been named due to the need to maintain confidentiality.

To enhance community consultation, prior to ethics approval, a meeting was arranged with an elected official of a large specific Asian community group. The community group was located in the area accessing the selected hospital site for maternity care. An appointment was arranged to discuss the study and to request advice regarding any cultural concerns and recommendations related to other Asian communities within the area who may be willing to provide input. A copy of the

study proposal was forwarded to the elected official prior to the meeting. The study was received favorably and no cultural concerns were identified by the official.

SUMMARY

The methodological framework and method presented in this chapter highlight how ethnography as methodology and method has framed the research. Ethnography was the most appropriate methodology to explore, understand and interpret midwifery practice when providing intrapartum care for Asian women during the second stage of labour and birth. The ethnographic methods ensured the validity and reliability of the findings. The ethnographic approach provided for an in-depth understanding of the complex practice world of midwives, within an acute hospital Delivery Suite setting in Australia. The ethnographic methods enabled me, as researcher, to collect data in a sensitive and considered way that has led to the detailed, rich and deep understanding of the meaning behind what midwives do and why, when attempting to minimise perineal trauma for Asian women during the second stage of labour and birth. The following results chapters are the evidence of contribution that ethnography can make towards understanding the world of midwifery clinical practice.

The first results chapter offers an opportunity to step into the practice world of midwives in a Delivery Suite setting. Recognising the influence of the geography of care and organisation of the processes surrounding childbirth, provides a foundation for understanding midwifery perceived beliefs and shared patterns of practice when caring for Asian women.

CHAPTER 4

RESULTS: PLACE AND BELIEFS

INTRODUCTION

The preceding chapter described the methodological framework and method underpinning the ethnographic research. This initial results chapter portrays a culture of care situated within a Delivery Suite. The practice culture frames midwifery reality and is influenced by the physical environment (geography of care), which is linked to the organisation of women's progression through the intrapartum experience. Perceived cultural beliefs and shared patterns of practice help to clarify the meaning behind specific care strategies as midwives care for Asian women.

To fully explore what midwives do to minimise perineal trauma when caring for Asian women during childbirth, it was necessary to observe the intrapartum care setting. Data from a variety of sources enabled in-depth identification and exploration of embedded patterns of care, shared beliefs and knowledge. This process built understanding as to what influences midwifery clinical practice when attempting to reduce perineal trauma for Asian women.

DEMOGRAPHICS

This study was conducted over two years (April 2008 to March 2010) in an acute hospital Delivery Suite. During the study, 18 birthing room observations were conducted. Length of time for observations ranged from 17 minutes to eight hours and five minutes, with most being approximately two hours. Thirteen interviews

were conducted (lasting approximately one hour) with ten midwives and three midwifery students. Four focus groups were conducted (each lasting approximately 50 minutes) with three to four midwives or midwifery students attending each group.

At completion of the ethnography 30 midwives and ten midwifery students had consented to participate in the study, with 22 midwives and six midwifery students actually participating. Midwives had between four months and 37 years of experience mainly in Delivery Suite (Table 2).

Table 2: Midwife participant demographics

Name*	**Midwifery experience**	**Ethnicity**	**Asian language**	**Study participation**
Kim	4 months	Caucasian	Yes	Obs x1, interview
Dora	1 year	Caucasian	No	Focus group
Sunni	1 year	Asian	Yes	Focus group
Beverley	1 year	Caucasian	No	Obs x2
Le	3 years	Caucasian	No	Obs x1
Gemma	4 years	Caucasian	No	Obs x2
Brenda	5 years	Caucasian	No	Obs x2, interview, focus gp
Adele	5 years	Caucasian	No	Focus group
Sopheap	9 years	Asian	Yes	Obs x1, interview
Gwen	14 years	Caucasian	No	Interview
Ahn	18 years	Asian	Yes	Obs x2, focus gp
Biyu	20 years	Asian	Yes	Obs x2, interview, focus gp
Mary	20 years	Caucasian	No	Focus group
Rose	20 years	Caucasian	No	Obs x1, interview
Sally	20 years	Caucasian	No	Obs x2, focus gp
Cait	21 years	Caucasian	No	Interview
Vicki	21 years	Caucasian	No	Obs x1, interview, focus gp
Debbie	23 years	Caucasian	No	Obs x2

Janice	25 years	Caucasian	No	Obs x1
Anne	26 years	Caucasian	No	Focus group
Colette	29 years	Caucasian	No	Obs x2, interview, focus gp
Xiaoli	37 years	Asian	Yes	Obs x3, interview

*Names are pseudonyms, Obs = observations, gp = group

Students had almost completed their 12 months midwifery university course and all had previously completed registered nurse training in Australia (Table 3).

Table 3: Participant midwifery student demographics

Name*	**Length of time as a student**	**Ethnicity**	**Asian language**	**Study participation**
Zoe	11 months	Caucasian	No	Observation x1, interview
Elizabeth	11 months	Caucasian	No	Observation x1, interview
Nancy	11 months	Asian	Yes	Observation x1, interview
Susan	1 year	Caucasian	No	Observation x1, focus gp
Stephanie	1 year	Caucasian	No	Focus group
Doris	1 year	African	No	Focus group

*Names are pseudonyms, gp = group

For the study, 48 women consented to participate, with 18 women being observed in the birthing room setting.

Women were all having their first baby and ranged in age from 20 to 34 years (mean age of 27 years). Less than a third of the women were able to communicate fluently in English (28% n=5). Almost one half of women could speak very little English (44% n=8) and almost one third were unable to speak English (28% n=5). Half the women self-identified their ethnicity as Vietnamese (n=9), with the remainder identifying as Chinese (28% n=5), Cambodian (11% n=2), Laotian (5.5% n=1) and

Chinese/Cambodian (6% n=1). The length of time women had resided in Australia was from between two months to 27 years.

THE GEOGRAPHY OF CARE

The hospital site, in which the selected Delivery Suite is located, is situated on a main road within a residential area. The maternity unit consists of an ANC positioned within a separate outpatient building in the hospital grounds. Other maternity services (Delivery Suite, Antenatal-Postnatal Ward and Special Care Nursery) are located on the ground floor in the main hospital building and provide care seven days a week, 24 hours a day. Throughout pregnancy, birth and the postnatal period, women are cared for by a variety of health professionals (midwives, O&G medical officers or general practitioners).

Between 0600hrs and 2100hrs, women and their families can access the Delivery Suite through the main hospital entrance. Amongst other numerous signs, a sign (in a variety of languages) provides directions to the closed, front, double doors of the Delivery Suite. An intercom on the wall (adjacent to the right hand door) provides a communication link to the midwives inside Delivery Suite. Further along this main corridor is an open staff entrance, with clear double swing doors, so access to one end of Delivery Suite is locked and secure, whereas the other end of Delivery Suite is completely open and anyone can walk in, which occasionally happens.

Women can arrive via ambulance or through the emergency department at any time and those who attempt to access Delivery Suite between 2100hrs and 0600hrs, will find they have to go through the emergency department, and request access, as the main hospital doors are locked during these times. Any woman (whether booked or

unbooked to the hospital) can present for care at the Delivery Suite at any time of the day or night. Often women have limited English and sometimes they may speak no English, which can present problems for many of the midwives.

WORK AREAS IN DELIVERY SUITE

Central work area

The central work area is situated close to the open staff entrance and faces birthing rooms number four and five. It is often a busy central point for the staff working in Delivery Suite. This is where family members come looking for 'their' midwife and where midwives attend to a variety of tasks such as, writing in women's health records, working on one of two computers updating the maternity electronic record, reviewing pathology results (or other numerous computer tasks), answering telephones, attending change of shift handover, discussing current issues with medical officers or other relevant personnel and, answering the front door intercom.

There is a white board on the wall behind the desk space, which has details of the woman in each birthing room and the name of the midwife providing care. There is no dedicated ward clerk in Delivery Suite – in fact a ward clerk was observed once (fleetingly) in this department throughout the study period. All six birthing rooms run from left to right along the opposite side of the corridor facing the central work area. Only the doors of birthing rooms four, five and six are visible from the work area, the rest are further up the corridor to the left. Often, sounds of women in labour are heard coming from the birthing rooms and the volume increases or decreases as midwives (or others) move in and out of the rooms, opening and

closing the doors. Sounds of a midwife encouraging a woman to push may sometimes be heard:

"....like you want to go to the toilet. Push down into your bottom like you want to do a big poo...harder...harder! Put your chin down, on your chest" [Observation 13 field notes].

The voice is slightly muffled once the door closes but is still audible. Women's health records are placed in this work area, so they are easily accessible for review by midwives, other health professionals or for shift handover. Occasionally, the record is taken into a birthing room. On the rare occasions when the workload is light, this is where the midwives congregate to complete online education, read or generally socially interact. The midwives are tuned to the sounds of the labouring women as they go about their tasks.

Assessment Room

If not in active labour or imminent birth and no emergency response is warranted, pregnant women are assessed in the small two bedded Assessment Room, which is situated close to the left of the central work area, on the opposite side of the corridor to the birthing rooms. On walking into the room, both beds (basic metal framed hospital issue) are to the right, against the wall and to left, is an old wooden work desk and then a bench top. There are wall mounted brackets for piped oxygen, air and suction next to each bed and a rack of different size disposable gloves is attached to the wall near the desk. Equipment available in this room enables assessment of (amongst other things) maternal blood pressure, blood sugar level, vaginal/rectal swabs and fetal heart rate monitoring. The emergency resuscitation

trolley is situated in the corridor, close to the entrance of this room. Women are assessed by the midwife and medical officer (when necessary) and are either admitted as an inpatient, or go home. If an assessment reveals a need for tertiary level care, transfer occurs via ambulance.

Birthing rooms

All six birthing rooms have a large window, with venetian blinds encased within double glazing, facing onto the hospital grounds and overlooking the local golf course. There is an open view of lots of trees, vegetation and sky. The blinds can be closed if required but this tends not to happen during the day as the birthing rooms are not overlooked by other buildings or structures. If occupied, the doors of the birthing rooms are kept closed.

On entering the birthing room, most times a long curtain has been pulled across the inside entrance of the door to maintain privacy. The birthing bed is the central point of the room, with the head of the bed positioned against either the left or right wall of the room depending on where the bathroom is located. The birthing bed can be electronically raised or lowered and manoeuvred into a variety of positions. The end of the bed can be removed and the woman's feet placed on supports to facilitate vaginal examination and/or perineal repair. Feet can be placed in stirrups either side of the bed to facilitate an instrumental birth.

The bathroom in each room contains a shower, toilet and small hand basin and there is a door for privacy. No hand washing facilities are available for staff in any of the birthing rooms. Staff must exit the room if they want to wash their hands or access water for any reason. There are connecting areas through closed doors, between

rooms, that provide hand washing facilities. Two or three upright chairs are usually placed near the birthing room window. A metal stool and a trolley (with two shelves and a birthing pack on the top shelf) are usually positioned against a wall. On the left hand side of the bed against the wall, sits a cardiotocograph (CTG) monitor on a mobile metal trolley. On the other side is a bedside cupboard on wheels, containing such things as sanitary pads, blue absorbent pads, drinking straws, disposable sterile gloves and vaginal examination cream. There is a wall clock on the opposite wall, which is clearly visible from the bed.

Piped oxygen, air and suction are positioned next to the bed and there is adult and neonatal resuscitation equipment available. An adult sphygmomanometer is attached to the wall near the top left side of the bed. To one side is a clear Perspex bassinet (on wheels) placed under a neonatal overhead heater. A metal trolley, with a drawer, contains equipment for maternal venous access and taking blood samples, including fetal cord blood (if required). A floor mat and beanbag are available.

All rooms are set out in approximately the same way except room one, which is furthest away from the central work area. This room is furnished with a low double pine bed, a bedside table, a small low coffee table and chairs. Technical equipment is less obvious. This room was not seen to be occupied during the study. When asked why, Vicki said that it was just a pine bed so, *"...we can't wind it up and save our backs" [Field notes]*. Anh had mentioned previously that they used room one for women who had stillbirths. She felt the room had *"...a creepy feel about it" [Field notes]* and did not feel comfortable using it.

Midwives move in and out of the birthing rooms as they provide care for women in labour - assessing for normality and progress. They try to remain in the birthing

room with women as they progress through the second stage of labour towards birth. The door of the birthing room remains closed and the midwife remains alone with the woman and support people until the birth of the baby is imminent. Then the midwife either pushes the call buzzer, or opens the birthing room door and calls out to the midwives at the central work area to ensure a second midwife or midwifery student is present at the birth to care for the baby.

Alternatively, the workload is frequently so high that midwives and midwifery students can be seen moving rapidly between rooms (trying to keep up with events) as the sounds of labour from different rooms becomes a crescendo and then either silence, or the insistent sounds of a baby's cry can be heard. If a woman is taking longer than expected to complete second stage, sometimes a midwife will lean out of the birthing room door and with a raised voice say to the midwifery team leader for that shift *"Just wanted to let you know it's been an hour" [Field notes Observation 1]*.

At times, the need to move the woman rapidly through the birthing process comes to the fore due to the fluctuating workload. This practice is ingrained into the culture – to a point that speed in practice is an expected way of working for some midwives. Sopheap recognises the pressure to 'hurry up' when it is applied in her direction from some midwives. She prefers to give the woman time to involuntary push, whereas when a woman's cervix is found to be fully dilated a significant number of midwives actively encourage pushing before the involuntary urge to push is felt. Sopheap feels that the woman's perineum is placed under tension when active pushing occurs. She describes her response to this peer pressure on practice:

"I don't ask [the woman] to push that early. You see different practices. You work your own way. I have [said to me] why is that baby not delivered? You should have delivered it and you are still there" [comments from other midwives working in Delivery Suite] Take it easy! Why do you have to push them [women] so hard, you know? It's not right!"[Interview].

Midwifery students also recognise this expectation of speed in practice:

"As a student everybody is kind of senior to you and you're kind of "Oh, I don't want them to come in and think I'm bad..." You're worried someone's going to come in and [say] "God, she's a multip Elizabeth. She should have had her baby by now and it's been 20 minutes!" It's how quickly you can do things" [Elizabeth, Interview].

Depending on the workload and proximity of the birthing room to the central work area, it is common practice for some midwives to sit, relax and read while listening to the sounds emanating from the birthing room as the woman progresses towards second stage – occasionally going into the room to attend to the obligatory observations. The midwife will enter the room when maternal vocalisation tells them that the woman is progressing well into second stage, or the support people come to the central work area seeking assistance.

Education room and antenatal health record storage

The education room is the first door on the left when walking through the closed Delivery Suite double doors with the intercom. This room is occasionally used for educational purposes – particularly for midwifery students. A large window provides natural light. The room furniture includes several upright chairs, a low table and a laminated table. As all hospital antenatal health records are stored in a

very large, three sliding door cabinet in this room, there is always the chance that ANC administration officers or Delivery Suite midwives (depending on the day and time) need to access files.

Communal staff tearoom

All health professionals working in maternity use the Delivery Suite communal staff tearoom, which is situated to the right of the central work area and further down the corridor from birthing room six. On entering the room, it contains two rectangular laminated tables pushed together to make one long table, with chairs placed around the table. To the right is a large refrigerator/freezer and along the bench top is a microwave oven. An instant hot water appliance is mounted on the wall. Staff members use these facilities to warm-up food and make hot drinks. A television is mounted on the wall and usually turned on. Staff toilets and lockers are outside Delivery Suite, through the open entrance and turn left - some way down the corridor and not easily accessed. Midwives have to leave the clinical area if they want to access these facilities.

Midwifery manager and O&G offices

The Delivery Suite MUM has an office situated close and directly to the right of the central work area. Working Monday to Friday, the MUM (when able) takes a clinical load and has input into clinical practice. The O&G Staff Specialist for this unit has an office near the communal tea room. Monday to Friday, during daytime hours, it is normal practice to see midwives discussing issues (if any) and providing updates on women's progress, with the O&G Staff Specialist (if on site), Resident

Medical Officer or Registrar. The O&G Resident Medical Officer or Registrar (obstetrician in training) is rostered on after hours and weekends.

SUMMARY

The Delivery Suite physical surroundings provide the foundational context on which midwifery intrapartum care is situated and the environment in which childbirth occurs. Women and support people step into this unknown context of care to engage in a most sensitive life changing event. Midwifery practice and the woman's childbirth experiences are shaped by the Delivery Suite and birthing room physical environments, which set the potential for reducing or increasing the incidence of perineal trauma.

The following section considers midwifery cultural beliefs and shared patterns of care for Asian women during childbirth.

MIDWIFERY CULTURAL BELIEFS AND ASIAN WOMEN

The use of different methods of data collection (observation, interviews, focus groups and casual conversations) increased awareness of discernible patterns of midwifery behaviour and thoughts related to Asian ethnicity, perineal trauma and clinical practice. Ongoing discussion and observation revealed a number of embedded perceived beliefs influencing the way midwives interact and care for Asian women during the second stage of labour and birth. All midwives attempted to reduce perineal trauma for women during childbirth. Most midwives believe Asian ethnicity increases the risk of perineal trauma for women (particularly with the first baby) and that a myriad of factors combine to undermine perineal integrity. There is a midwifery expectation that Asian women, and their support people, will

behave in a certain way in the birthing room setting, which may affect practices initiated to support perineal integrity. These midwifery cultural beliefs influence the practice approach taken towards intrapartum care for this specific group of women.

The following three midwifery beliefs describe the reasons why midwives believe women of Asian origin have an increased risk for severe perineal trauma following vaginal birth.

BELIEF 1: ANATOMICAL VARIATION INCREASES THE RISK AND SEVERITY OF PERINEAL TRAUMA DURING CHILDBIRTH FOR ASIAN WOMEN

Midwives used the following terms to describe the perineum of Asian women when comparing women from other ethnicities during the second stage of labour and birth:

> *"...more rigid. ...not stretchy. ...very firm elastic band. ...tight. ...very long. ...very short. ...will tear more often. ...they are rock hard. ...they don't stretch – they snap"[Observations, Focus groups, Interviews, Field notes].*

The belief of anatomical variation was seen to influence clinical practice towards the end of the second stage, prior to birth of the fetal head, when a newly qualified midwife, Kim, asked the advice of an experienced midwife as to whether she should perform an episiotomy. The fetal head was visible at the introitus and the woman continued involuntary pushing. Kim was unsure what to do, as birth of the head had slowed and there were signs of minor perineal tearing (skin) in two places. She asked the midwife, Anh, if an episiotomy was appropriate and Anh supported this clinical practice intervention. This was the first episiotomy Kim had attempted so,

Anh provided support during the procedure. The episiotomy was performed and birth of the baby progressed without further incident. As Anh left the birthing room she said *"Asian perineums are not stretchy. They are often fibrousy, inelastic, tough" [Observation 12 field notes]*. Perineal anatomical variation had influenced initiation of a clinical practice technique. I was unable to discuss this further with either midwife as the Delivery Suite was busy. During a focus group discussion, Anh explained that often:

"...with the Asians, anatomically, the vaginal orifice is very small and tight, and very inelastic so, they don't stretch well. So if you don't control you can either rip (a sudden rip if you don't do an episiotomy), or the baby's head will just be continually pushing on the perineal muscle and there's no signs of improvement in the advance of the presenting part. ...I find that their perineal tissues are very friable – they break away very easily and if I don't initiate an episiotomy she most likely will end up with a third degree or fourth degree tear" [Focus group 1].

Anh clearly recognises perceived anatomical variation in Asian women and the potential for increased incidence of severe perineal trauma during childbirth. As a result of this midwifery cultural belief, clinical practice is modified during childbirth to avoid major perineal trauma. However, this surgical intervention in practice reflects only one midwife's view. Other midwives may decide on alternative clinical practice approaches. Another experienced midwife, Biyu, describes the fragility and difference between skin types, when Asian women with:

"...darker skin tend to have really nice stretchy, elastic kind of skin [and] perineums, whereas ...[an Asian woman with] fair skin has a kind of more oedematous look and tends to tear – yeh, its fragile" [Focus group 4].

She felt that:

"...all perineums are not the same. Some...you can see are ready to stretch forever, to the end. There are other perineums that look [swollen] before [they] even start and you know that perineum is going to tear" [Focus group 4].

The majority of midwives believe that Asian women tend to have a shorter, more rigid perineum, which sometimes becomes oedematous. Both factors (independently and combined) are thought to increase the risk of perineal trauma. However, a significant proportion of midwives also associate Asian ethnicity with a long perineum for example, Cait describes how Asian women can have:

"...a really long perineum or they almost have a non-existent perineum. They [do not] seem to have a nice in-between Caucasian perineum" [Interview].

Sally describes how she feels when during the second stage of labour she finds that an Asian woman has a very long perineum:

"I'm always scared because [of] the long perineum. If they tear they go right to [a] third degree..." [Focus group 4]

It is clear that most midwives recognise anatomical variation in Asian women as a factor that increases the potential for perineal trauma (particularly severe perineal trauma). Consequently, there is an attempt to adapt practice to counteract the negative effects of any identified anatomical variation during childbirth.

BELIEF 2: ASIAN WOMEN ARE HAVING BIGGER BABIES, WHICH INCREASES THE RISK OF PERINEAL TRAUMA DURING CHILDBIRTH

Some of the midwives describe how they remember when Asian women experienced less perineal trauma than today and their babies weighed less:

> *"When I first started midwifery [there were] all the boat people, the Asian people coming – the refugees. They were...small, very tiny people and they still had their Asian diets and their babies were all around 2.5 to 2.6 kilos" [Rose, Interview].*

Since then, midwives feel that the increased risk of perineal trauma for this group of women may be partially influenced by the effect of a Western diet and change in lifestyle. For example, midwives describe the not uncommon occurrence of internal tearing prior to visualisation of the baby's head at the introitus. To further illustrate this point, during a birthing room observation blood was seen to start oozing from the woman's vagina. Suddenly, as the woman pushed, a long squirt of blood from the vagina shot in an arc across the room (distance of about two metres). The midwife watched as this happened and then said calmly: *"That was the internal [vaginal] ring breaking" [Observation 11 field notes].* Elizabeth, a midwifery student, describes how this hidden trauma sometimes presents:

> *"...you can see no head and you're getting that trickle of blood and you know there's a tear that's already happened" [Interview].*

Midwives suspect this internal trauma may be related to the physical stature of Asian women compared with the size of the babies they are now giving birth to, for example, Brenda feels:

"...often these Asian women are so small but a lot [have changed] to a Western diet and so...tiny, little [Asian] women are having three point eight kilo babies, [which] has got to contribute to [perineal trauma] as well" [Interview].

Vicki agrees with Brenda and feels that:

"...in the end it's [the woman] pushing the baby out and...the baby's size (from the excellent Western diet) that determines if [the baby is] gonna fit through" [Focus group 3].

Biyu believes:

"European or Caucasian [women] are designed...bigger [body size/framework] than a tiny [Asian woman], which is a high risk [for a] third degree tear" [Focus group 4].

The belief that acculturation may be the cause of an increase in fetal weight due to a change in diet and lifestyle, is a fact as far as this group of midwives are concerned. The resultant change in neonatal birth weight compared to some Asian women's body habitus makes trying to avoid perineal trauma in the following typical scenario, a challenge:

"...you could have your little 45 kilo Asian woman having your three and a half or four kilo baby and surprisingly pelvis to head circumference fits well. But then you've got this tiny vagina, with this huge [or short] perineum... So the actual vaginal outlet is quite tiny [and there is] a lot of rigidity of [the] perineal floor and perineal body" [Cait, Interview].

The potential mismatch between Asian women and their babies is thought to lead to increased interventions during childbirth for example, when asked if perineal outcomes were worse when fewer midwives are rostered on a shift (only two midwives work on night shift) Anh advised:

"It depends [on] what clientele you've got. ...if you [have] Asian clients...probably their perineal trauma is a lot higher...because there is a lot more intervention with the deliveries such as, [a] vacuum" [Focus group 1].

The above examples highlight that the majority of midwives firmly believe that the physical disparity between some Asian women and their babies contributes significantly to the incidence and severity of perineal trauma. This belief guides the approach taken towards care and clinical practice during the second stage of labour and birth.

BELIEF 3: ASIAN WOMEN DISPLAY DIFFERENT BEHAVIOURAL CHARACTERISTICS DURING CHILDBIRTH, WHICH COULD UNDERMINE PERINEAL INTEGRITY

When asked if there was any difference between the behaviour of Asian women compared with others during childbirth, Sopheap responded *"Oh! There is much difference, yes!" [Interview].* The majority of midwives are accustomed to the following behavioural characteristics for Asian women during labour and birth, which they believe have the potential to impact on perineal integrity.

Asian women swallow their pain

There is a recognisable difference in behaviour between Asian women born in an Asian country and subsequently coming to live in Australia, versus some Asian women born, or having lived most of their life, in Australia. Midwives know that Asian women born in an Asian country are mostly very quiet during labour and birth, whereas there is a tendency for Australian-born Asian women to vocalise like other Australian born women. This variation can have implications for clinical practice and perineal trauma. Biyu helped to clarify this behavioural difference from the Asian woman's cultural perspective:

"Asian [women] growing up overseas or growing up in Australia [are] very different. Asians growing up overseas...they come to Australia [and] have a baby. They shed tears, they don't scream, it's shameful, because the whole world knows...you are having a baby. Shame on you if you scream. When [Asian women] are born [in Australia] they scream for nothing. A little bit of pain... And they [do] not really care about you [the midwife]. ...They just blast you to pieces. They come across as quite queer people like that. But...born overseas...they respect you [midwife] so much. They listen to everything you say" [Interview]

Brenda describes Asian women crying during labour and birth:

"...it's like a sort of withdrawn cry. As if they're very withdrawn into themselves... It's not a vocal cry that some women find helpful....I would say they're very quiet" [Interview].

As most Asian women are generally known to be quiet compared with other women during labour and birth, midwives have learnt to be more observant of this group of women. Consequently, assessment of progress of labour can sometimes be

inaccurate if there is reliance on visual signs of maternal distress. Anne provided the following example: during a telephone conversation to discuss transfer of an antenatal Asian woman from the Ward to Delivery Suite, the Ward midwife mentioned that the woman was *"... looking a bit distressed" [Focus group 1]*. On arrival in Delivery Suite, Anne attended an immediate assessment and found: *"... the [baby's] head's on view! And you think "Oh!" [Focus group 1]*. Transfer of care to Delivery Suite had occurred almost at the end of second stage. No one had recognised the woman was in active labour, which may have implications for perineal trauma. The following field note provides an opportunity to visualise an example of the described maternal behaviour during a birthing room observation:

It is approximately 2130hrs, the woman is lying on the bed almost flat on her back with one pillow under her head, is fully dilate and involuntary pushing. The woman is not making any sound at all - her eyes are closed – very quiet in the room. No one is speaking...waiting...the midwife is [gently] palpating the woman's fundus. The partner says something to the woman very quietly in an Asian language. The woman nods with eyes still closed and clenches her left hand. The midwife, Kim, recognises that the woman has a contraction and is involuntary pushing. It is not apparent that the woman is doing anything. Her eyes are closed, no change in the position of her body, no noise, no obvious tension in her body apart from the clenched left hand [Observation 12 field notes].

Impact of 'Ying and Yang' on practice

Most midwives are aware of the need for cultural sensitivity when providing care for Asian women. Knowing how a woman will respond to various clinical practices during labour and birth is thought to help guide practice and support the midwife –

woman relationship. Biyu explains about the cultural belief of 'Ying and Yang' [cold and hot] when caring for an Asian woman in the birthing room setting:

"Asians, they don't like [a] shower. Once you have [a shower] you have lost the heat...your body is really weak. If you put coldness on to it [your body] you are sick for life...and you may develop arthritis" [Interview].

Therefore the 'Ying and Yang' belief limits the use of water for Asian women during childbirth and also reduces the clinical practice techniques available to midwives when trying to minimise perineal trauma. Colette has found that:

"Asian [women] are very resistant to [having a shower]. But I have found that babies born under the shower and the mothers [non-Asian], have felt quite comfortable with the warm water. They [Asian women] seem to think that on the bed is where they should be" [Interview].

During observations in the birthing room setting no woman used, or requested to use, the shower. Midwives are aware that a shower is frequently avoided by Asian women during and after childbirth and as a result, the option of the use of a shower was not mentioned to women during the second stage of labour and birth. The majority of midwives respect Asian women's cultural beliefs.

They like to lie on the bed

During birthing room observations most women were seen to be lying almost flat (with a pillow) or semi-recumbent on the birthing room bed. Depending on individual assessment and practice, the midwife did occasionally encourage a woman to sit on the toilet to push, but the woman always went back to the bed to

birth, whether encouraged by the midwife, or not. Midwives differ in their opinion as to the most appropriate maternal position for birth and the subsequent effect on perineal trauma, with some suggesting or encouraging alternative positions for labour and birth and some not. The expectation is, however, that most Asian women want to lie on the birthing room bed during labour and birth. As Cait describes:

"They just birth that way and they seem to adopt that position [semi-recumbent on the bed] automatically" [Interview].

As a strategy to try and minimise perineal trauma, some midwives try and counteract the natural inclination of the woman to 'get on the bed'. Rose has found:

"With Asian ladies, it's very, very hard to get them off their back. Once they are on the bed you cannot get them off and I have no idea why... So, I try and keep them off the bed" [Interview].

However, some midwives prefer the maternal semi-recumbent position when trying to reduce perineal trauma during birth as the midwife has *"...more control..." [Anh, Focus group 1]*, which means the woman stays on the bed for birth. Cait believes that a preference for lying down on the bed works quite well for the Asian woman:

"...because when they're lying down [on the bed] they don't actually get that perineal oedema" [Interview].

This approach towards maternal care during childbirth has implications for practice and perineal trauma.

Too tired to push

Midwives have found that Asian women are often too tired to push in second stage and feel this may be one of the reasons why they want to lie on the bed.

"...they just don't have the strength in their legs [to stand]. ...The support people would be saying: too tired Sister. Lay down Sister, too tired" [Cait, Interview].

Asian support people (particularly the partner) frequently express concern that the woman is 'too tired'. Asian women usually have few support people in the birthing room (often just the partner) but they are found to be very supportive, which makes a difference to how labour and birth progress as Brenda comments:

"In comparison to others [partners/ethnicities] who will just sit in a chair...Asian men always seem to be there [for the woman] rubbing her back or, yeh... I find they get very, very worried and concerned for their partner [the woman] – even when they can speak English...in comparison to...all other cultures we have here [in Delivery Suite]..."Please, my wife be OK?" and "My wife, very bad pain." and they come and get you [the midwife] and you will explain to them that "I am going to leave you now for about ten minutes and I will just be at the desk." And they will come out a few minutes later and say "My wife is having another pain." [Interview].

Due to the reluctance or inability of Asian women to push during the second stage of labour (mainly with the first baby), a significant number of midwives believe they have to intervene in this situation to try and reduce the risk of an instrumental birth such as a vacuum, which may occur due to a prolonged second stage. They are conscious of the fact that this type of intervention increases the risk of perineal trauma. Cait describes the next step when the woman is 'too tired to push':

"...it [is] up to us to...encourage the pushing...otherwise we'd never get there [birth the baby] and they [Asian women] would all be a vacuum" [Interview].

This phenomenon shapes the direction of midwifery clinical practice as Adele and Sally describe:

"Well, most [midwives] encourage active pushing. There's not too many people that don't, especially with Asian primips because... Cos they refuse to do it [push]. They [women] say '[I] can't do it. I can't do it' and they just lie down there without [any] effort at all, so you have to encourage them [to push] ...it's the only way...there's no other way to do it" [Focus group 4].

This clinical practice approach was seen during a birthing room observation. To place things in context, the Asian partner and support person in this observation could speak some English, although they continued to talk to the woman in an Asian language throughout the observation. The woman did not speak English fluently. The midwife did not speak the woman's language. English was also the midwife's second language and she had a strong accent. As the midwife pulls on sterile gloves, she says to the woman:

"Now, if I ask you to push – it depends on how you push. ...I am going to show you how to push. Hold your breath – aim to have three pushes with one pain. The woman says "I can't push." The midwife says "You just have to try first." There is a lot of noise as she raises the bed and moves the metal trolley with the birthing pack closer to the bed. She says to the woman "I just want you to understand." The woman talks in an Asian language and looks and sounds distressed (remains semi-recumbent on the bed, with the gas mouthpiece in her mouth.) The midwife takes away the gas mouthpiece saying "No need to use this now. You need to push." Between contractions the midwife practices with the woman and support person how to push.

The midwife says "We are going to see how you go. If you want another position – on the bed or off – what you feel is a better position to push." The midwife adjusts the bedrest more upright. The woman has a contraction and says "I can't [push]" [Observation 11 field notes].

The majority of midwives were observed to encourage active pushing throughout the second stage of labour and several initiated a variety of clinical practices to facilitate progress. There are some midwives, however, who prefer not to instruct the woman to push unless a problem is identified. When trying to reduce perineal trauma, they allow the natural process of the second stage to bring the 'head on view' at the introitus. Rose feels that:

"...encouraging active pushing prolongs second stage. It wears them [Asian women] out, they run out of energy and they're more likely to have an instrumental birth" [Interview].

Anh agrees that Asian women have *"...no energy to push" [Focus group 1]* and their *"...energy reserve is very, very, limited" [Focus group 1].* However, she describes an alternative clinical practice approach used by a few midwives when the woman is encouraged to *"...breathe on the gas...turn on [to] the lateral position and...just breathe through with the contraction[s]" [Focus group 1]* during second stage. Anh feels that this practice gives time for the fetus to *"descend of its own accord…" [Focus group 1]* through the pelvis and reduces the woman's stress about *"...I've got to push and it's hurting" [Focus group 1].* Therefore, Anh believes that this approach is helping the woman to *"...reserve all the energy for the big time to*

come...when the head's crowning" [Focus group 1]. Gwen also reflects on the Asian woman's difficulty with pushing and exhaustion, and wonders whether:

"...they've exerted so much energy keeping quiet through labour that when it comes to that second stage they've...lost a lot of energy from just trying to keep so quiet" [Interview].

There is a shared understanding amongst most midwives that the behavioural characteristics of Asian women during labour and birth can differ from the non-Asian population, which has the potential to undermine perineal integrity.

SUMMARY

Midwifery cultural beliefs and shared patterns of care combine with the physical environment of a Delivery Suite to influence midwifery intrapartum practice when caring for Asian women. The influences on certain midwifery practices when attempting to reduce perineal trauma for Asian women, can be more easily understood.

This results chapter provided the basis of a foundation for understanding a midwifery culture of care situated within the Delivery Suite. The effect of this practice culture and organisation of intrapartum care on the midwives, women and support people can be appreciated.

The following chapter provides insight into how midwifery cultural beliefs shape relationships and practice, and influence the direction of care. The practical and emotional aspects of the midwife-woman relationship are considered as midwives attempt to maintain the perineal integrity of women in their care.

CHAPTER 5

RESULTS: SHAPING RELATIONSHIPS

The previous chapter offered a foundation for understanding place and midwifery beliefs when caring for Asian women during the second stage of labour and birth. This chapter illustrates the shaping of midwifery relationships with Asian women, and support people, within a Delivery Suite culture of care. Midwives explain how they make sense of their shared routine practices and knowledge as they endeavour to relate to, and communicate with, Asian women, whilst attempting to minimise perineal trauma during childbirth.

When describing the practices used to reduce risk of perineal trauma for Asian women, midwives initially describe the practical techniques of practice. However, when encouraged to reflect further on their practice knowledge and expertise, they reveal the importance of the emotional aspects of care. They describe how hard they have to work to build that connection/ bond between themselves and the woman, the difficulties experienced when there is a language barrier and how they attempt to overcome this barrier to make it a better experience for the woman. Support people can provide a vital communication link, when midwives need to overcome a language barrier. Moreover, midwives are aware the additional presence of maternal fear during childbirth has the potential to undermine the midwife-woman relationship and communication link, which increases the risk of severe perineal trauma.

THE MIDWIFE-WOMAN RELATIONSHIP

Individual midwifery skills and approaches towards care vary, and maternal responses may differ depending on a number of factors. This influences the midwife-woman relationship. Patterns of behaviour and practice were identified during birthing room observations when midwives were providing care for Asian women during the second stage of labour and birth. A key element of care included building relationships within the birthing room setting to facilitate normal birth. Having the opportunity to view different styles and approaches of midwifery care, combined with conversations, helped to support understanding and clarify meaning behind midwifery behaviour and practice. Stepping through the door of the birthing room into the world of the midwife brings the reality of a culture of intrapartum care into focus.

ESTABLISHING A RELATIONSHIP

The extent of perineal trauma can be reliant on the individual interpersonal skills of the midwife. Establishing a relationship with the Asian woman is considered essential by most midwives. The need for rapid development of this midwife-woman relationship is explained by Rose:

"I think it's very important [establishing an early relationship with the woman] because if you don't have that communication and rapport, and the [woman] hasn't started to feel comfortable with you, then they're more likely to listen to their support people [when]...you want them to listen to you... So, if I start looking after them really early on in their labour…, then they're more likely to focus on what I'm saying" [Interview].

Vicki confirms the importance of the midwife-woman relationship and feels that:

"...if they're [the woman] stressed and you don't have a relationship with them – when you speak to them they won't listen to you. At the point when they're stressed they need to already have that relationship established so they [can] hear your voice and know that you've got something...worthwhile...to say to them" [Focus group 3].

The midwife may only have a short time to establish a relationship. For example, the woman could be in advanced labour when she arrives in Delivery Suite, or a changeover of shift occurs and a different midwife takes over care of the woman. Midwives explain how these factors may affect the midwife-women relationship:

"...you've got to try and get that [rapport and trust] but you might only have them [the woman] for an hour. ...she might walk in, she's eight centimetres [dilated cervix] and the next thing you know is that she's fully [dilated] so, you've got to try and get a little bit of what she's all about in that short period of time and it's very hard sometimes. ...if she [the woman] walks in [to Delivery Suite] fully [dilated] you can't do that [build a relationship]" [Mary, Focus group 1].

Rose describes the effect of when there is:

"...a changeover of shift and you have taken on [the care of] this lady, and she is nine centimetres [dilated], you don't have time to get that rapport going so, it's a bit harder" [Rose, Interview].

Sally finds it: *"...very hard to bond with the woman in such a short time" [Focus group 4],* especially if she is with the woman only one or two hours before the baby is born:

"...To give all the information about 'What I want you to do. What you can do. We have to try to prevent your perineum [from tearing]...' I give all the instructions to the mother [woman] but when they are here [in Delivery Suite] they are distressed because they are in pain. It's such a short time – we can't"[Sally, Focus group 4].

Some midwives, however, feel that time makes no difference to the midwife-woman relationship and subsequent incidence of perineal trauma. For example, when there is an increased workload in Delivery Suite:

"...if you have the same skills [and] you are the same midwives, there shouldn't be any variation in the rate of their [the woman's] perineal trauma. And...there's really no relation to the time of when they come in" [Ahn, Focus group 1].

Mary supports this view and believes:

"It [time] shouldn't make any difference really [to perineal trauma]. ...you assess the woman on her basis – it's not just because you're in a hurry or short staffed. You've still got to go with the way the woman's delivering anyway" [Mary, Focus group 1].

The differing midwifery views on practice are evident in the above expressed opinions relating to 'time', the midwife-woman relationship and reducing perineal trauma for Asian women.

A TRUSTING RELATIONSHIP

Most midwives recognise they cannot work in isolation when trying to protect the woman's perineum. Conversations and observations highlight how midwives know that working together with the woman and support person, within a trusting

relationship, increases the likelihood that perineal trauma will be reduced. Therefore, the midwife-woman-support person relationship is viewed as being important in maintaining perineal integrity.

Midwives are aware that their individual ways of relating to the women and support people differ, ranging from trying to empower the women, as Brenda explains:

"...treat them [women] as an equal rather than 'I'm in charge. You'll do what I say.' Working with them saying 'We're in this together, we're working together', rather than...disempowering them by taking on that 'I'm in charge. You listen to me' role" [Focus group 3].

To an authoritarian approach towards care as described by Cait:

"Some midwives I've seen are very authoritarian, very controlling and think that they can control it [labour, birth, the woman and support people] all. And I've been surprised that the patient [woman] has...accepted and actually thanked them [the midwife] for that [authoritarian approach towards care] and enjoyed that because I know as a patient I wouldn't enjoy that" [Interview].

Vicki feels that:

"...It doesn't mean that people don't have empathy because they are authoritative, I'm sure they do. ...even though they are authoritative, maybe they are just not giving the explanation in as nicer floral way as they could. It's still the same information" [Focus group 3].

So how the midwife relates to the woman and support people varies. However, what is said and practised by the midwife, when providing care during the second stage of

labour and birth, has identifiable ritualistic elements and patterns of practice. Consider the following example as the midwife guides the woman through birth of the baby's head:

Midwife says [to woman] "Is it coming?" Woman says nothing and starts pushing. Midwife to woman "Good! Good, more, more, more, good, good and again, good, and again, good, keep going! Midwife points to the baby's head, looks at the support person [woman's mother] and says "See?" Support person says "Yes." ...Midwife to woman "Want a mirror? Good, that's good, very good, very good, very good. Head down, come on, good, good, good, good, good, good." Support person constantly talking to the woman in a low, quiet voice in an Asian language [Field notes, Observation 4].

The midwifery ritualistic repetition of words and short phrases relating to instructing the woman how to position her head when pushing and birthing of the baby's head, are apparent. The Asian woman and support person communicated only in an Asian language throughout the observation. The woman could speak English but the support person could only understand a few words.

Vicki recognises that the midwife-woman relationship is pivotal in limiting perineal trauma:

"You get in her [the woman's] head-space – she understands that you have got to take it slowly [birth of the fetal head]. She controls it [expulsion of the fetal head] more than you do and if you can get in a good relationship with her, and explain to her what's going on, I think you will have much less perineal trauma" [Interview].

Therefore, it seems the midwife-woman relationship enables women to understand and have self-control during a significantly emotional and physical event. When

asked the meaning behind the midwife-woman relationship, Vicki said *"...they trust you" [Focus group 3]* and Brenda feels that *"...trust is huge" [Focus group 3]*. A description of how a feeling of 'trust' grows between the woman and midwife was provided by Vicki:

"They check your statistics before they trust you. They like to know your background. ...have you had children? Have you been working here a long time? Have you seen this before? Is this going OK? ...They're just checking things and once they feel secure – then when it's time for something stressful, they're more likely to listen to you [the midwife]" [Focus group 3].

Midwives know that a trusting relationship will grow if they look and act confidently in the birthing room setting, even if the woman and support people are unable to speak English. The following 'trust' building strategies were described by midwives and observed in the birthing room setting: making direct eye contact with the woman, calling the woman by her first name, using therapeutic touch, positive body language/facial expression and displaying empathy and compassion. Eye contact is one 'trust' building strategy that Vicki confirms she uses and was observed using in the following observational extract:

Woman resting back against the pillow, eyes closed. Woman says "I want to push." She places her feet on the midwife and partner's hips [legs wide apart]. Midwife is watching the perineum, resting her left hand on the woman's left leg, makes eye contact with the woman. Woman closes her eyes – grimace [pushing]. After the contraction the midwife leaves the room for a short time and comes back holding a health record. Midwife and partner help the woman place her feet on their hips. Midwife encourages the woman to push "...long hard pushes. Just do the best you can – that's all you can do." Midwife changes the soiled blue sheet under the woman – stops as the woman wants to push. Midwife's voice (when talking to the woman) is

very quiet – does not raise her voice. Talks directly (using eye contact) to the woman. Midwife continues changing the blue sheet. Explains to the woman and partner that she can see signs of the baby moving down when the woman pushes but can't see the baby's head yet. [Field notes, Observation 10].

Working together in a trusting relationship is recognised as an important factor when trying to minimise perineal trauma. Most midwives feel the woman's support person makes a significant contribution to the woman's childbirth experience. Therefore, building a trusting relationship with the woman's support person is essential, as Rose explains:

"...if you...get the husband on your side as well and he starts to trust you, then he's likely to listen to you and what you're saying to his wife...he's going to be saying the same thing. I find the older women, like the...mother-in-law [or] the mother, are harder to get a rapport with... You've got to have that rapport with the support people...if you don't have that, everything goes out the window because they [the woman]have known their mother longer than they have known me" [Interview].

Cait provides some background to the 'trust' and unique relationship she perceives has developed over decades between the midwives working in Delivery Suite and the local Asian women:

"So, they [woman] have no predetermined ideas about what they want and what they don't want. They, 100%, allow the midwife to do whatever is necessary and so does the partner...without ever obstructing us. It's the most unbelievable culture... They completely trust us and we, (because of that) we're very humbled by it and I have never seen a midwife...abuse that power. So, the midwives actually respect 100% that level of respect and ...will do everything in their power to work with that woman to have that baby. ...maybe some midwives are better than others" [Cait, Interview].

Clearly, the importance of trust within the midwife-woman relationship is a vital ingredient when attempting to reduce perineal trauma during childbirth.

MAINTAINING A RELATIONSHIP AT A DISTANCE

Current accepted practice during second stage is for the midwife to stay in the birthing room with the woman to monitor progress and to assess fetal heart sounds (FHS) after every contraction. Circumstances dictate that sometimes during second stage the midwife cannot always stay with the woman. Anh describes how she tries to deal with this situation:

"...second stage can be a touch and go situation. The minute you turn your back the baby will be on the bed so, you just tell them [the woman] 'Whatever you do don't push. Just do the deep breathing.' Give her the gas if she's using it and...[say] you'll be back as soon as possible when you answer the phone or see who's at the door, or who is ringing in the next room so, that will make her realise that she's not being abandoned at that time. She is so scared that things [are] going to happen and I think that will actually help her to concentrate on her breathing and knowing that you are coming back" [Focus group 1].

The above comment reveals Anh is aware that leaving the birthing room at such a critical time places the woman in a very vulnerable state and potentially undermines the midwife-woman relationship. Anh aims to maintain that link of 'trust' at a distance, when she is not able to be with the woman. The situation Anh describes occurred during a birthing room observation. The labouring woman can speak fluent English, however, she speaks only in an Asian language throughout the observation unless someone speaks to her in English, and then she responds in English. Her elderly mother is her support person and she cannot speak English. The woman is

wearing a white gown and lying semi-recumbent on the bed. All the lights are on in the room:

The woman is crying out during involuntary pushing – then uses the gas in-between contractions. The support person [mother] is standing on the left hand side of the bed. The midwife enters the room and documents in the health record after ensuring the woman is in the left lateral position... The midwife leaves the room after changing the blue sheet underneath the woman. The midwife quickly re-enters the room and attends to further documentation in the health record and then leaves the room again. She does not say anything during this time. The support person leaves the room. The woman is alone – pushing in second stage [Field notes, Observation 13].

Midwifery compassion and support are not offered to the distressed woman in the above observation. A second observation finds the room lights dimmed. The woman is wearing a white gown and lying on the bed in a semi-recumbent position. She is exposed to the top of her fundus. The partner is standing near her, next to the right hand side of the bed. The woman has been in Australia for six years, is not fluent in English and speaks an Asian language throughout the observation. The partner has lived in Australia ten years and can speak English fluently. He appears to translate what the midwife is saying to the woman all the way through the observation. Caring and support are evident in the following observation:

The midwife is standing on the left side of the bed - waiting. A contraction occurs [midwife to the woman] "Good, very good! Well done! Good pushing! Excellent!" The midwife is standing by the side of the bed with her right hand on the woman's right leg/knee, smiling at both the woman and partner. She says to both of them "I am just going to the door [of the birthing room]. I will be coming back." The midwife opens the birthing room door and calls out something to another midwife

sitting at the work desk and then walks back to the woman and partner [Field notes, Observation 18].

During the first observation, Delivery Suite was very busy and the midwives were running from room to room trying to provide care for women in labour. There was a sense of fear and aloneness in this birthing room. The midwives would hurriedly come into the room, attend to the essential observations and then leave. The support person (the woman's mother) was ignored unless she asked a question in an Asian language (a midwife understood some words in her Asian language). She spent a lot of time sitting and watching her daughter crying out in distress or she talked and laughed very loudly on a mobile phone. She tried to look after her daughter (stroking her arm, head, covering her over with a sheet when it slipped off) – no one involved her in care provision. She was mostly ignored. The labouring woman eventually experienced a vacuum birth with an episiotomy. During recruitment to the study the woman's mother had talked (through an interpreter) about how she had an episiotomy in her Asian country of origin and was very concerned that her daughter might have one. As the vacuum was conducted, the woman's mother was hiding behind the bathroom door – too frightened to stay and watch her grandchild being born. No one noticed. This is in contrast to the second observation where few women were in Delivery Suite and the midwife was able to stay in the birthing room with the woman. Most midwives have an ideal view of how they should and would like to practice, but this was seen to be not always possible.

THE SYSTEM OF CARE

The model of care in place within Delivery Suite can disturb or prevent the development of a midwife-woman relationship. Cait recognises how the system works against midwives and women being able to generate a supportive relationship:

"...it's a very fragmented model so, we [midwives] don't know the women... ...I have found in my experience that there [isn't] ...time to have a relationship [laugh], communication and rapport. Because, seriously, they've [woman] walked in and had a baby and they've never seen you [midwife] before in their life and they've only been there one or two hours and they just trust…" [Interview].

Consequently, most midwives recognise the situation is not ideal regarding the development of a midwife-woman relationship and that the Asian woman is disadvantaged as Susan, a midwifery student, explains:

"I think it helps reassure them if they are with the same midwife for several hours in labour and usually it is a terrifying, scary, unknown experience for women so, having a constant person there to reassure them, to guide them through...it helps, yeh, it does build that rapport and...then they trust you so, when you say [to the woman] everything is normal and you're doing well, then they believe you and they can relax and do what their body tells them to do and [in] that way maybe [perineal] trauma can be reduced by pushing correctly or at the right time when they feel like they need to push, or staying in the positions that suit them best also reduces trauma. They are reassured and that "OK, this person knows me. She's helping me and everything is going well so far so, I am going to believe what she is saying and I'll do what needs to be done" and I am just guessing that will reduce trauma a lot because of that reassurance and that trust – someone is looking after you. I think the role of a midwife is very important in reducing [perineal] trauma, definitely"[Focus group 2].

Not knowing the woman before they arrive in the Delivery Suite is an expected normal occurrence. Midwives recognise the distancing and detachment between themselves and the women they provide care for in Delivery Suite. The midwife-woman non-therapeutic relationship is shaped by the current system of care. This system outcome has been in place for many decades and most midwives have internalised and accepted this reality. A midwife for several decades, Colette describes the internalised, professional distancing and acceptance from a midwifery perspective:

"It never worries me if they never remember who I am [or] what I did...because I consider myself a...facilitator. I am just the unknown person in the room...and they [the woman] get through this period in their life as good as they can... Some of them don't. Some of them do it really hard and then some of them come along and you think "Wow! This is how it should be for every woman." But it's not" [Interview].

When asked why it is harder for some women compared with others, Colette replied:

"I think it's a whole lot of things. Some of them [women] haven't got any idea at all on what to expect. Some of them don't have the right support people with them. Some of them...are so frightened and so scared. Everything goes out of their head and afterwards some of them will thank me and I have done nothing, you know? ...and they feel as though I have... They have done just everything and I have really done nothing" [Interview].

This is the accepted reality of a large proportion of midwives working in Delivery Suite. For them, there is no foreseeable alternative.

SUPPORT PEOPLE

Support people usually accompany Asian women to the Delivery Suite. Colette provides the following observation:

"A lot of them [Asian women] come in with not much support apart from their husbands. But in saying that, the husbands are involved. ...[and] most of them....are very supportive of their women" [Interview].

Getting the relatives 'on your side' by relating to them and involving them in the childbirth experience is considered an essential practice skill by some midwives because:

"...if the mother-in-law or the mother has confidence in you she relays that confidence to the woman as well" [Anne, Focus group 1].

So, midwives know that when they walk into a birthing room to provide care for a labouring woman the support people *"...are already sizing you up [general laughter]" [Anh, Focus group 1].* Rose emphasises that an effective relationship with support people:

"...make[s] sure they [support people] are listening to what you're saying to the [woman] so, they are taking it in as well. So, if I'm saying [to the woman] 'OK, I don't want you to push now' or 'OK, you're doing really well', that they [support people] are understanding that everything is good, that everything is OK and they can stay calm. Calmer than what they would normally be. So if you think of everybody focused on this person [the woman] that is actually doing all the work...they are the most important person" [Interview].

Building relationships with support people is considered an important step in attempting to reduce the woman's perineal trauma. Words such as, *"...approachable, patient, tender...loving care" [Interview]* are mentioned by Biyu to describe the approach the midwife should take when trying to relate to the support people to *"...show them that you care" [Interview]*, which helps build a feeling of trust within the birthing room setting. When these qualities are not evident then a fragile, trusting relationship is compromised. Midwives find that Asian families are very respectful and more open to support from midwives *"...they tend to fall in with whatever you want to do" [Colette, Interview]*. Some describe this as an overall submissiveness of the woman and support people towards health carers and believe this is normal Asian cultural behaviour. Cait describes how Asian partners:

"...will not rock any boat. They will not refuse care. They will never say "No." They will go 100% with what you say" [Interview].

A varied collaborative/non-collaborative approach to care involving the midwife and support person was observed, with the support people and women responding to midwifery cues during the labouring and birthing process. The support person's involvement in the birthing room ranged from being actively encouraged by the midwife to participate physically and verbally, to the midwife working around the support person as if they were not in the room. The following two extracts from observational field notes provide a view of relationships and support people's involvement and experience in the birthing room during childbirth. The first

observation finds the partner talking to the woman in an Asian language throughout. The woman speaks very little English and the partner is not fluent in English:

The partner asks the midwife if the woman can push. The midwife says "Yes, If she feels like pushing, she can push." The partner is near the top right-hand side of the bed stroking the woman's head – talking quietly to her – standing, waiting – silence. The midwife stands on the left side of the bed palpating the woman's fundus with her left hand. The woman...raising her left shoulder slightly – pushing... The partner talks quietly to the woman – she nods. Partner talks again – nods. Woman is pushing – silence – baby's head is visible. Midwife is gently palpating the woman's uterus – quiet. Checks FHS. Woman's eyes remain closed. Partner is talking to the woman – whispering. The woman's legs are relaxed, apart. Midwife is palpating – watching genital area – fetal head coming up – palpating – pause – silence... [Midwife to the woman] "You are doing beautifully, doing so well" (speaking quietly, stroking the woman's arm). Partner gets a drink of water for the woman" (Field notes, Observation 12].

The partner is able to respond to the woman's needs using therapeutic touch, verbal support and care. The midwife smiles and has eye contact with the woman and partner. The interpersonal dynamics change in the next observation. The partner speaks more English than the woman:

The partner is standing near the window – well away from the woman. He walks towards the bed looking as though he wants to help, unsure, stepping back. The midwife is not talking to the partner – she is working around him. Does not encourage him to interact or show him how to support the woman. The partner is still standing near the window, arms folded. The midwife is sitting on a chair (between the partner and woman) next to the bed. She has a hand on the woman's abdomen feeling for a contraction. Midwife says "OK, big breath in, pretend you are sitting on the toilet, good pushing, one more, nice big long one to push him forward. When the contraction has gone just relax... You are doing fantastic. Would you like a

drink of water? No? OK." Checks FHS with the CTG and sits down on the chair again. The woman is quiet, lays there, doesn't say or do anything apart from looking intently at her partner near the window. The partner moves around to the opposite side of the bed from the midwife. Stands near the woman – holds his hands together, does not touch the woman – looks anxious... The partner is not important – does not have a role. The midwife seems to look through the partner (he isn't there). Very quiet – can hear room air conditioning working and people talking outside the room [Field notes, Observation 1].

There is still a quiet environment in the above observation but the midwife does not relate well or involve the partner in the woman's care. The partner is distanced from the childbirth experience. The midwife does not provide him with any prompts or support to actively participate. The woman is not an active participant. The next observation is a midwifery student 'follow-through' case (under the guidance of a midwife, the student provides care (when able) and follows the woman during pregnancy, birth and the postnatal period):

The midwifery student says "It's hard work having a baby" and smiles at the partner." Quiet...waiting. Contraction – pushing. The partner is holding the woman up, with his arm around her back – whispering… [Field notes, Observation 6].

The woman and partner are seen to relate well and appear relaxed in the company of the midwifery student. They know the midwifery student because she provided antenatal care throughout their pregnancy. The partner provides the woman with physical, verbal and emotional support. It is also recognised throughout all birthing room observations, when the midwife relates to the support person and involves

them in the care of the woman in some way, the support person often physically or verbally copies what the midwife says or does for example:

The woman says "I want to push." Midwife says "OK, grab your legs. Put your energy where the baby is. That's a good girl. Your body is making you work hard." Midwife grasps the woman's right foot and places it onto her own hip. The partner does what the midwife does and places the woman's other foot onto his hip. Woman's knees are flexed and legs are widely spaced apart. Midwife places her left hand gently on the woman's right knee. Midwife says "Long push! Long push! Good girl, that was very good work!" FHS attended via CTG. The woman rests back against the pillow, eyes closed [Field notes, Observation 10].

The following extract is a verbal example of a support person's behaviour:

Contraction - the partner is saying to the woman "...keep going, keep going, keep going." The midwife says to the woman "Good girl – that was good" [Field notes, Observation 16].

If a midwife gives the Asian support person permission (verbally or otherwise) to actively participate in the childbirth experience, they tend to willingly respond. No support person was seen to decline a midwife's request to provide the woman with physical, emotional or verbal support during birthing room observations. The willingness or ability of midwives to relate to, or strengthen the relationship, with the support people varies for example, Colette feels that *"I don't know that they [support people] are involved in the [child] birth process" [Interview]*. This limiting of the role of the support person may have the potential to undermine perineal integrity due to a reduction in trust, communication and escalation of maternal fear. The support person's participation in the childbirth experience rested

on individual midwifery interpersonal skills and attitudes, the level of staffing in Delivery Suite and workload.

A COMMUNICATION LINK

Most midwives recognise that without effective communication, the relationship with the woman is tenuous and childbirth processes and outcomes are more likely to compromise perineal integrity. Anne feels that *"Communication is vitally important..." [Focus group 1]* when trying to reduce perineal trauma. Midwives find that an effective communication link helps to build confidence, trust and reduces fear. Consequently, some midwives view barriers to communication between the woman, support people and midwife as having the potential to significantly increase perineal trauma.

Strategies to overcome or work around identified barriers to communication are regularly used by Delivery Suite midwives in response to the large number of women speaking only limited or no English. Routine patterns of midwifery behaviour and practice were seen to occur when attempting to surmount barriers to communication between the woman and midwife in the birthing room setting.

LANGUAGE AS A BARRIER

Language is simply one tool of communication used by midwives to communicate with women during childbirth. Midwives perceive that women from a non-English speaking background in labour have a strong need to be able to communicate with health professionals in their own language. It is known that *"...more often than not..." [Anh, Focus group 1]* when an Asian woman arrives in Delivery Suite:

"...the first question they ask you is can you speak 'such and such' a language?" [Anh, Focus group 1].

Women in labour with their first baby are frequently assessed by midwives as being anxious when arriving in Delivery Suite. There is a perception that not being able to communicate effectively with a midwife increases a woman's anxiety as Susan, a midwifery student, explains:

"I do feel sorry for those women, especially the first timers, because it must be even more terrifying than normal. Because you can't ask for help or you can't be reassured. ...you can tell by the tone of the midwife's voice she's being kind...But you don't know what the words mean" [Focus group 2].

Midwives perceive that Asian women:

"...feel comfortable with the staff who can speak the same language. Immediately they can identify where they are and they feel very happy and relieved as well. ...if you feel relieved you somehow are not so conscious of the pain and you feel that as though you are not in danger as well. ...you can relate to that person" [Anh, Focus group 1].

The relief offered to the woman by communication in a language she understands, is thought to make a difference to her childbirth experience. Therefore, midwives try to ensure allocation of a midwife who speaks the woman's language. The number of non-English speaking Asian women, however, far outstrips the number of midwives in Delivery Suite who speak an Asian language. If an Asian speaking midwife is unavailable, a number of alternative approaches are used to facilitate development

of the midwife-woman communication link. Anh describes trying to reduce women's fears when a language barrier is identified:

"...we try to ask them [to] speak slowly and ask them [what] the problem [is]... So I just find that sometimes language is a matter of how you express yourself, how you look after them and the way you portray yourself across to them" [Focus group 1].

Use of non-verbal language techniques in practice such as, body language, tone of voice, use of eye contact, pointing to charts on the wall, therapeutic touch and use of words in the woman's own language (learnt by exposure to similar scenarios) have been identified in observational field notes and conversations. Some midwives consider non-verbal language strategies are effective when there is a maternal language barrier during the second stage of labour and birth. Vicki describes how she applies non-verbal strategies when attempting to minimise perineal trauma for women who speak limited, or no English:

"They [the woman] can tell that you know what you are doing. You've just got to look confident [general laughter]. Look them in the eye. You look them in the eye and they just can tell that you know what's going on. ...when they're pushing, I always like to have some eye contact so they understand that we're working with them" [Focus group 3].

A few midwives feel that the woman not being able to speak English makes no difference to the incidence of perineal trauma. Biyu considers non-verbal strategies are really effective during childbirth:

"I don't see any difference [to perineal trauma and fluency of English]. ...in the first stage leading onto the second stage, I always prepare them and explain with the

picture on the wall [wall chart] "This is what happens." So, make them understand and kind of shaping of their mind... So...prepare them...this is what happens. And as they push and the baby start[s] to come, come, come – ...that is the time you refresh their memories "See, do you remember that I told you that the baby come through now, come more, stinging, pain around here more than this place and here?" Just explain and guide them, ensuring they understand more" [Interview].

Colette feels that a maternal language barrier makes no difference to perineal trauma because:

"I think it's a body thing. It's their body – it's the way their body is. How it responds to what is happening to them. I don't think whether they can speak fluent English or not makes any difference [to the incidence of perineal trauma]" [Interview].

The majority of midwives, however, are of the opinion that not being able to communicate with the woman in a language she understands may increase the risk of perineal trauma for example:

"I think it's good if you can talk to them cos if you say "Slow down" [to the woman] and she understands "Slow down" and she can control her breathing, well that's good. If you have to say [to the support person] "Tell her to slow down" and then he has to tell her to slow down and then she has to understand to slow down, and then she has to do – then by that point the slowing down time may well have passed by. So, the timing – it's only seconds passing by, but...if you can directly talk to the person [woman] (obviously) and they're listening to you..." [Vicki, Focus group 3].

The above description reveals some of the challenges midwives face when attempting to reduce perineal trauma for Asian women during the second stage of labour and birth. It is clear that midwives believe Asian women have a need for

communication in their own language. Moreover, most midwives consider effective communication between themselves and the woman, as an essential component of care when attempting to reduce perineal trauma.

USE OF INTERPRETERS

Face-to face health interpreter services are not utilised by midwives during the second stage of normal labour and birth. Contact with a telephone interpreter for the woman is complicated by the fact that there are no telephones in any of the birthing rooms, although some time ago midwives did have access to a cordless phone they could take into birthing rooms if required. However, this telephone stopped working and was never replaced. Midwives recognise that it is not ideal using a member of the woman's family as an interpreter, but query the value of using a health services interpreter:

"It's very difficult because...having just been somewhere where we heard a talk on using interpreters in Labour Wards, which is - ideally, it would be lovely but you can't just have an interpreter there for one or two questions. You would have to have the interpreter there for the whole labour because it, it doesn't work that way – having someone pop in [to the birthing room] answer a couple of questions, walk out and then two or three hours later the lady still hasn't had the baby. Do you call the interpreter back in, have another few questions answered and then the interpreter go out? ... the [woman] doesn't know them – they are just an interpreter" [Colette, Focus group 3].

The above comment about the woman not knowing the interpreter identifies midwifery awareness of the potential impact of an unknown face entering the privacy of the birthing room setting, the innate need of women to 'feel safe' during childbirth and the value placed on the midwife-woman relationship.

Susan, a midwifery student, explains why communication is perceived as important in a woman's own language at this time:

"So she [woman] has a thorough, proper understanding of what's going on. So she's informed" [Focus group 2].

However, the feasibility of being able to ensure all women having access to an interpreter is questioned by Susan:

"...we have...probably well over 40 or 50 languages of people that we have coming through [Delivery Suite]. It's sort of impractical that we could get an interpreter [for every woman]. In an ideal world it would be great...but I just don't know how it's possible to get an interpreter available at two in the morning for a 'whatever' language speaking person" [Focus group 2].

Therefore, practicalities and protection of the birthing space goes some way to help explain why health service interpreters are under utilised by midwives. Vicki also prefers not to have health service interpreters present during the birth and feels that:

"They [interpreters] would leave the room in an instant and you can't really explain that process until it's occurring... ...so, I don't see any value [in having an interpreter present] unless it's a family member who is in the room" [Interview].

Consequently, when a communication barrier is identified, most midwives tend to build a communication link with the labouring woman through her support person. The strength and accuracy of this communication link may be questionable depending on numerous factors.

SUPPORT PERSON AS TRANSLATOR

Most midwives include the support person in the communication link to try and strengthen their relationship with the woman when attempting to prepare, inform and provide guidance throughout labour and birth. The quality and effectiveness of that link can be influenced by the midwife's approach to care and interpersonal skills. There is awareness that, even if the woman is fluent in English, they invariably revert back to their original language during the second stage of labour and birth. Therefore, a significant number of midwives feel that using the support person to interpret conversation between themselves and the woman (depending on the support person's ability and willingness to interpret) will lead to a reduction in the language barrier. The resultant strengthening of the midwife-woman communication link is perceived to reduce maternal morbidity such as perineal trauma. Rose speaks for a number of midwives when she explains that:

"I think that it's a joint thing. I think...you can do as much as you can but you have to have the support of the woman as well – you can't do it [protect the perineum] yourself. You can't do it yourself. You have to both work together" [Interview].

Working with support people to unlock communication channels is one way of being able to rapidly build trust and rapport with both the woman and support person:

"...if you...get the husband on your side as well and he starts to trust you, then he's likely to listen to you and what you're saying to his wife or partner, he's going to be saying the same thing" [Rose, Interview].

Unfortunately, sometimes the information the midwife is trying to relay to the woman is perceived as not being translated accurately by the support person, which may impact on the incidence of perineal trauma:

"...they [support person] don't always tell them [the woman] what you want them to. ...if you're saying "OK,...just do a little push now" or "Try to just breathe through this contraction" They don't always translate that [accurately] and then the woman will...do a great, almighty full-blown push and out shoots the baby and you're thinking "I had no chance to even look at the perineum, never mind protect it [laugh]" [Rose, Interview].

Alternatively, Colette describes how sometimes there is a sense that the support person does not want to translate what the woman is saying to the midwife:

"...you get just so much feeling from them [the woman] but you don't know for sure how it is, what they are saying, you know? Sometimes they will have their husbands interpreting and you will say "What does she want?" He will say "No, no. It's alright, alright." He's placating us whilst she might be very upset. He doesn't want to tell us. ...you are never quite sure" [Interview].

Therefore, midwives are aware they are attempting to work with the woman and support person in a world in which clarity or accuracy of communication is not guaranteed. This is where a balance of verbal and non-verbal communication skills can play a part in care:

"...you can usually get it with the body language – mime... ...to get them to do what you want them to do" [Colette, Interview].

Mary describes the effect of other support people (apart from the partner) when a language barrier is in place:

"...if they've got their mother or their sister, or their sister-in-law standing there [in the birthing room] talking in their [the woman's] ear. She's [support person] saying [in an Asian language] "Come on, come on, come on, come on, come on [telling the woman to push]" and you get nowhere. ...even the tone of the voice can be different. ...what you're saying can be translated to their language but not with the same tone or emphasis that you're putting across [in] your message" [Focus group 1].

This is when the midwives are aware of the need to maintain their professional composure, not show their frustration and continue to provide support (in any way they can) in order to try and hold onto the trust developed in the relationship with the woman. Elizabeth, a midwifery student, perceives that problems with communication during the second stage of labour and birth increase the incidence of perineal trauma. Perceived behavioural differences between Asian support people are considered:

"For the English speaking ones, depending on how old, the younger generation were probably born here. I treat them like I treat everybody else really. ...they have been westernised basically. They have watched videos that I have watched and ER [television programme] and all of that, you know... ... It's the non-English speaking ones that get really excited or don't do anything that makes it hard. It's like "Tell her to push" and they just sit there, or "Tell her to stop pushing!" and they go "Push, push, push, push, push!" [Elizabeth, Interview].

Overall, most midwives believe that effective communication with the woman (by whatever means available) does reduce the incidence of perineal trauma during the

second stage of labour and birth. Not all agree with this point of view. One midwife felt that if she was not in the birthing room the incidence and severity of perineal trauma would be the same. Adele makes the point, however, that:

"If you've got someone that doesn't have a clue what you're saying - it's just really hard. Like, we're using sign language and we're doing the best we can to get her to understand. But at the end of the day if she doesn't understand well, she doesn't understand. So, that's pretty tough" [Adele, Focus group 4].

NOTIONS OF FEAR

Feeling fearful is an emotion that holds negative implications for childbirth, including perineal trauma. Midwives attempt to reduce maternal fear by building a trusting relationship, having an effective communication link and incorporating the assistance of support people if at all possible. Anh describes the midwife's role in this situation:

"You are there not only as a midwife, but as somebody who they can trust and know that they do rely on you, and they don't have the fear, you know, to relate to you. And I find that if you can overcome the patient's fear of pain, fear of unknown, of what you are going to do to them. They tend to manifest in a lot of anxiety and it makes it hard for you to look after them because then you can perceive a lot of unexpected outcomes" [Focus group 1].

Anh is aware that maternal fear has the potential to increase the risk of adverse outcomes such as, an instrumental birth. This practice intervention has a known increased risk of severe perineal trauma. Reduction of maternal fear may increase the opportunity for a normal vaginal birth. A birthing room observation provided a

glimpse of this in action. The following information will help place this birthing room observation in context. The first midwife providing care is Caucasian, English is not her first language and she has a strong accent. The labouring woman can speak a small amount of English and the partner knows only a few words of English and has been living in Australia for three months. The midwife has been providing care for the woman for seven hours and the woman is now in the second stage of labour and has been looking and sounding very distressed for some time. The midwife has been trying to encourage the woman to push as *"The baby is just there and needs to come out" [Field notes, Observation 11].* The woman responds to the midwife *"I have no energy!"[Field notes, Observation 11]* and says she is not able to push. The midwife encourages the woman to sit on the toilet so, she can push more effectively:

"Midwife (1) to the woman "Good, very good - keep pushing – another one and keep pushing." The second midwife enters the room [changeover of shift]. Midwife (1) to the woman "OK, push, push, harder, harder, harder, harder, harder!" The woman groans, gives short pushes – gasping. Midwife (1) "Do you want to go back to bed or do you want to stand up?" The woman does not respond. Midwife (1) comes out of the bathroom and hands over care to midwife (2). Midwife (1) says "...she [the woman] is sitting there [on the toilet] because she doesn't have any idea how to push." Midwife (1) introduces midwife (2) to the woman [Field notes, Observation 11].

The woman has been crying out and looks distressed, and as midwife (1) has a very strong accent, this may have affected the woman's ability to understand what was being said in English. Midwife (1) seems to be half-heartedly going through the motions of care, saying what she needs to say but not expecting to make any

progress. It could be that she is waiting for the change of shift because she knows midwife (2) speaks the same Asian language fluently.

As soon as midwife (2) takes over care the woman's behaviour changes dramatically. Midwife (2) has a very calm, quiet voice and looks directly (eye contact) at the woman when speaking in an Asian language:

Both midwives and partner help to move the woman from the toilet to the bed. Midwife (1) says "She is only having 2:10 contractions." The woman is now semi-recumbent on the bed, head slightly raised. Midwife (2) is talking to the woman in an Asian language quietly. Midwife (1) says to the woman "You are doing a good job." Holding woman's hand and smiling at her and then leaves the room. Midwife (2) supports the woman's right leg and the partner supports the other leg in the same way. The woman's legs are spread wide open. FHS attended. Midwife (2) talking to support people in an Asian language – has finger near the woman's vagina – seems to be explaining something to the woman. The woman is more controlled, quiet. FHS – quiet, waiting. Midwife (2) has a hand on the fundus – feeling, waiting – talking to the woman. Contraction. Midwife (2) has a finger in the woman's vagina – distending posterior wall of vagina and perineum while the woman pushes. The woman is yelling and lifts her bottom off the bed. Midwife (2) is talking to the woman in an Asian language. Woman quietens... The woman's right foot is placed on the midwife's shoulder by the midwife. She distends the lower vagina again with a finger and the woman pushes... The woman is pushing, calmer, quiet... The midwife pointed out that the woman's perineum is swelling and swelling instead of stretching – she got some local. The woman is pushing well. Midwife (2) looks as though she is discussing the woman's genital area with the woman and support people [Field notes, Observation 11].

After birth of the baby, midwife (2) describes what happened between her and the woman when she took over care in the above observation:

"When I walked into the birthing room the look on the woman's face changed. The woman said to me [in an Asian language] "I pray to God that you come and you did." I said to the woman "Will you try and push?" and the woman said "I will do anything you want." And she did. The woman said "I trust you" [Field notes, Observation 11].

Midwife (2) explained that the Asian community knows her by reputation and there is a great deal of trust and respect. Midwife (2) had a 'presence' in the birthing room – it was very peaceful, calm. The woman immediately calmed down when midwife (2) took over her care. The woman's pushing became much more effective and things progressed. Later, midwife (1) stated that she knew midwife (2) spoke the woman's language and that the woman would be able to understand more once midwife (2) was caring for her. That was why she was quite happy leaving the woman when she did. Trust and effective communication helped to reduce maternal fear and support normal childbirth. Situations, however, often occur that could potentially increase the risk of maternal fear as Susan, a midwifery student, describes:

"I think with not being in the room – you can see it [fear] in their [women's] faces. That when you come back in the room it's the [woman's] relief 'Oh! Thank God!' because they're scared. They don't know, like, especially the first time. You always see the first time mothers are scared when you do your stuff. They have never been there – everything is unfamiliar and new so, anything that happens "Is that normal? Was that supposed to happen? Am I going OK? Is everything OK?" They want that reassurance and that – and you are having to leave [the room] and come back. You are not, not becoming so trustworthy to them, I guess." [Field notes, Focus group 2].

Leaving the woman alone during the second stage of labour sometimes occurs during both busy and quiet times in Delivery Suite. These times of maternal 'aloneness' were apparent during birthing room observations:

The partner is holding the woman's right hand against his face. Her mother is standing (doing nothing) by the side of the bed. She says something in an Asian language to the woman. Contraction. The woman is breathing rapidly. The midwife is sitting outside at the work area, with the other midwives, reading a newspaper. No one is busy. The birthing room buzzer is heard. The midwife enters the room. The woman looks distressed and says "I can't do it anymore! I want a Caesarean Section! I am in too much pain!" The midwife puts some sterile gloves on and says to the woman that she is just going to check her. Contraction – loud vocalising. The midwife waits until the contraction goes. [Partner to the midwife] "What about the other option instead [Caesarean Section]?" The midwife says "No, that is not an option. She has to deliver normally." [midwife to the woman] "With the next contraction can you push?" After attending a vaginal examination the midwife says she can't feel any cervix and says to the woman "A lot of women have done this – you can do this too" [Field notes, Observation 17].

Some midwives tend to leave the woman alone with the support people until the sounds of maternal distress are heard or the support people come out of the room asking for help. The following observation provides another view of 'aloneness':

The midwife attaches stirrup uprights to the bed and attaches thick elastic straps to them. Helps the woman raise her legs into the stirrups and gives her the straps to pull/hold onto... Inserts in-out urinary catheter (without saying anything to the woman). FHS slowing during pushing. Midwife encourages the woman to push – inserts two fingers of each hand into the vagina – distending posterior and lateral vaginal walls of vagina. Looks like feeling for head position. The midwife leaves the room. [saying nothing] The support person leaves the room. The woman is alone in stirrups and contracting [Field notes, Observation 13].

The above scenario may undermine trust and support development of fear due to the lack of consent, explanation and maternal 'aloneness'. The Delivery Suite was very busy during this observation.

SUMMARY

This chapter describes how midwives make sense of their shared routine practices and knowledge when trying to minimise perineal trauma, as they attempt to relate to and communicate with, Asian woman during childbirth. The importance of the emotional and communicative aspects of care is highlighted. Specifically, how midwives work to build connections between themselves, the woman and support people to work towards reducing the risk of perineal trauma. Midwives believe that an effective midwife-woman communication link and maternal trust reduces fear, which lowers the risk of severe perineal trauma. The next chapter explores intrapartum care practice and the role of the midwife.

CHAPTER 6

RESULTS: AN INTRAPARTUM CULTURE

Chapter 5 described the influences on the formation of midwifery-woman relationships and practice in the Delivery Suite and birthing room settings. The everyday emotional milieu is apparent as midwives work towards reducing the severity of perineal trauma during childbirth for Asian women.

This chapter presents the cultural dimensions of midwifery intrapartum practice and identification of the skills or techniques midwives believe safeguard maternal perineal integrity during the second stage of spontaneous labour and normal vaginal birth. Midwives and midwifery students help clarify understanding of their role and of routine practices within the birthing room setting, when providing care for the labouring and birthing Asian woman.

PROTECTING THE PERINEUM: RITUALS AND PATTERNS OF PRACTICE

All midwives have their own distinctive approaches to clinical practice, particularly when attempting to prevent perineal trauma during childbirth. Individualising intrapartum care and adapting practice in response to an immediate situation also plays a part in clinical decision making. Patterns of routine midwifery words, behaviours and practices are identified, which shape intrapartum perineal care practice. Each birthing room observation provides a partial picture of a variety of everyday midwifery practices used during the second stage of labour and birth. Collectively, study observations, interviews, focus groups and casual conversation

field notes help to provide a more complete picture on which to understand what midwives do and why when trying to maintain perineal integrity during childbirth for Asian women. Clarifying meaning behind specific practices related to protection of the birthing woman's perineum helps strengthen understanding of the midwifery cultural group.

CULTURAL BEHAVIOUR AND PRACTICE

Well women, anticipating a normal vaginal birth, are allocated to one specific midwife for intrapartum care. Normal practice is for the woman to remain under the care of this midwife until the end of a rostered eight hour shift, when a different midwife takes over care. When labour progresses from first stage through to active second stage and birth, the same midwife stays in the birthing room with the woman throughout the process, unless there are issues such as, several women in labour or giving birth at the same time and only a limited number of midwives available. During this time only the woman and support person are aware of the specific clinical practice techniques initiated by the midwife to reduce perineal trauma. Colette explains how it is:

> *"I either work with a student or I do the delivery myself. I don't usually work with another midwife. ...if she [midwife] is conducting her case I don't go into the [birthing] room and interfere. She lets me know if she needs me when the birth is imminent and I will go in and receive the baby. But I am not in there [the birthing room] while...they [the midwife] are doing whatever they're doing" [Interview].*

Therefore, most midwives tend to practice in isolation and are unfamiliar with the intrapartum practices of colleagues. Colette agrees she has:

"...no idea [of] the practices...of my colleagues. And sometimes I am surprised but it is only because I have actually walked in [to the birthing room] on something that they do different to me. ...but I don't feel like I can say well "What you're doing is wrong and what I do is right" [Interview].

Colette recognises different practice approaches used by midwives can be very confusing for midwifery students:

"I tell them "Look, this is the way I do it but it is not necessarily the way other people [midwives] will do it and it doesn't necessarily mean that they [the midwives] are wrong and I am right, or they are right and I am wrong. The most important thing you are looking at is safety for the mother and a good outcome for the baby" [Interview].

To know and grasp the meaning behind what midwives do within the confines of the birthing room, it is necessary to be able to visualise patterns and rituals of place, position and practice.

RITUALS OF PLACE AND POSITION

When walking into the birthing room, during active second stage of labour, the midwife is usually found standing facing the lower left-hand side of the bed waiting, watching and sometimes talking to the woman lying on the bed. She often has a hand resting on the woman's fundus waiting to feel the next contraction begin for example:

Midwife says to the woman "The pain there now?" The partner says to the woman "The pain there honey?" Midwife says "Still soft." She has her hand on the woman's fundus feeling for the contraction. Midwife to woman "The pain is coming now" [Field notes, Observation 2].

In the majority of cases the woman is lying on the bed in a semi-recumbent position, exposed from the top of the fundus down, with her legs splayed. Occasionally, the woman may be sitting on the toilet pushing, with the midwife leaning against the wall opposite the toilet watching, or crouching down in front of the woman either attending or waiting to attend a vaginal examination. The woman invariably returns to the bed to give birth lying on her back, with usually a pillow behind her head. While rarely observed, the woman may give birth in an alternative position such as, all-fours while resting on a mat on the floor. If the woman is lying on the bed during second stage, a change of maternal position is sometimes mentioned:

Midwife to woman "You don't have to lie on your side. You can stand up, sit on the toilet – whatever makes you feel comfortable..." Partner is talking to the woman in an Asian language. Woman is lying completely flat on the bed, with legs resting to the right side – tilting the fundus [Field notes, Observation 12].

Women rarely respond to this suggestion. A change of maternal position is occasionally initiated by the midwife if the woman remains on the bed throughout second stage:

Midwife to woman "I might sit you up a little bit because we don't like you to lay flat (raises bed headrest)." Partner talking to the woman in an Asian language [Field notes, Observation 12].

The support person stands next to the top right-hand side of the bed near the woman, sometimes holding the woman's hand, stroking her forehead, or often doing nothing – just watching. Occasionally, a chair has been placed in this position so there is an option to sit down. When birth is imminent the second midwife enters the room and

stands next to the support person on the opposite side of the bed facing the midwife accoucheur. They have the responsibility of caring for the baby following birth as the first midwife is concentrating on birthing the placenta.

WHY THAT POSITION?

Maternal position during labour and birth is thought (by some midwives) to influence perineal outcomes in Asian women. Biyu describes the midwifery approach to maternal positioning and care in Delivery Suite:

"We tend to encourage women to do active birth, you know, walking, warm shower, squatting, pelvic rocking, yeh" [Focus group 4].

Colette agrees that women *"...should remain as active as possible..." [Interview]* during labour. Nevertheless, she finds that *"...a lot of the ladies just stay in bed...but it's hard to get over that" [Interview]*. Anh advises why the maternal semi-recumbent position works best for the perineum:

"...because I think the upright and the all-fours [position] you [the midwife] just have no control" [Focus group 1].

She also finds:

"...very rarely any Asian women would like standing up [Asian women do not like standing upright during labour and birth]. I haven't done anybody standing up" [Focus group 1].

Sally has the same opinion as Ahn and feels that the squatting position causes traumatic perineal injury as she has had:

"...a few experiences about squatting women when we [midwife] can't help the explosion of the [fetal] head coming down. ...most of the girls [women] they end up with huge [perineal] tears because they can't control themselves to push slowly" [Focus group 4].

Brenda is also unsure about the benefits of the squatting position for birth:

"I always thought squatting was a good [maternal] position, but I had a terrible tear with my lady that was squatting and it seemed to be a very fast descent" [Interview].

However, Brenda has the opposite view to Ahn and Sally regarding the maternal all-fours position:

"I don't know what the evidence says, but I have delivered four or five babies [whose mothers] have been on all-fours and all those peris have been intact" [Interview].

And yet, Biyu advises that *"...most of the women – they don't like it [all-fours position] here" [Interview]*. Then again, Biyu is supportive of women adopting the squatting position:

"I love them [women] to stand up and squat. You don't have to do anything. Because when they [women] squat there is no choice but relax around there [the perineum]" [Interview].

Xiaoli and Biyu express opposing views about women using the toilet during labour and birth. Xiaoli advises that:

"I wouldn't let them [women] sit on the toilet [in second stage]. ...on the bed they can turn over – whatever they want, it's alright because it's safe, because it's soft.

Into the toilet it's hard and the head [pause]. Even though the toilet water – it can give infection too, isn't it?" [Interview].

Whereas Biyu finds:

"...if they [the woman] refuse to go down [get off the bed] say, for standing up pushing, I ask them to go on the toilet because we don't have a birthing chair, you see. We don't have" [Interview].

One practice approach Xiaoli and Biyu do have in common is that they prefer women, who adopt the all-fours position for birth, to be on the bed rather than use a mattress on the floor. Xiaoli finds that when women adopt the all-fours position on the bed *"...at least you can easily see it [the woman's genital area]" [Interview].* Both midwives find it difficult *"...to bend down there [on the floor], it's so hard" [Xiaoli, Interview]* to provide care in this position and as Biyu explains *"...it's safer for me...I have to look after both of us [the woman and herself]" [Interview].* The disparate views regarding maternal position for the second stage of labour and birth illustrate the different clinical practice approaches used by midwives during intrapartum care. Individual experiences when providing intrapartum care and subsequent maternal perineal injury, influence midwifery practice related to maternal position. It is evident that most midwives consider maternal position and pushing to be closely associated with perineal trauma.

MATERNAL PUSHING

Vicki talks about maternal pushing during childbirth and how individual culture and interpersonal relationships within the birthing room may influence the woman:

"...their mothers are telling them to push from the moment...they arrive in the hospital so, ...it doesn't matter what the midwife says, there is a lot of cultural stuff going on that you are not aware of... ...It's only if they are from an English speaking country that you become aware that you can hear the word "Push" in what they're saying. ...they are encouraging this [pushing] when they shouldn't be" [Interview].

In other words, there is an awareness of multiple undercurrents in the birthing room around the process of maternal pushing, which could impact on midwifery practice and perineal trauma. Two methods of midwifery practice observed and confirmed during interviews, focus groups and casual conversations were involuntary or active/directed pushing during the second stage of labour and birth. Involuntary pushing occurs when the normal physiological process of second stage stimulates the woman to spontaneously commence pushing. Active or directed pushing occurs when the woman's cervix is found to be fully dilated and the midwife encourages pushing, even if there is no urge to push. The following section finds midwives considering their practice approach towards maternal pushing and the connection with perineal trauma for Asian women.

Physiological second stage

Brenda *"...just let[s] them [women] involuntary push..."* [Interview] and has found this *"... reduce[s] perineal trauma" [Interview].* The reasoning behind this practice, Rose explains, is that:

"...if they're involuntary pushing I don't encourage them to push because they're doing it anyway so, why should I encourage them?" [Interview].

A number of midwives are aware of the importance of waiting for the onset of second stage rather than to go looking for it. The only times Rose might encourage the woman to push is when there is fetal distress, the head is on view or if the woman's pushing efforts are *"...not effectively moving the baby down..." [Interview]*. In the following observation, ritual phrases are used by the midwife as the woman pushes. The woman speaks virtually no English and the support people are translating throughout:

Gentle moaning. Woman pushing – encouraged quietly by the two support people (speaking to the woman, partner and each other in Cambodian). ...Midwife to woman "Good, that's really good. Beautiful pushing. That's the way (nods head and smiles)." Calls woman by name. "Only push with contractions – in between rest, that's good. ...Keep it going for as long as you can. That's it, beautiful. Close your mouth and push. Do you want a mirror to watch or not?" Two support people laugh. Midwife explains this practice sometimes gives an impetus to push. Woman says "No". ...Midwife to support person "Just let her push her way... She knows what she is doing." Looks at woman and says "Good" [Field notes, Observation 7].

Verbal instructions give way to acknowledgement that maternal pushing efforts are effective. The midwife encourages the woman and shows caring through verbal expression and body language. An inclusive, running commentary of the progress of labour and explanation generates a supportive environment for the support people as well as the woman. Everyone in this birthing room is actively participating in the childbirth experience. Biyu describes the woman's involuntary urge to push:

"...the strong urge that she feel[s] inside her. That if she doesn't feel the urge, doesn't have...the strong urge to push, then she is not ready, even though she is fully. She need[s] to have that strong urge, then she has no control of pushing. The urge like you have no control" [Focus group 4].

There is strong affirmation of this description and Sopheap feels midwives should know to *"Leave them [women] alone..." [Interview]* at this time thereby, enabling the woman to respond instinctively to her body's needs and *"...push whenever [she] can't control it" [Sopheap, Interview].* Adele advises that:

"Most of us are very reluctant to do VE's around that time [general laughter] when you think they might be fully, cos we'd rather not know. ...We'd rather wait until you can physically see it [the baby's head]. ...we're right to let her body finish the job itself [second stage] without us intervening" [Focus group 4].

Midwives know that intervention during second stage may increase the incidence and extent of perineal trauma. The following observation provides insight in relation to the above comments on maternal involuntary pushing:

Midwife to woman "If you feel like pushing – just do what your body wants to do and push if you want to. You are doing beautifully." ...Woman looks very relaxed in between contractions – small moaning, gentle, calm. ...The woman is giving very short involuntary pushes. Midwife to woman "A little bit at a time [baby's head now on view] - nice and slow [midwife looking and saying this to partner]." Partner rapidly speaking to the woman in an Asian language. Midwife standing quietly by the side of the bed, smiling, quiet, not saying anything, waiting. Looking at the woman and partner and nodding her head. Contraction. Midwife to woman and partner "Good one! That's it [woman's name]." ...Midwife just standing there – not doing anything. Woman involuntary pushing – the fetal head becoming more visible.

Moaning increasing – not loud. Midwife just standing there – arms relaxed [Field notes, Observation 18].

The quietness and calmness in the room is palpable, and the midwife provides minimal instruction to the woman in a quiet, gentle voice. Informal discussion following birth identifies the midwife was aware the woman:

"...was just involuntary pushing with each of her contractions and there was definite progress happening with each contraction…" [Field notes, Observation 18].

Looking for and assessing signs of progress during second stage helps to confirm or disconfirm normality. Instead of relying on regular vaginal examinations, some midwives look for clinical signs of the beginning of second stage such as, *"...how they [woman] are reacting, what they're doing" [Colette, Interview].* Occasionally, progress is not seen to occur:

"I mean, you can be caught sometimes with them doing that [involuntary pushing] and they are about four centimetres and they shouldn't have been doing that but, you know, if you think after a while "No, no, she should be a bit further. Something should be there by now"...I might examine her and think "Oh, no! You are not quite ready yet" [Colette, Interview].

Involuntary pushing enables midwives to support women to conserve energy so:

"...even if she [the woman] is fully, she can maybe breathe it [the baby] down so, that...when you realise that she's fully...she's not as [exhausted] as what she may be if you get her pushing too early" [Mary, Focus group 1].

When the fetal *"...head is at the spines..." [Sopheap, Interview]* and women are actively encouraged to commence pushing by the midwife *"They are not pushing really well…" [Sopheap, Interview]* because they do not have an urge to push. However, *"...when the presenting part is a little bit lower, it presses...on the anus..." [Sopheap, Interview]* and the instinctive urge to push becomes apparent. Sally advises that when some Asian women eventually feel the urge to push they *"...just push, without...stopping. Like "I want this baby out!" [Focus group 4],* which has the potential to increase the risk of perineal trauma. Brenda feels it depends:

"...on the person [woman]. Most of the time I don't encourage active pushing. I tell the woman to follow her own instincts. ...Some primips - I do find you need to guide them with the active pushing but I really hate the legs back and the hands underneath [thighs], and the chin on the chest and the [sigh]…" [Interview].

Rose does not "...encourage them to push" [Field notes, Observation 16] and:

"...never say[s] OK, put your legs up, hold your hips and chin on your chest and push. No, I never say that" [Field notes, Observation 16].

When asked why, Rose explains:

"Because I think you extend the second stage...they [women] get tired a lot quicker, the baby gets more tired quickly and they are more likely to have intervention... ...then people feel as though they have to go in there and do a vacuum or forceps, when half the time you shouldn't have known they were fully and you shouldn't have been encouraging them to push [laugh]! You should be leaving alone – waiting" [Field notes, Observation 16].

Therefore, encouraging the woman to push before she feels the urge to push is described by Sopheap as *"...bad..." [Interview],* practice, which creates *"...more [perineal] damage" [Interview].* Rose is unable to explain why some midwives advocate active/directed pushing during second stage. She feels that:

"...it might be just the way they're taught. But I have found that some people [women] can get to fully dilated and not have they urge to push for a while – until the baby's head comes down and hits the perineal floor. ...I don't encourage them and say "Let's start pushing. Hold your breath. Two pushes in each contraction" [Interview].

When reflecting on why her practice has changed, Rose advises *"I think I trust the woman's body and the body knows when to push" [Interview].* Some feel the labouring woman should have a choice and be able to do *"...what she feels like doing" [Elizabeth, Interview].* However, as a midwifery student, Nancy, has found:

"...once the second stage begins, some midwives do, some midwives don't, agree to let them [women] involuntary push" [Interview].

Directed pushing during second stage

Directed maternal pushing during second stage is not an uncommon practice:

Today, about half the birthing rooms are occupied by women in various stages of labour and birth. It's nearly handover time and some midwives are sitting or standing around the work desk and talking to each other. The door of the birthing room opposite the work desk is closed and a raised voice from inside the room says "...push into your bottom, good, good, keep coming and again! Good, good, more, more, more, good, good, and again!" None of the midwives are taking any notice and continue talking to each other [Field notes].

When asked what type of maternal pushing usually occurs during second stage, Adele and Sally advise:

"Well, most people [midwives] encourage the active pushing. There's not too many people [midwives] that don't, especially with Asian primips... [Adele, Focus group 4]. Cos they refuse to do it [push]. They say "We can't do it. I can't do it." And they just lie down there without no effort at all so, you have to encourage them... to...push... There's no other way to do it" [Sally, Focus group 4].

Study observations confirm most midwives tend to use the active/directed pushing approach for Asian women during second stage. When using this practice, midwives direct the woman to:

"...take a deep breath, give a push, try and give three big pushes for every contraction. Sometimes they [woman] are not quite able to do that because their contractions are quite short. Encourage them to rest. Don't [get the women to] push while they haven't got a contraction" [Colette, Interview].

Directed pushing is apparent in the following birthing room observation:

Midwife attends VE and says to the woman "...just double checking, making sure no cervix is there... When the pain comes push hard – hold your legs here and here [moves woman's hands under her thighs]. Push hard when you feel pain." Midwife instructs the partner what to do when contractions occur – keep the woman's chin on her chest, head forward. Midwife explains to the woman what to do when the contraction comes "...one pain...three big, long pushes." Contraction. Midwife places woman's foot on her hip "Push hard, go to toilet, keep going, keep going, keep going and again." ...Midwife "Hold your legs and push." Partner talking to woman in Asian language. Midwife's fingers in woman's vagina during pushing – moving fingers from side to side but not obviously distending vagina or perineum. ...Animated discussion between midwifery student and midwife [talking over the

woman] discussing in-out catheter "...if she [woman] is not progressing." Woman asks midwife if she should push. Midwife replies "Yes, you are 10cm now, you can push..." Midwifery student to woman "You have done very well." Woman lays back, eyes closed [Field notes, Observation 8].

When directed pushing is to occur, midwives usually explain to the woman how they should push and the position to adopt when pushing. Women are often encouraged *"...to hold your breath and push into your bottom" [Field notes, Observation 17]* during directed pushing although, Colette thinks:

"...holding your breath and pushing...all of that went out years ago. I don't think anyone does that anymore. I hope they don't" [Interview].

A few midwives feel directed pushing *has "Nothing to do with the perineum..." [Vicki, Interview]* and extent of trauma, whereas others try and avoid this practice as *"...active [directed] pushing can actually cause more trauma" [Brenda, Interview]*. Vicki has found that directed pushing:

"...helps them [women]. I think they appreciate the instruction. If there's no effective progress on their own, I think the instruction or the direction as to what we are aiming for and the fact that...the first baby doesn't happen in an easy five minutes. Some realistic explanation is quite useful to them because they have some plan for the future "This is what we have to do to get the delivery" and whether people [midwives] believe in telling people [women] to push or it'll just come out on its own [pause] it's up to them [midwives]" [Interview].

Therefore, type of maternal pushing to occur in the birthing room setting is often strongly influenced by the beliefs, values and experiences of the midwife caring for

the woman. Once the woman's cervix is known to be fully dilated and pushing commences, there is an expectation of fetal descent. If *"...fifteen to twenty minutes later...you can't see anything..." [Vicki, Interview]* such as, *"...anal dilatation, no parting of the labia..." [Vicki, Interview]* then women "*...appreciate some direction and some explanation of the timeframes and the practices" [Vicki, Interview]*. In the following observation, a VE confirms the woman's cervix is fully dilated:

The time is 0315 and the midwife has been sitting at the work desk reading a book or talking to other midwives - rarely going into the birthing room (only twice since the last assessment four hours ago)... The partner is standing next to the bed opposite side to the midwife. Woman to midwife "I want to push." Midwife removes the sheet covering the woman and helps her to turn to a semi-recumbent position. Midwife to woman "Think where the pressure is, bring your legs up like this and push into your bottom." Midwife is standing on the left side of the bed facing the woman, resting her right hand on the bed. Midwife "Push into your bottom and another one, push again." Woman "I don't feel like pushing." Midwife "Baby is coming round so, you are not actually doing a poo. It just feels as though you are. I know you are tired but you are going to have to push him through. You want to finish this – to meet him (Midwife smiles at woman)." ...The atmosphere is calm, very quiet between contractions. Midwife looks at woman "Is it coming? Help the baby. Very good. Push the baby. Can you do one more? Good girl. Good pushing." Woman (gasping after pushing) "How long?" Midwife "It takes about one hour to push the baby out." Woman "I want to push." Midwife "OK, grab your legs, put your energy where the baby is. That's a good girl. Your body is making you work hard." Midwife places woman's right foot on her hip. Partner copies what the midwife does and places the woman's other foot on his hip. Midwife resting left hand on woman's right knee. Midwife "Long push! Long push! Good girl, that was very good work! Woman rests back against the pillow, eyes closed [Field notes, Observation 10].

Stated practice contrasts with observed practice, as directed pushing is initiated as soon as full dilatation of the woman's cervix is confirmed. The midwife, Vicki, changes the woman's position to semi-recumbent and uses predictable word patterns to encourage directed pushing.

Involuntary or directed pushing?

Choosing not to 'officially' know when the woman is fully dilated is considered a useful practice for some midwives as it *"...gives the woman more time…" [Susan, Interview]* to naturally complete the second stage. When the woman's cervix is found to be fully dilated the practice approach is:

"You have to have that baby out in one hour" [snapping her fingers twice – emphasising urgency]. Once you know something [the cervix is fully dilated] it's – Quickly! Partogram! Deadline! And, yeh" [Susan, Focus group 2].

Rose's experience has been that women:

"...can get to 10cm and not have the urge to push straight away, but people [midwives] take second stage from there because that's what they found – they are 10cm. "OK, now you have to push." It doesn't matter that the head is above spines, so you have extended your second stage...you have found out something you really shouldn't have" [Interview].

When the woman's second stage is extended they have *"...only got [a] short period of time to push before they get intervention..." [Rose, Interview]* such as*, "...an episiotomy...a vacuum, or whatever" [Susan, Focus group 2],* which has implications for perineal integrity. However, involuntary pushing enables the midwife to *"...just let her [the woman] do what she needs to do. There's no hurry*

then" [Susan, Focus group 2]. Directing the woman to push early in second stage may lead to increased perineal trauma:

"Because by pushing early she [the woman] will also cause the perineum to get swollen and when the perineum is swollen you are not going to get any stretching, and you can end up with a lot of haematoma as well" [Anh, Focus group 1].

Mary also feels that directed pushing is:

"...not allowing the natural progression, you know, and that stretch, that natural stretch [of the perineum...if they're just pushing and pushing, and pushing. Are we getting them to push too quickly, too fast and that's where you don't get that, you know, how it stretches and comes back [showing with hands/fingers how the perineum stretches] and then things…and, ...it will just sit there and just stretch" [Focus group 1].

On reflection, most midwives are aware directed pushing may increase the risk of perineal trauma. Nevertheless, this practice is used by a significant number of midwives when caring for women. Less experienced midwives are aware that most experienced midwives:

"...are very much into the active [directed] pushing - "Get her pushing [experienced midwife to less experienced midwife]." A few of them are very much into episiotomies as routine for primips. ...And I think too if you haven't got the passion for the job, you haven't got the patience so, it's all very – oh, I don't know, clinical and "Come on, let's push this baby out!" Whereas, as a midwife, I think, you know, the woman should be telling you when the baby's coming, not the other way around" [Brenda, Interview].

Ownership of childbirth is demonstrably in the hands of the majority of midwives, not Asian women. Sally suggests one of the reasons directed pushing occurs is that:

"Sometimes we are busy and we encourage the women to push. ...they [midwives] don't wait for all the [physiological] process of labour" [Focus group 4].

Not being able to wait for the natural physiological processes of labour and birth may increase the risk of perineal trauma. Rose has worked in Delivery Suite for a long time but she is still unsure:

"...why other people [midwives] do that [directed pushing] but a lot of us [midwives] are from the 'old school' and that is what we were taught...once we knew they [women] were fully dilated, we should get them pushing" [Interview].

Colette is *"...a great believer in just finding the baby's head on view [laugh]" [Interview]* and prefers not to direct women how to push and feels that *"...If you can avoid that [directed pushing], avoid it" [Interview]*. However, if it has been identified that a woman's cervix is fully dilated in the previous shift *"...then the clock starts ticking you know" [Colette, Interview]*, which ensures directed pushing is mandatory for the midwife taking over care. Cait paints a vivid picture of directed pushing and progress of the fetus through the birth canal:

"Well, [laugh] it probably goes against all the literature but the instructions are always the same "Take a deep breath with the contraction, at the peak of the contraction put your chin on your chest" - because they are laying down. They like to lay down. ...Right at the end [of second stage] they're fairly flat, with just a pillow [under their head]...because it just aids delivery and opens up the pelvis. But early on in the pushing they may be sort of semi-recumbent, you know? A bit more elevated. So, using gravity, right? They're grabbing their own legs...or grab their

ankles, chin on their chest, pushing down into their bottom. ...if there was a delay and slow progress of the [fetal] head, the back of the bed would go down (this is what I always use). The back of the bed would go down, down, down, down, 'til virtually there's just a pillow under their head by the time they're crowning, which maximises...pelvic diameter and [then] deliver. So, that's really about pelvic dimensions, you know, the head fitting through a pelvis" [Interview].

Therefore, directed pushing is the most common practice during the second stage of labour even though most midwives are aware this approach may increase the risk of perineal trauma.

INDIVIDUAL VARIATION IN PRACTICE

A variety of practices became apparent during observations that are dependent on individual midwifery preference:

Midwife to woman "Now the same again (puts gloves on), good, and again, more, more, more. Come on, good, good, and again, very good." Index finger in vagina – pressure on lower vaginal wall, distending... "Same way, pull your legs back, pain coming, good, good, keep coming and again, more, more, more, more." Midwife massaging perineum with index finger in vagina – backwards and forwards (repeating-distending). Finger resting in vagina on fetal head [Field notes, Observation 2].

Digital distension/ stretching of the vagina and perineum (mostly without maternal consent) often occur during second stage. Sometimes midwives find *"...you have no choice but...to do perineal massage" [Biyu, Focus group 4].* Biyu uses the practice of *"...stretching and sweeping [moving fingers back and forth]..." [Focus group 4]* the vagina and perineum to help when the woman has *"...a tight perineum...and*

to...help descen[t]" [Focus group 4] of the fetal head. This practice is demonstrated by Biyu in the following observation. The birthing woman cannot speak English:

Midwife's index finger distending vagina, moving right around vaginal opening – fetal head seen. Midwife says "If I didn't do this she wouldn't know where to push." Quiet, waiting. Midwife talking quietly to support person and partner in an Asian language. Feeling fundus" [Field notes, Observation 11].

During casual conversation after the birth, Biyu confirms the woman *"...would not have known how or where to push…" [Field notes, Observation 11]* if her index finger had not been distending the woman's vagina. Digital distension during vaginal and perineal massage is thought to combine with the woman's pushing efforts and:

"...the head pushes down, bang[s] on it [the perineum] and [does] not move back. And the woman feel[s] more pressure – start[s] to feel more pressure. Then "Oh, yes, now I know what you mean [the woman understands what the midwife means]." And they start doing it [directing their pushing efforts in the right area – down into the perineum] and you stop doing [vaginal and perineal massage" [Biyu, Interview].

Biyu uses one finger to distend the vagina and perineum. However, others may place *"...two fingers..." [Field notes, Observation 13]* or sometimes position *"...four fingers..." [Field notes, Observation 13]* (at 4-o-clock and 8-o-clock) into the vagina and apply downward pressure during *"...a contraction…" [Field notes, Observation 13].* Jane explains she tries to be:

"...hands off but sometimes you have to help them along so, probably stretch along the bottom of the perineum. Yeh, give it a few stretches and see if the baby's head

will come down. Hopefully that will help to reduce the [perineal] trauma" [Field notes, Observation 13].

Jane uses this practice because:

"It gives her [the woman] more momentum to push because they don't really... A lot of the Asian women have problems with pushing. They don't push down into their bottoms so, you sort of [say to the woman] "Push down here towards my fingers" and that way it'll give them "Oh, OK." And they tend to push better as well when you give them a stretch" [Field notes, Observation 13].

Sometimes perineal stretching is seen as an intervention that may prevent *"...a vacuum or something like that" [Gwen, Interview].* Casual conversation reveals Sally finds:

"Some women, especially Asians, have a tight ring (ligaments) and going in there [vagina] with your fingers helps split the ligament. You are going to get a tear anyway and you may cause a tear to happen, but that's OK because they are going to tear anyway. You can feel it tearing when your fingers are in there stretching the vagina" [Field notes, Observation 6].

Biyu feels that perineal massage helps *"...guide the woman..." [Interview]* and says to them:

"...it's OK to push around this even though it's painful. Just push around here, it's OK" [Interview].

Biyu firmly believes perineal massage and distension make a *"...difference..." [Interview]* and the woman *"...they [do] not…move at all…" [Interview],* they push, become more focused and do not move around the bed. Applying downward digital pressure in the vagina helps the woman relate to where she needs to push *"...but I have nothing to prove it on paper" [Biyu, Interview]*. Zoe, a midwifery student, has:

"...seen it [stretching of the vagina and perineum]. ...they [midwives] are in there doing that stretching. I couldn't do that. I don't see why you have to... You are going to cause more [perineal] trauma... You are forcing this thing [perineum] to stretch and I couldn't do that. I don't feel comfortable with that, with my fingers in there... We are not taught that at...uni" [Interview].

Sopheap advises that *"[I] never put my hands in there [vagina]..." [Interview]* and has seen *"...a lot of trauma..." [Interview]* from [midwives] stretching the vagina and perineum. She knows it:

"...causes more trauma...it [perineum] is already swelling. That area is very sensitive. When you touch - it is swelling, already swelling. When you suture you put local and...it never closes properly" [Interview].

Sopheap does not understand why:

"...a lot of people [midwives] want to stretch and stretch, and stretch [the vagina and perineum] for what?" [Interview].

Some midwives know increased perineal trauma occurs with the practice of stretching the vagina and perineum, whereas others support this practice as they

believe it reduces perineal trauma and facilitates descent of the fetal head. Rose does not *"...believe in stretching the perineum..." [Interview]* as she knows it would *"...be extremely painful..." [Interview]* and Vicki suggests that:

"As much as you can - avoid any of that. I think it doesn't help and I don't know if it causes bruising but it might so, I try not to touch too much. I don't wipe too much either. Keep the nice juices flowing for lubrication. I don't know if that helps – it can't hurt" [Vicki, Interview].

Stephanie, a midwifery student:

*"...hate[s] it [stretching of the vagina and perineum]. They, [women] like, scream. My women that I've seen, they were my two follow-throughs [*continuity of care experiences as part of midwifery education*] and they both had the midwives – they had their fingers in stretching the perineum and they [women] were just screaming – that's all I can remember them doing" [Interview]*.

The midwives explain they *"...do it [perineal stretching] to guide the woman so, they know where to push..." [Stephanie, Focus group 2]* and say to the woman *"...can you feel my fingers? Push where my fingers are" [Susan, Focus group 2]*.

Stephanie recalls:

"...they just leave their fingers in there [in the woman's vagina between contractions]. I don't know if they [midwives] are thinking about what they are doing but [pause]. ...one [woman-a follow-through] ended up being an episiotomy and the other one just had, I think, a [first] degree tear" [Focus group 2].

It is recognised that having *"...different ages, different generations of midwives...makes a difference [to practice]..." [Susan, Focus group 2]*. Cait:

"...know[s] some of them [midwives] do it [vaginal, perineal stretching] and it's more the Asian midwives that do it. ...most of us [midwives] don't like it. I don't like it at all" [Interview].

The practice of vaginal and perineal stretching exposes the woman to *"...pain, unnecessary pain..." [Cait, Interview]*. Nevertheless, Cait *"...knows it [vaginal and perineal stretching] does go on..." [Interview]*. During one birthing room observation:

The midwife's finger is distending the woman's lower vagina/introitus each time she pushes. Her perineum is swelling and swelling instead of stretching... ...midwife injects local [anaesthetic] into the perineum between contractions (fanning out)... [Field notes, Observation 11].

An episiotomy is performed.

EPISIOTOMY

Rose advises that "Most people [midwives] do not do episiotomies here..." [Interview]. They are considered "...very out of fashion...very unsuccessful, and...messy" [Vicki, Interview]. Vicki has found:

"...every time I've done them in the past they [women] have ended up with a third degree tear...so, then you don't know if it was the episiotomy or they were going to end up with a third degree anyway" [Vicki, Interview].

Therefore, Vicki does not perform an episiotomy to try and avoid major perineal trauma. However, there are times when she is *"...not completely averse..." [Interview]* to conducting an episiotomy *"...in certain situations..." [Interview]* such as,*"...assisted..." [Interview]* birth or *"...fetal distress..." [Interview]*. Some *"...older midwives still do it [episiotomy]... [Rose, Interview]* but usually only if:

> *"...the lady has been pushing for a long time and the head's not advancing, or if there's some sort of fetal distress like fetal bradycardia..." [Rose, Interview]*.

Cait also does an episiotomy when the woman is *"...in distress..." [Interview]*, though she would *"...much rather let the woman tear..." [Interview]*. Ahn considers *"...maternal exhaustion and...stress on the baby..." [Interview]* important markers for when to perform an episiotomy. Rose knows *"...the doctors still believe that episiotomy is one of the best things..." [Interview]* but she *"...think[s] it's crap*" *[Interview]*. She has not *"...done an episiotomy for a very, very, very, very long time" [Interview]* and there are no circumstances she can think of when it would be necessary. The reason why Rose is so opposed to this intervention is:

> *"...because I think that putting a pair of scissors on somebody's perineum would be extremely traumatic. I believe that if you do an episiotomy you are not giving her [the woman] a chance to have an intact perineum. Once you have done it [an episiotomy], that's it. I believe that it hurts less with a tear than with an episiotomy" [Interview]*.

This individual practice approach is based on current research evidence, personal experience and *"...watching..." [Rose, Interview]* midwives in other hospitals. Rose feels that:

"...if it's going to tear, it's going to tear where it needs to tear, where an episiotomy cuts straight through the muscle. ...it [perineum] heals a lot better if it's allowed to tear and it's probably going to be a lot smaller than an episiotomy" [Interview].

Trying to prevent severe perineal trauma by performing an episiotomy is an alternative practice strategy used by Jane when *"...if it [perineum] looks like it's going to burst (the whiteness and shininess) I'll cut..." [Interview]* and Kim would be more prepared to *"...do an episiotomy if it [perineum] looked like it was going to explode" [Interview].* Words used to describe or recognise a perineum under this increased tension are *"...tight...shiny, button holing..." [Kim, Interview].* Sopheap bases her decision on whether to do an episiotomy on "...the size of the *baby..." [Interview]* and when *"...the lady pushes and you can see how it [perineum] stretches..." [Interview].* An episiotomy is performed if there is *"...overstretching of the perineum..." [Sopheap, Interview].* Sopheap worked as a midwife in an Asian country for several years and remembers:

"...we prevent...perineal trauma in [Asian country], no matter what, if it is first baby you have the episiotomy... Multips we let them tear unless the baby is big and we do an episiotomy... ...But the practice in [Asian country], you just close your eyes. No matter what, you just cut. When I come here [Australia] a lot of research tell[s] you that episiotomy causes more damage" [Interview].

Anh watches:

"...for signs of trauma. Normally if I know that it [perineum] is not giving – it's not yielding, then I have no choice but to explain [to the woman] I need to do an episiotomy. But more often than not you find that usually there is signs of trickling [of blood] before even the crowning, with a lot of Asians" [Focus group1].

Anh is describing signs of internal tearing before there is evidence of external perineal or genital trauma. When Biyu finds a woman has a *"...very short [perineum]..." [Interview]* she knows there:

"...is a risk of a third degree tear. Then you have to assess very carefully – you must give an episi to avoid the anus. I do it with just a snip...we have to, especially like Asians" [Interview].

Thus an episiotomy occurs to avoid severe perineal trauma, but this must be combined with *"...control [of] the head...stop it from birthing quickly..." [Biyu, Interview]*. Biyu describes her thoughts behind the action of performing an episiotomy:

"...some perineums they don't stretch, but swell and really you can see the stretch going to tear...you can see the skin is already grazed into the anus. You try to avoid that, you sense it, [there is] still a lot more of the head still coming and this is all crowned already but that crown is not slipping back. But you know there is head sitting there but in fact it's the caput and you know the perineum is swelling and ready to burst and that's when I give a bit of an episiotomy to release it. And when you give [do episiotomy] I always estimate how much more the head comes out and how much I cut. I don't just go ahead and cut an almighty cut" [Interview].

A small cut or *"...a semi-cut..." [Biyu, Interview]* may be all that is needed *"...to release that pressure [fetal head against the perineum]..." [Biyu, Interview]* to reduce the risk of extensive anterior and posterior genital trauma. This practice decision also involves the notion that *"...you don't want a sick baby..." [Biyu, Interview]*. The following observation opens a window to thoughts on this practice:

Contraction. Midwife to woman "OK." Midwife places fingers in woman's vagina – moving fingers to either side of vagina – extending perineum slightly. Midwife describing to midwifery student about assessing perineum "...because the woman has a short perineum we must try and not get a third degree tear today. We may need a short cut. Instruct the lady, at the same time hold the perineum and control the baby's head to prevent a tear." Contraction. Midwife to woman "Push, keep going, keep going and again, longer, longer!" [Field notes, Observation 9].

The midwife is unable to converse with the woman in her own language as the woman understands very little English, however, her partner does speak English fluently. A second degree tear was the outcome following a spontaneous normal vaginal birth. Another image is provided by the following observation:

Pushing and head on view. The woman's eyes are closed, looking calm, composed. Fetal head crowned. Vaginal orifice looks tight around the head. There is a pause in the pushing – waiting – quiet. Woman starts to push – giving short, high pitched cries. Midwife standing by the side of the bed, picks up the scissors, places two fingers in the vagina (right medio-lateral position), places the scissors into the vagina against her fingers (pointing away from the vaginal orifice) and makes two quick cuts into the perineum... Midwife to woman "Give a small push" [Field notes, Observation 5].

Later, the support person, whose English was fluent, approached the midwives work desk and questioned *"...why the perineal tear so big and why the nurse cut...?" [Field notes, Observation 5]*. She was advised to ask the midwife involved in the case. The Delivery Suite was very busy and this question was not able to be raised with the midwife during the observational session. There were three areas of trauma to the perineum:

...episiotomy cut at nine-o-clock, one area at six-o-clock that looked like either an episiotomy cut or second degree tear (difficult to determine) and one second degree tear at three-o-clock. Only the muscle was sutured as the vaginal tissue was very friable [Casual conversation, Field notes].

Sally agrees that:

"Episiotomy is a trauma anyway but sometime it is a choice because in the case of the Asian girls when they tear, it's like a flower [an explosion] so...there are pieces everywhere. ...it would help in a way if you just do a nice cut [episiotomy], it's easy to suture and I think it's easier for the mother, to heal better and feel more comfortable than to have stitches everywhere, here, there, everywhere. Because it's not only the tear of the perineum, sometimes they tear on the clitoris or beside the vaginal wall" [Focus group 4].

The only time Adele would perform an episiotomy is:

"...if a) the baby's in trouble or b) there was a button hole tear down near the anus because...I'd say nine times out of ten, if you've got button holing down near the anus they gonna go all the way [third or fourth degree tears]" [Focus group 4].

Birth events such as, a *"...shoulder dystocia..." [Biyu, Focus group 4]* is also considered a risk factor for an episiotomy, however, (if possible) Sally prefers to *"...just wait..." [Focus group 4]* in the hope an episiotomy can be avoided. Elizabeth, a midwifery student, advises that some midwives are known to be *"...happy choppers [laugh]" [Interview]* and when women are being cared for by certain midwives she knows *"...that woman's going to get an episiotomy whether she likes it or not. Which is sad" [Interview].*

BIRTHING OF THE FETAL HEAD

When attempting to protect the perineum, shared and individual practices around crowning and birthing of the fetal head play an important role:

"...we have to...guard the perineum. It really depends on the woman and how much she's pushing and what she's doing. But if she's pushing really well there's no instruction...as the head's crowning we just...tell her to breath and not push – just breath through the contraction" [Cait, Interview].

When the fetal head is visible at the introitus most midwives feel this gives them *"Permission [laugh]..." [Cait, Interview]* to instruct the woman how and when to push. However, if no instruction is required all the midwife has to do is:

"...monitor the fetal heart rate and slow the head down if it's coming too quickly (if you can), or encourage them [the woman] to slow it down" [Vicki, Interview].

Ritual words and phrases are heard during the following observation as the midwife provides explanation and encouragement. The woman speaks very little English, is semi-recumbent on the bed and the fetal head is close to crowning:

Midwife to partner "As the baby's head comes out I am going to tell you to breath or blow [breathe out]. When I tell you." ...Partner talking to woman in an Asian language. ...Contraction – involuntary pushing. Fetal head much more visible. Midwife standing next to the bed. Not going anywhere near the perineum... Midwife to woman "...Don't be scared. She is almost here." FHS. ...Contraction – involuntary pushing. Midwife "Good! Beautiful! Very good [woman's name]! Very good! Starting to burn and sting?" [expression of concern on woman's face] Partner talks to the woman. She nods in agreement to the midwife. Midwife presses the

buzzer to alert other midwives of imminent birth and need for assistance [Field notes, Observation 18].

The above observation shows the midwife standing back and not touching the perineum as she follows the woman through this experience. Using the partner as translator, the midwife warns the woman of impending discomfort and communicates her understanding of what the woman is feeling as the fetal head begins to crown. Using the partner, the midwife is able to connect with and reassure the woman. Another midwife has entered the room and birth of the fetal head continues:

Midwife to woman and partner "Little push [woman's name]. Excellent! Very good!" Midwife's fingers remain on the fetal head – small frequent pushes occurring. The head is now just sitting there – really distending the perineum and introitus. Stays like that – waiting. Midwife "OK, just relax. Waiting for the next pain [woman's name]." Fetal head looks very large – just sitting there. Contraction – woman giving small pushes. Midwife "Good pushing! Good! Another one, another one, another one." Midwife and woman continuously looking at each other during this time. Midwife nodding her head and smiling as she talks to the woman. At the same time, the partner is talking to the woman in an Asian language. Midwives discuss tightness of the perineum – standing, looking. ...Fingers remain on the fetal head – waiting for the next contraction. Midwife "Coming, OK. Little pushes. And again." Fingers remain on the fetal head – allowing the head to slowly stretch the perineum – not rushing. Midwife "The baby's head is nearly out and we are nearly there." Waiting. Midwife's finger remains on the fetal head. Woman is quiet – resting. Partner continues to translate. Woman has eyes closed – quiet – looks relaxed. Midwives standing, waiting, not saying anything. Midwife has a hand on the fundus feeling for a contraction. "Pain is coming. Another little push, another little push, another little push, another little push." The head is slowly birthed. "There she is! Isn't she beautiful! Congratulations! You did it!" [Field notes, Observation 18].

When the fetal head crowns, a thumb and two fingers of the midwife's right hand are placed *"...lightly..." [Field notes, Observation 18]* on the fetal occiput and remain there throughout birth of the fetal head to *"Not so much... flex the head – more, just guiding...not a lot of pressure..." [Field notes, Observation 18]* as there is a fear that the head may catch the midwife unawares and birth rapidly, which may increase the risk for perineal trauma. The baby's head (in the above observation) birthed very, very slowly and at one point did not move for some time before the next contraction. Brenda, the midwife, in the above observation:

"...was allowing it [fetal head] to sit there...and I thought that as long as baby is happy, as long as the baby sits there, the better that perineum was going to stretch out. Because I felt it was very tight and I felt she would tear... ...I usually get nervous when the baby is sitting for that long but it was obviously a happy baby [FHS heard] so, I didn't rush it" [Field notes, Observation 18].

While the baby's head was 'sitting' on the perineum, Brenda placed the CTG just above the woman's symphysis pubis and listened to the FHS until another contraction occurred. She explained that:

"Normally I just listen [to the fetal heart] after every contraction [intermittent auscultation], but...with the baby sitting there for so long, I felt better just listening to the baby and knowing it's OK and I can afford to take time with this. It was good that perineum did give [stretch], yes. It was good" [Casual conversation, Field notes].

After the birth the midwife found the woman's perineum was intact and there was no genital trauma. Slowing and reducing the intensity of maternal pushing from when the fetal head crowns:

"...allow[s] the perineum to stretch - because the more it [the head] sits to stretch it [the perineum], hopefully the less chance of needing stitches. It's not an exact science, it's luck of the draw really. But that's the usual practice...to try and take it a bit slower and steady and then you usually have a better outcome. Less explosive pushing is less [perineal/genital] tearing" [Vicki, Interview].

Vicki describes the importance of getting *"...your best diameters [of the fetal head]..." [Interview]* by applying *"...head flexion - head control really... [Interview]* to facilitate slow birth of the fetal head. The practice of controlling and/or flexing the head is thought to reduce the risk of perineal trauma:

"...as the head is advancing...it's not a lot of pressure, but I'd have my hand there controlling it [the fetal head] in case the baby…"[Brenda, Focus group 3].

Colette offers the word *"Expulsive" [Focus group 3]* and Brenda agrees *"...[laugh] That's right, which can cause perineal trauma" [Focus group 3].* Therefore, the practice of placing fingers or the flat of the hand onto the fetal head gives midwives a sense of *"...control..." [Jane, Interview]* when trying to minimise perineal trauma. The meaning behind trying to slow things down is to *"...let the perineum thin out as much as possible..." [Colette, Focus group 3].* As Colette describes her practice of controlling the fetal head and guarding the perineum, differences in, and a lack of understanding (by some midwives) of, the meaning behind these ritualistic practice techniques becomes apparent:

"I can't say I flex anything these days. I might have my fingers just on the head because you can't physically flex anything. You've got the force of that contraction pushing down and you can't push back and turn it round and squeeze it up and all that. It's just a matter of habit I suppose that I just put my fingers on the baby's

head... I'm not supporting the perineum. I just like to have my hand, my two fingers, either side of the peri. I don't touch the middle part of the perineum at all" [Focus group 3].

Close observation of the perineum at this time is considered essential when attempting to maintain perineal integrity. A combination of close assessment and guiding the woman enables the midwife to *"...see what's happening with the perineum..." [Anne, Focus group 1]* and to decide whether specific practice interventions are required such as, an episiotomy. As Colette places a thumb and index finger either side of the perineum:

"...the baby's head's in the middle and I'm just watching as the presenting part's being pushed up, pushed up and the perineum's thinning out, and thinning out each time [there is a contraction]...asking the woman to breathe through some of those contractions. Not to give a strong expulsive action, if she understands what I'm saying" [Focus group 3].

A variation of this practice is to place a dry soft pad *"...on the peri and hold it there as the head is coming" [Elizabeth, Interview]*. The flat of the midwife's hand is on the pad, which is placed over the perineum *"...and as the head comes out the hand kind of curves around the head" [Elizabeth, Interview],* which may give some control of the head. Elizabeth does not:

"...like putting anything on the peri because I...want to be able to visualise it. You know, do we have any blanching? Is it starting to tear? What's going on down there? Like, I had a lady have a buttonhole tear on me and it was the most horrific thing. ...if I...had a combine there I would never have seen it, which probably would have been better for me because it scarred me for life [laugh]!" [Interview].

Rose thinks:

"...that [touching the perineum] is pretty traumatic [for the woman] and hurts. ...I mean it's already burning and all that, because it's stretching up... I think that most of the time tearing starts from the inside. So it's already started to tear before you have actually seen any evidence. You get that bit of blood [escaping from the vagina] and that shows you...it has already started to tear inside so, I don't believe that putting any pressure on the perineum is actually going to prevent tearing" [Interview].

Rose remembers the birth of her own children and one thing that stood out *"Was that pain of the perineum being touched..." [Interview].* As a midwifery student, Zoe, is aware of a variety of practice approaches when caring for the perineum during birth of the fetal head and knows:

"...some of the other students..., especially the Bachelor of Midwifery. The Bmid ones don't do any touching [of the fetal head and perineum]. And we had one girl [midwife] come out from England and she came and did one birth and did not touch anything. She...didn't touch the peri, she didn't touch the head, she didn't touch the vagina at all and, you know, there's all these different beliefs and different methods that people [midwives and midwifery students] have been taught" [Interview].

Diversity of practice is experienced by midwifery students. On the one hand, some university lecturers encourage a *"...no hands..." [Susan, Focus group 2]* technique for the fetal head and perineum, whereas Susan has seen *"...the difference between no hands and hands [on]...*" *[Focus group 2]* during births. She prefers having her *"...hand not on the peri, but on the baby's head..." [Focus group 2]* as she has seen *"...the head shoot out really fast – that's when...tears happen..." [Focus group 2].*

Not touching the woman's perineum during crowning and birthing of the fetal head is sometimes called "*...hands off..." [Casual conversation, Field notes]*. Alternatively, midwives may practice a 'hands on' approach such as,*"...guarding...the perineum..." [Casual conversation, Field notes]*. Zoe remembers feeling *"...shocked..."* at the beginning of her training when the first woman she cared for:

"...was off the bed. ...I didn't know what to expect because it was back to front. She was leaning over the bed and just squatting. Yeh...it was really good but I couldn't do anything. I was putting flexion on but you had no control. You couldn't see anything. You couldn't see the peri... ...I think that's why a lot of midwives don't like them to birth off the bed" [Interview].

Zoe suggests that a significant number of midwives prefer women to lie on the bed for birth as they feel *"...they have got that control over things..." [Interview]* and when a midwifery student or midwife attempts to practice a 'hands off' approach during birthing of the fetal head *"...they [midwives] tend to stress a bit…" [Nancy, Interview]*. A cache of predictable words and phrases are used by midwives to guide women through slow birth of the fetal head:

Contraction. Midwife "It is coming – good." Midwife places midwifery student's hand (three fingers) onto the fetal head and with the other hand places two fingers either side of the perineum. Quickly puts her finger into the vagina again as the head moves forward. Midwife to woman "Slowly! Small push! Stop! Stop! And again!" ...Midwife to woman "Cough for me." Woman breathing rapidly (does not respond). Fetal head slowly birthed [Field notes, Observation 9].

Partners, of women who are unable to effectively communicate in English, are considered an important intermediary during birth of the fetal head when midwives attempt to minimise perineal trauma during this critical phase of birth.

"...most of the time...the partners are there and they will listen... ...it's not just the person [woman] delivering the baby. ...I will be going like this (hand signals), you know, and he will be watching. Midwife to partner "Slow down, slow down, don't push, don't push" and, those sort of actions" [Colette, Focus group 3].

Hand signals as well as verbal instruction facilitate the link between the midwife, woman and partner. In the following birthing room observation the woman, partner and midwives communicate only in an Asian language:

Midwife has a hand on the fetal head – seems to be encouraging the woman to give very small, slow pushes as the head is emerging from the vagina. Whole hand on the fetal head as it slowly births. Running fingers under fetal chin as head born. Depresses head slightly downwards when checking for cord around the neck – pulls loop of cord over the fetal head. Looks like tearing of the perineum occurs during birth of the head (look of concern by midwife). Midwife attempting to prevent perineal trauma during birth of head – can hear it in encouraging tone of voice and how the woman is responding to the midwife's verbal encouragement during birth of baby. 0023 birth of baby girl. Baby placed on woman's chest (woman wearing gown) [Field notes, Observation 15].

The woman in the above observation was lying in a semi-recumbent position on the bed. The atmosphere in the room was calm and everyone was speaking quietly. Perineal trauma was found to be a second degree tear despite the midwife working with the woman to facilitate slow birth of the fetal head.

Sweeping the 'peri' across the face

While not observed during this study, a practice thought to minimise perineal trauma is described as *"...sweeping the perineum over the face..." [Cait, Interview]*. This is sometimes used as the woman is *"...breathing the head out over the perineum..." [Cait, Interview]* and occurs only if it is taking several contractions for the perineum to *"...just peel down over the face..." [Interview]*. Gwen also uses this practice and sometimes *"...massages the...perineum as well..." [Interview]*, though she does not *"...think about it [massaging] consciously. I just do it..." [Interview]*. Some midwives use a combination of massaging, stretching, sweeping *"...but otherwise 'hands off' [the perineum]" [Biyu, Focus group 4]*.

Elizabeth has seen midwives sweeping the perineum across the face and wonders *"...Oh, my God! Why would you do that?" [Interview]* She remembers an Asian woman at the point of birthing the fetal head when a:

> *"...senior midwife...came in [to the birthing room] and decided she wanted to take over and pushed the peri down... It wasn't a big third degree tear" [Interview]*.

As a student, Nancy has been taught to sweep the perineum *"...very slowly across the face, little by little..." [Interview]* when *"...the perineum is too tight and will be torn..." [Interview]*. An alternative method of practice is to slowly ease the labia over the occiput as observed in the following birth:

> *"Midwife encouraging the woman to give short, gentle pushes for birthing of the fetal head. She is pushing the labia gently back over the occiput. Midwife is controlling speed of expulsion of the fetal head [hand on head]. Bracing of the perineum. Short, quick pushes. Midwife to woman "Good, again. Like that. Yes, one more. Short pushes [the head is birthed], push again" [Field notes, Observation 2]*.

Both woman and partner in the above observation spoke fluent English and had Australian accents. Examination of the woman's genital area identified a perineal graze only. Following birth of the fetal head the midwife usually waits for the head to restitute and the shoulders to rotate into the anterior posterior diameter of the pelvis. A midwifery student places a hand:

...either side of the fetal head (assisted by midwife) and applies downward pressure... Midwife to midwifery student "Watch the perineum, watch, watch!" Baby is lifted up and onto the woman's abdomen by midwifery student [Field notes, Observation 9].

As the posterior shoulder is born the midwife urges the midwifery student to observe the effect on the perineum. One approach to birthing the fetal posterior shoulder is that *"...you always do it [birth posterior shoulder] slowly..." [Biyu, Interview]* as it is felt that rapid birth of the posterior shoulder can *"...damage..." [Biyu, Interview]* the perineum. On the other hand, some are of the opinion that the impact of the posterior shoulder on the perineum is *"...nothing special..." [Vicki, Interview]*, although with a compound presentation *"...sometimes you can lose a bit of the perineum as they come out" [Vicki, Interview]*. Vicki describes how she bases her practice on her midwifery training:

"When I was trained you were told to hold the head, support the head, not to worry about the body. The body should just come out in one flowing motion. ...I say to the students you're to make a baby sandwich. Your hands on either side [of the fetal head] the head is in the middle and then you just pull down [and] straight up. I never take my hands off the head. And it [the baby] should deliver in one curve. ...Straight down, straight up in one go" [Interview].

Within the myriad of practices used to protect the perineum midwives offer insight into what they believe really works.

WHAT PRACTICES REALLY MAKE A DIFFERENCE?

Midwives know *"...there are very limited things you can do..." [Vicki, Focus group 3]* to reduce or prevent perineal trauma during labour and birth. However, Vicki mentions practices she has found make a difference:

"...control the head as much as you can. You can encourage the perineum to stretch by going slowly. You can wait for the shoulders to turn... ...you can't decide "I'm going in there today and she's not gonna tear because I'm gonna do all my interventions." Eventually these things sometimes...happen to people [women]. Some people [women] need suturing" [Focus group 3].

During study observations, all midwives place fingers or part of their hand on the fetal head in an attempt to facilitate slow birth of the fetal head. Initially, when Adele *"...first started...working in Delivery Suite..." [Focus group 4]* she used a 'hands off' approach during birth of the fetal head:

"...and then I saw a couple of perineums did shatter. Like, you could just see it [perineum] exploding out. And then a couple, you know, where you try and slow it down a bit if you can...and try at the same time [to] encourage the woman, you know, to slow herself down if she possibly can, and it seems to make a difference in my experience. But whether or not that's been proven... Maybe that's just the Adele's experience of midwifery, I don't know [laugh]" [Focus group 4].

The main practice that Vicki *"...believe[s] has any effect..." [Interview]* in reducing perineal trauma is *"...just slow it [the fetal head] down" [Interview]* and *"...avoid*

explosive pushing..." [Interview] during birth or *"...you're gonna have a big tear..." [Focus group 3]*. The midwife needs to not focus *"...on the baby's head" [Vicki, Interview]* but:

"...focus on the woman's head and get into her head space [then] she understands that you have got to take it slowly. She controls it [expulsion of the head] more than you do and if you can get in a good relationship with her, and explain to her what's going on, I think you will have much less perineal trauma" [Vicki, Interview].

This approach is *"Critical..." [Vicki, Focus group 3]* and is:

"...the best you can do. I am not saying that you will have 100% success [no perineal trauma] because at the end of the day it depends on the diameters of the head to the diameters of the perineum. I don't know – it's not muscle tone, it's maybe skin elasticity or something, you know, plus I think also hands off the perineum because I think there is too much wiping and too much pulling on it to see if it stretches" [Vicki, Interview].

Therefore, building rapport, trust and effective communication between the woman and midwife enables the woman to *"...control the breathing. ...control the pushing – the expulsive force..." [Vicki, Focus group 3]*. Consequently, the extent of perineal trauma in the presence of an effective midwife-woman relationship is *"...usually minimal..." [Colette, Focus group 3]*. Communication helps with *"...reducing [perineal] trauma..." [Susan, Focus group 2]* as this:

"...lets...her [the woman] know what's going on, what's happening so, you can give her advice. ...like, "Deep breaths" or "Cough now." That really helps because it stops them from doing a big, long push" [Susan, Focus group 2].

These practice points on minimising perineal trauma are strongly supported by the majority of midwives. Adele reflects on suggestions that providing maternal comfort, support and being *"A patient midwife" [Sally, Focus group 4]* helps to prevent maternal perineal trauma:

"It's funny how...no one's said anything physical. It's all emotional. ...Yeh, and I know I said "Oh, controlling the head" or, you know, a hot compress on the peri, or position, or pushing, or timing of pushing, or, you know, technique of pushing. It's all been on the relationship, the communication, the trust, the, you know, all those kind of things" [Focus group 4]

This insightful comment underlines how the midwife-woman interpersonal relationship and emotionally supportive aspects of care can strongly influence the incidence or extent of perineal trauma. Therefore, 'being there' for the woman and making a positive contribution to the birth experience is recognised as being important by the majority of midwives. Adele knows her:

"...practice doesn't change for the physical things that I do – whether it be the English speaking, you know, Caucasian woman or the Vietnamese lady who is looking at me blankly. ...At the end of the day, if I'm not there the woman's gonna push the baby out. I'm just there to facilitate her really. She's the one doing all the work. So at the end of the day anything that I physically do is not gonna make a really big difference in my opinion. But to make the experience better for her well then, yeh, maybe you can help by reassuring, educating and making sure she feels like she's not petrified. It's quite – especially primips, you know. If she's in a foreign world where people are not speaking her language" [Focus group 4].

Childbirth is an intensely emotional and physical experience, and has numerous factors impacting on the midwife's ability to instigate an effective interpersonal link

with the woman. However, midwifery decision making related to techniques of practice to reduce perineal trauma *"...does not change for the lady's ethnicity. It's the same..." [Vicki, Interview]* for all women. The following observation provides an example of clinical practices and ritual words, and phrases as the woman is encouraged to slowly birth the fetal head:

Midwifery student places two fingers on the occiput. Woman is pushing hard. Midwife to woman "Just stop! Stop! We need just little pushes if you can manage them. Just bring your legs up a bit – that's good." Midwifery student dabbing, wiping the perineum with a pad. Two fingers remain on the occiput. Woman pushing. Midwife to woman "Open your legs, slowly, slowly, little, little, little, little, slow, slow, good, slow." Midwife to student "Put your fingers either side of the peri, not on the peri." Midwifery student's fingers remain on the occiput. No contractions. Everyone waits quietly for the next contraction. Midwife [hand on woman's fundus] "Coming again. OK, no strong pushing, just little, don't push, don't push." Midwifery student "Nice deep breaths." Women breathing slowly – baby's head slowly being born. Midwifery student "No big pushes!" Head slowly birthed. Midwifery student checks for cord around the neck. Baby is crying and is not fully birthed (head just born). Midwife to woman "Baby's head is out (baby crying) – wants to come and meet you!" Midwifery student waits for restitution of the head and rotation of the shoulders. Places hands either side of the head and pulls down gently, birthing the anterior and then upwards with birth of the posterior shoulder" [Field notes, Observation 3].

Following birth of the placenta, the midwifery student unsuccessfully attempts to assess for perineal or genital trauma. The midwife demonstrates the assessment technique and identifies a second degree perineal tear. A medical officer is notified of the need for perineal repair. Following completion of the third stage, the majority of midwives assess for genital trauma for example:

Midwife changes the blue sheet under the woman's buttocks. Midwife to woman "We need to check what damage was done [check for genital trauma following birth]." ...Midwife...says to the woman "This is going to hurt a little bit, I'm sorry." Uses a large clean swab to visualise the genital area, vagina and perineum, and identifies a second degree tear. Midwife advises the woman she has a little tear that needs a few stitches. The woman asks "It's not too bad is it?" The midwife reassures her that it is not [Field notes, Observation 16].

Sometimes perineal trauma cannot be avoided.

Using a variety of basic practices and strategies, midwives attempt to minimise perineal trauma for Asian women during the second stage of normal labour and birth. An individualistic variation in approach to care is identified as a constant pattern. However, there is also a conscious awareness those strategies are ultimately dependent on the skills of the individual midwife providing care at that time.

Most midwives are unsure of the practices of their colleagues and some can relate to the phrase 'practising in isolation'. 'Old ways' of practice are being bombarded and slowly surrounded by 'new ways', with some midwives and midwifery students finding these professional and interpersonal group dynamics challenging. Few midwives encourage or recognise maternal ownership of the birthing process. Even less work in partnership with the woman and support people to ensure their needs are met.

SUMMARY

This chapter described a culture of midwifery intrapartum care during the second stage of normal labour and birth, with a focus on midwifery clinical practice and reducing perineal trauma. Midwifery practice is embedded within a group culture of

'sameness' recognised by traditions of place and position within the birthing room setting. A progression of clinical practices including maternal position, type of pushing, slowing birth of the fetal head and specific individual variation in practice are thought to contribute to perineal outcome following birth. Ultimately, the midwife-woman emotional communication link is recognised as underpinning the effectiveness of all clinical practice strategies in reducing perineal trauma for Asian birthing woman.

The next chapter explores the dynamics of power and control embedded within the midwifery cultural group. The subsequent effects on perineal integrity are considered.

CHAPTER 7

RESULTS: DYNAMICS OF POWER AND CONTROL

Chapter 6 described various midwifery practice approaches for reducing perineal trauma during the second stage of labour and birth. The essential nature of the midwife-woman interpersonal relationship and the effect of maternal fear are recognised as having implications for perineal integrity.

This chapter describes the balance of power and control surrounding and influencing the culture of midwifery in Delivery Suite, and considers implications for clinical practice and perineal trauma during childbirth. Exploring the dynamics of power and control, embedded within this cultural group, broadens understanding and helps make sense of internal and external pressures influencing shared patterns of actions, behaviours, beliefs and events that may impact on perineal integrity for Asian women during the second stage of labour and birth.

THE RIGHT TO INFLUENCE OR CONTROL

THE WAY IT IS BETWEEN MIDWIVES

The majority of midwives have been working in Delivery Suite for a long time. Cait completed her midwifery course at this maternity unit and knows that:

"...all of them [midwives working in Delivery Suite], apart from one or two, have been there since [the] unit opened [laugh] 20 years ago so, they all trained me to be a midwife and...that's how it operated 20 years ago... It's always been the way. So, there is a lot of trust cos everybody knows everybody... It's not one of those units that has a continual turnover of [midwives]. It's the same staff apart from your students. So, the [midwifery] students are learning. The students learn, I guess, the way the

midwives are teaching them and then they [students] might move onto other places and see differences [laugh] but [pause] and a lot of them like to come back to where we are and some don't. Some like greater control from a doctor and not have to take on those responsibilities and others still think we are too interventional and go somewhere else so, it doesn't suit everybody. But for me it really suits the way I like to...work as a midwife" [Interview].

The core group of midwives working permanently in Delivery Suite have a great deal of expertise that others, who are rotating through such as, midwifery students, less experienced midwives and medical officers, can draw on. Most of these experienced midwives are committed towards supporting women to achieve a normal vaginal birth. As a member of this core group, Biyu views herself and these midwives as:

"... colleague[s], friends, sisters and perhaps [as a] daughter to [midwives] much older than me. I respect them. And most of the time with friends, you know, like sisters too...sometimes you fight, you talk [laugh], and sometimes you are sad and you talk. Share our ups and downs. Like a family" [Interview].

Biyu sees her role in Delivery Suite as:

"...not just a midwife but...a friend – a resource person and...a helper to the doctors who need my guidance, or the [midwifery] students – everyone really" [Interview].

With more than 20 years of experience as a midwife, Rose explains why she continues to work in Delivery Suite:

"...once you're here [in Delivery Suite] you don't want to leave. Or you leave and you come back. ...It's friendly. It is supportive. ...the people...I work with are like a

family because most of us have been working together for a long time. So, you know how other people think and how they work, and you know what they like, and what they don't like, and they know what you like, and what you don't like, and you go out of hours together so, yes, yes, friendly is probably the best way to put it. And supportive. ...I have been doing it [midwifery] for a long time and sometimes get an urge to do other things and then I come back because this is what I like – what I enjoy. So, I have tried other things but I always come back here. ...I like being with women when they're in labour. I like to feel that I am helping them birth and it makes me feel good" [Interview].

Describing herself as *"...basically a pacifist by nature..."* Vicki still finds working as a midwife in Delivery Suite as:

"...good. It's interesting. I think I do OK with...people – like the personnel [colleagues and other health professionals] and the patients like me. ...I don't go out of my way to cause too much trouble with people... It does get a bit monotonous sometimes but I think that's just life. Because it's day in day out, year in year out – but I mean, there's still a lot of job satisfaction involved" [Interview].

When asked if she was happy with the way things are in Delivery Suite, Vicki replied *"Yes, I am not a person who likes change anyway so, I am happy with how...things [are]" [Interview].* There is, therefore, minimal interest in change such as, alternative models of midwifery care and Vicki explains why:

"I like medical back-up. ...a second opinion to be able to discuss things with because a lot of the time I am the most senior person on [in Delivery Suite] so, I like to have someone that I can basically, for litigious reasons, ...blame... Because a lot of decisions I am making on my own and I am quite concerned that I do the right thing for people" [Interview].

Midwifery autonomy, expertise and commitment are evident in the concerns expressed by Vicki, as well as a sense of vulnerability and professional awareness of the need to not step outside her midwifery scope of practice. Most experienced midwives are known to work well together, respect each other and have an expectation of safe standards of clinical practice within Delivery Suite. Xiaoli has worked in better places and feels midwifery is *"...just a job. I suppose you work anywhere – it's the same" [Interview].* She mentions several times that she has *"...been working too long..." [Interview]* and would retire if she could. As a group, Xiaoli feels the midwives work well together *"...you have got to [laugh]. That's the way" [Interview].* Kim began her rotational position in Delivery Suite after recently completing midwifery training at another maternity unit. She describes her role as a midwife in Delivery Suite as:

"...a junior midwife – very low... Very well supported by the senior midwives but allowed to be autonomous within my own scope of practice and, yeh, I enjoy it" [Interview].

Kim explains why she wanted to come to this maternity unit:

"I [came here] to learn...that has been my sort of goal...to glean as much wisdom and information from the senior midwives as possible so, taking everything that they say onboard and taking bits I like and excluding bits I don't like... ...I don't say anything to their face... I just sort of take it onboard and think about it later and adapt my own practice according to how I see how well it has worked, or sometimes I'll do what they do and sometimes I'll do what other people do, or sometimes I do my own thing" [Interview].

Most midwifery students describe positive experiences during their Delivery Suite rotations and towards the end of her training, Zoe feels that:

"I really liked it [Delivery Suite]. I feel confident. Like, at the start obviously I was not happy – just taking it all in. But now I am feeling a lot more confident. The midwives there, especially the senior ones – I take in what they have done and I have learnt from them, their actions...and...what I have observed" [Interview].

Zoe appreciates the presence of the substantial midwifery expertise and range of learning opportunities offered in Delivery Suite. Starting her midwifery training the same time as Zoe, Nancy describes a slightly different experience:

"There are some [midwives] that are supportive but there are some that are not... I guess that's everywhere" [Interview].

Nancy found that if she had a query when working in Delivery Suite, the unsupportive midwives would not answer her questions and *"You had to find someone else..." [Interview].* However, Nancy feels most midwives working in Delivery Suite:

"...are very good teachers...supporting me, giving me opportunities to learn on my own – always knowing they would be behind me if I need them" [Interview].

Having not worked previously in this maternity unit, Gwen provides the dual perspective of an acting Delivery Suite midwifery manager who, as part of the role, works clinically in the department. She describes how the midwives function collectively in Delivery Suite:

"...most of them [midwives] are fairly cohesive...[and] work well together. But, you know, if there's a problem they'll come and tell me about it [laugh]. Somebody's not...pulling up their socks or not meeting the standards. They'll let me know" [Interview].

Therefore, a solid core of experienced midwives underpins and monitors clinical practice standards of intrapartum care provision in Delivery Suite.

PEER PRESSURE AND PRACTICE

Cait has a background as a midwifery manager as well as working as a midwife in Delivery Suite. She talks about how the midwives have discussions around clinical practice:

"Well, it'll [clinical practice] sometimes come out like at our ward meeting or we'll just generally sit around and discuss it [clinical practice] and I'll bring in some literature about perineal trauma, third degree tears, and we talk" [Interview].

The core group of midwives, Cait explains:

"...have poor computer skills, poor research skills... I think [midwife's name] and [midwife's name] have a [tertiary qualification] – none of the others do. So research for them is difficult. They do go to a lot of study days, they do...read, cos we always [bring] in the...midwifery magazines. So, we'd talk about articles in the midwifery magazines...it seems to be a waste of time for some of them because they will continue to do [practice] what they have always done. ...regardless of what anyone says... ...it's peer group pressure not just [midwifery manager] pressure that can change practice" [Interview].

Peer pressure, as a control mechanism for what are considered safe standards of midwifery clinical practice, was found to be present during observations, interviews, focus groups and casual conversations. When describing changes or challenges to clinical practice, Xiaoli uses the words *"They [the group] say..." [Interview]*, several times, making it evident the core group of midwives apply peer pressure if there are concerns regarding individual clinical practice. For example, Xiaoli describes peer pressure related to use of episiotomy during the second stage of labour and birth and explains why she prefers to regularly perform this surgical procedure, rather than allow the perineum to tear spontaneously:

"One midwife...did the research – going back auditing. She said "Oh, you did a lot [of episiotomies]." Me and [two other midwives] "You three did a lot of episiotomies." I said "Oh, yes, probably." But 'touch wood' I work all this year – I think there might have been two - won't be more than three third degree [perineal] tears [total occurring in Delivery Suite for the year] ... I know I did a fair bit [number of episiotomies performed] in comparison [to other midwives] but you see 'third degree tear', 'third degree tear', 'third degree tear' [documented in the Delivery Suite birth register]. If they [women] have a third degree [tear] sometimes they have a PPH as well... But some of them [Asian women] if you don't do an episiotomy they tear here, here and here, all over the place [referring to multiple areas of tearing on the perineum] instead of one cut [episiotomy]. Such trauma, you know" [Interview].

Peer pressure and discussion increased Xiaoli's awareness of the connection between episiotomy and third degree tears. However, Xiaoli has not changed her practice as she believes an episiotomy reduces maternal risk for severe perineal trauma and co-morbidities during normal vaginal birth. Peer pressure was also apparent during a birthing room observation in which Xiaoli was the accoucheur. To

place the following observation in context, the woman converses in an Asian language throughout the observation, although she does speak some English. Xiaoli is unable to speak the woman's language. The support person (the woman's mother) does not speak fluent English. The woman is lying on the bed in a semi-recumbent position and the fetal head has crowned:

The midwife's (four) fingers of the left hand are flexing the fetal head. An episiotomy is performed. The midwife says to the woman "Just breathe in and out. Small one [push] if you want to. Don't push, small one" [Observation 4].

Delivery Suite is busy (during the above observation) and the second midwife walks into the birthing room just as the baby's head is born. After birth of the baby, Xiaoli checks and wipes the woman's perineum with a large white swab. The second midwife is watching and says pointedly to Xiaoli:

"You had to do an episiotomy?" Xiaoli replies "She started to tear down into a third degree" [Observation 4].

The woman's perineal trauma (an episiotomy and a second degree tear) was repaired by a medical officer. Xiaoli continues to conduct episiotomies as and when there is a perceived need during the second stage of labour and birth. Regardless of peer pressure, she holds onto the belief this practice minimises the risk of major trauma to the perineum for birthing Asian women. Within the core group of midwives there is tension regarding appropriate use of episiotomy:

"...we [Caucasian midwives] just continually tell them [Asian midwives] that episiotomy [is] only for fetal distress or if your [fetal] head's sitting there for...four or five contractions, not gonna yield and that perineum's just not going to stretch or whatever. It just won't tear, it won't give, then I've done an episiotomy for that, but I would never routinely do an episiotomy. And we had them [Caucasian midwives] agitated all the time about the Asian midwives who had a liberal use of episiotomy. The discussion was weekly about 'episiotomy' – 'not episiotomy' and we certainly told them, gave them the literature. Again, behind closed doors [within the birthing room] there was always a justification for it [performing an episiotomy]. ...and then it was "You weren't there. You weren't there, you don't know how long it [fetal head] sat there. You don't know – the fetal hearts were falling" you know, there was always an excuse for that episiotomy" [Cait, Interview].

Cait considers resistance to clinical practice change in this instance:

"They [Asian midwives] just feel that's the way they do it [pause]. I don't know. They were trained that way. Anecdotally they believe their episiotomy was needed. ...Twenty years they've been doing it [episiotomy] and they'll do it their way" [Interview].

Midwifery autonomy and individual control over initiation of clinical practice techniques for experienced midwives is the norm. Within the core group, peer pressure appears respectful and not of a dominating nature. Elizabeth provides a midwifery student point of view regarding perineal trauma following birth and the attitude of some midwives towards the accoucheur:

"There are some midwives that...if you get an intact peri you're perfect... Everybody – midwives, student[s] ..., it doesn't matter who you are, if you can get an intact peri you are really, really good and, you know, first, second degree tears are frowned upon... ...there are times where we can't do anything physically to stop them[women]

tearing and it's things like "[student's name] always gets second degree tears" or "[students name] has only ever had two intact peris" and, you know, it's not my fault. I have done everything I could do to try and stop it [tearing]" [Interview].

Some experienced midwives are known to apply pressure to facilitate cultural awareness of the importance of reducing the incidence of perineal trauma following birth.

BLAMING AND SHAMING?

The extent of a woman's perineal trauma and the name of the accoucheur conducting the birth are included in the details documented in the Delivery Suite birth register. All third or fourth degree perineal tears are circled in red pen in the register. A third degree tear is an event that Biyu advises *"Well, in my career, personally, I haven't encountered those [third degree tears]" [Interview].* She feels:

"...that you've got to reflect on their [midwifery] culture [practice]. They don't instruct the patient or control it [fetal head] properly at the same time. And when they swing the posterior shoulder [this] also cause[s] another extended tear as well because [they] don't look. You can control and you always do it slowly [control the birth of the posterior shoulder], not just swing it out quickly like that. You have got to do it slowly and watch [the woman's] perineum because even though you deliver the head with an intact perineum, sometimes you say "Why is it a second degree tear?" That is because your posterior shoulder is damaging it [the perineum] and you are not doing it [birthing the posterior shoulder] properly" [Interview].

Biyu's comments reflect the belief that maternal severe perineal trauma occurs due to midwifery clinical mismanagement. Rose believes a blame culture surrounds this type of event because some midwives:

"...feel that maybe you haven't had that control, or you haven't had that rapport with the woman, or [pause] I won't, I'm not going to say 'control of the woman' because I don't agree that is what it is but you haven't been able to maintain rapport with the woman to help reduce the perineal trauma. But again, if the perineum is really short, which I have found in a lot of Asian women (if she's Vietnamese rather than Chinese) where the perineum is really short – the risk of a perineal tear would be a lot higher than in Caucasian women. You don't see them [third degree tears] often though. I have only ever had one in my whole practice and I was extremely traumatised by the whole thing [laugh]" [Interview].

When a third degree tear occurs following a normal vaginal birth in which a midwife was the accoucheur, the doctor attending the perineal assessment and repair is often heard to say:

"...If you had done an episiotomy this wouldn't have happened." I'm thinking "Well, they've got perineal trauma anyway…" [Rose, Interview].

Rose finds that doctors *"... prefer episiotomies cos they're easier to repair" [Interview]*. She feels that *"...midwives shouldn't be made to feel bad if [women] have perineal trauma" [Interview]* and describes how it is for the midwife accoucheur when a woman experiences severe perineal trauma:

"...nobody ever wants [a woman] to have a third degree tear but sometimes it's going to happen and I don't believe that it's because of mismanagement most of the time. I mean maybe there is some mismanagement (I really don't know) but I don't believe that it is, and I don't think that we should be made to feel guilty for [a woman] having a third degree tear, and we are made to feel guilty. And everybody hates it, like, it just makes you want to curl up and die when you get a third degree tear because you feel terrible because you know the pain that it causes and some of the problems that will happen because of it. The discomfort that it's going to cause

and nobody wants that. Nobody wants that. And you shouldn't be made to feel bad because it's happened and [pause] you are made to feel bad. You are made to feel that you are not a good midwife." [Interview].

Vicki explains how:

"...midwives take it as a personal, like a personal slight on their name if it's recorded that their patient had perineal trauma. I do, myself, take it quite personally if a patient gets a third degree tear. It's very traumatic [for the midwife] because no one ever sets out to cause trauma. But I think midwives can get a lot of burnout if they just take it on too heavy...a responsibility [for] that. Looking at it from the fact that if they have done everything within their means – it is what it is and they have to... accept sometimes it happens. You sometimes (the students especially) they get very distressed or people you, not now-a-days, but I remember when I was training people would say "Oh, did you see that tear she [midwife] got? What was she doing?" [Interview].

Consequently, a birth outcome, such as severe perineal trauma, can find some midwives blaming themselves or talking about other midwives in a deprecating manner, which may exacerbate personal and professional distress as Vicki advises:

"...even here [in Delivery Suite], people here get, oh, you know "Oh, it's terrible that this one's [midwife] had a tear or this one does a lot of episiotomies" and all this sort of stuff, and I just don't think it benefits. ...Whatever the outcome is, it is the outcome and people shouldn't take it on as a personal burden for themselves. [Midwives] beat themselves up [about something], which is beyond their control" [Interview].

While midwives focus their efforts on trying to prevent or reduce the extent of perineal trauma during childbirth for Asian women, their distress is palpable when severe perineal trauma does occur. A blame and shame culture has the potential to intensify this distress. Some midwives recognise the oppressive nature of this negative culture, whereas others continue to impose this culture, particularly on those who are more vulnerable as Zoe, a midwifery student, explains:

"...there is one midwife here, she will come up to you and say "Oh, you did a good job, your lady was intact [perineum]." And she has actually said... to me "The main aim for a midwife is to have the woman intact. If she [the woman] has had a [perineal] tear, you didn't do a good job."... ...Yeh, she [the midwife]...said [that] to me...at the start of my [midwifery] course. I remember because I was listening to her... and I think I had only two ladies who were intact or otherwise they had labial tears or grazes and I thought - oh, my gosh, I am not doing a good job!" [Interview].

When asked what she thinks now at the end of her midwifery training, Zoe replied *"...I feel good if a lady is intact - that's good... ... but even if she tears, it's not her, it's not me..." [Interview].* A perineal trauma blame and shame culture does exist in Delivery Suite. However, not all midwives subscribe to this tactic when attempting to influence or teach clinical practice techniques to reduce the incidence of perineal trauma during childbirth.

LEARNING THE GAME

A quiet time in Delivery Suite found several midwives gathered around the central work area discussing how to minimise perineal trauma during the second stage of labour and birth. Sally, an experienced midwife, advocated flexing the fetal head and controlling how the woman pushes as the head is born (slow, no pushes, the

woman breathes the baby out) as being central to minimising trauma. Sally walked off to do something and Beverly, a recently qualified midwife, started talking about evidence-based practice techniques (to reduce perineal trauma) taught during her university training. She mentioned the 'hands-poised' technique but advised that the midwives in Delivery Suite *"...won't let me do 'hands-poised..." [Casual conversation, Field notes]*. When starting her rotation in Delivery Suite, Beverly found that the midwives insisted she put her hand on the fetal head (to flex) after the baby's head crowned. They physically took hold of her hand and put it on the fetal head and said *"This is how we do it here. We don't want you experimenting here on the women" [Casual conversation, Field notes]*. When she tried to explain to a midwife that the practice was evidence-based, the experienced midwife just repeated the words *"This is how we do it here" [Casual conversation, Field notes]*.

Beverly witnessed an overseas midwife (who worked in Delivery Suite for a while) using the hands-poised technique so, knows it can be done but does not *"...have the confidence or experience to do 'hands-poised...'" [Casual conversation, Field notes]*. Some experienced midwives are not supporting alternative clinical practice techniques learnt in midwifery training. Beverly is being compelled to adopt clinical practice techniques currently used by the core group of midwives in Delivery Suite.

Brenda, with approximately five years midwifery experience, describes how the experienced midwives find different clinical practice techniques challenging:

> *"There is another midwife here [who is] ...very ah-la natural. ...this [midwife]...is just talked about all the time because she has got different ideas and because she likes to turn down the lights, and doesn't do ARMs" [Interview]*.

When asked what was wrong with turning down the lights in the birthing room, Brenda replied:

"Well, I like it but when the midwife comes in to receive [the baby] all the lights go on. I [say] it's OK, I [have] enough light. And they say "Well, I don't!" [Interview].

Brenda interprets this as:

"...an obstetric practice, not a midwifery practice. It's all about, you know, what the midwife needs...she needs to see the colour of the baby or [pause]. As far as I am concerned if the baby's crying you are not too concerned about what colour they are. And if the baby's not crying and you need light then, of course, you put on a light. But to me, it's all about the woman's experience. It's her experience, not ours" [Interview].

The following birthing room observation underlines Brenda and Beverly's experiences. The birthing woman speaks no English and the support person is not fluent in English. The woman is lying on the bed in a semi-recumbent position:

Contraction. Midwife (1) says "Good, very good" (watching genital area) her hands resting on the bed. Midwife (1) asks support person to press the assist button. Midwife (2) enters the room, walks over to the light switch and turns the lights on fully. Midwife (1) says to midwife (2)"It's alright, I can see enough. The baby can see enough." Lights remain on. A very dominant presence has entered the room. It's almost as though she is saying "Look at me. I am the expert here." She walks immediately over to the bed and takes over. Does not introduce herself to the woman or others in the room and just takes over from midwife (1) without saying anything. As the birth progresses the frustration felt by midwife (1) shows in her facial features and body language (controls it well - says nothing to midwife (2)). Midwife (2)'s presence seems to have undermined midwife (1)'s confidence. It has rattled her – she is upset. Midwife (2) either doesn't care or is oblivious to midwife (1)'s frustration

and distress. Midwife (2) (talking urgently to the woman) "Push, slowly, slowly – listen! Cough! Cough!" The baby's head is born" [Field notes, Observation 7].

After the birth and prior to suturing of the perineum, midwife (2) came out of the birthing room and approached midwife (1) (who was near the central work area), grasped midwife (1)'s hand and hit it hard three times with her hand (like she was a child):

Midwife (1) said to midwife (2) "What have I done?" Midwife (2) said "You have put dirty things all over my stock trolley (she went to get more sterile items)." Midwife (1) said "I didn't dirty the trolley – I put all my things on the bottom shelf." Nothing further was said [Field Notes, Observation 7].

Later:

Midwife (2) said that Midwife (1) had not put her hand on the baby's head to slow it down so, that did not help [to reduce] perineal trauma. Midwife (2) also said that midwife (1) tried to deliver the baby's head with the shoulders in the transverse, which further compromised the woman's perineum" [Casual conversation, Field notes].

Midwife (2) was correct in her observations that midwife (1) had tried to assist birth of the baby by trying to birth the anterior shoulder prior to restitution of the fetal head and rotation of the shoulders. However:

Midwife (2) did not seem to care (or be aware) of the impact she had on the atmosphere in the birthing room when she entered. She was loud (in her speech and manner), turning on the lights when clearly midwife (1) did not think this was required. Midwife (2)...took over control [of the birth] as though it was her right.

Midwife (1)'s manner was subservient and she looked irritated [Field notes, Observation 7].

A few days later:

Midwife (1) said "That's what a lot of the more experienced midwives do - although they are supposed to be receiving [responsible for care of the baby following birth], they walk in [to the birthing room] and take over the case and do the delivery..." Midwife (1) said she had told midwife (2) prior to the birth that she was going to do a 'hands poised' birth and it must have been too much for midwife (2) when she walked into the room - she couldn't deal with it. After the birth, midwife (2) said to midwife (1) "If I had done the delivery she [the woman] wouldn't have torn [perineal trauma would not have occurred]" [Casual conversation, Field notes].

The woman in the above observation experienced a first degree perineal tear, which was sutured by midwife (2). A number of experienced midwives take issue with clinical practice techniques, unfamiliar to them, being introduced by less experienced midwives. Attempting to contain practice change by controlling (sometimes aggressively) the scope of midwifery clinical practice techniques in Delivery Suite, is becoming less feasible as the number of more recently qualified midwives slowly increases. Some midwives strive to protect the current mode of midwifery practice. As midwifery students are in a learning situation, they willingly accept guidance and are less likely to challenge practice. Zoe explains how the more experienced midwives tend not to 'jump in and take over' in some situations:

"When they [women] are your 'follow-throughs', it's like you're the senior midwife and they [experienced midwives] are just in to receive. But when I am [caring for] any other [woman], they have come in to receive [and] they are going "Push, push,

push!" [to the woman] while I'm gloved up [laughs] and...sometimes I...feel like I am just standing there watching [the experienced midwife takes over the student's role of accoucheur]" [Zoe, Interview].

In this situation, Zoe feels the experienced midwife's behaviour is:

"...an ego thing. They think they have to be doing something. And it's probably the way they were trained back then, you know. To tell women knees to your ears and above your head [laughs]. And push, push, push, push, push! We've been trained these women don't need cheerleaders – let them do what they want" [Interview].

Another picture of midwifery student alternative thinking on practice is provided by Elizabeth:

"...sometimes senior midwives will leave you in the [birthing] room and you know... [experienced midwife to student] "When the head's on view then press the buzzer and I'll come in." And you're standing there and you're waiting, and waiting. It's like "Come on head, please come quick [student thinking to herself]." And the senior midwife comes in and it's like "Alright, right [very firm tone]. Come on, push darl, push!" And you're like "Oh, just leave her! [student thinking to herself] So, as a student...you don't want to tell them [the woman] to push... and they come in and...tell her to push, and in two seconds there's the head... You're worried someone's going to come in and [say] - God, she's a multip Elizabeth! She should have had her baby by now and it's been 20 minutes!" [Interview].

However, Elizabeth has found that midwives *"...working for maybe five years" [Interview]* have a different midwifery philosophy and clinical practice approach towards intrapartum care compared with the core group of midwives. The more recently qualified midwives "*...are more like us [students]" [Elizabeth, Interview].*

As a midwifery student, Nancy describes how her hand was slapped by an experienced midwife during birth of a fetal head. When asked why, Nancy said:

"I didn't hold the perineum the way...they [the midwife] liked. Some [midwives] like to hold the perineum like that [two fingers guarding the perineum] so, they can watch. Some [midwives] hold it [the flat of the hand] against the perineum" [Interview].

Nancy was told by the midwife:

"You are a student, you are still learning and we have had plenty of years of practice" [Interview].

Nancy feels that the midwife's expectations were *"That I would learn and do it their way, I guess" [Interview]*. An experienced midwife, Colette describes what she thinks about *"...the students coming back from uni...[with] their 'hands off' techniques and everything like that" [Interview]*:

"Well, maybe it's because I have always had to use my hands that I have to use my hands...I like to do what you call 'guard the perineum' in the old days. But you never touched the perineum... The peri's there and just the [shows the thumb and fingers of one hand placed either side of the perineum]..." [Interview].

When asked the meaning behind the practice of 'guarding the perineum', Colette explains:

"It's probably not doing anything but it's just where I want to put my hands [laugh]. Yes, so I like to do that. I don't insist they [midwifery students] do it though because...that's me [what I do]... That's just how I am, anyway" [Interview].

The core group of experienced midwives demonstrates a varied ability to reflect on practice and willingness to accept or initiate change. A few have developed the ability to reflect on and change practice (when required), whereas others continue to practice as they were originally trained. The majority of midwives do modify practice, although not necessarily basing this on current evidence. They use their intuition and professional experience as the basis for practice change. Brenda finds that:

"...a lot of the midwives in [Delivery Suite] have been here a long time. It's very hard for them to give up their old ideas of practice I guess. And I guess I've come here with a lot of new ideas and different ideas, which they don't necessarily agree with. But to my way of thinking, I'm the midwife and...I'm responsible for the lady, and...responsible for her experience in a way so, I practice the way I want to practice, within the guidelines and within the policy. ...But I find here when you are always keeping the team leader aware of what is happening with your woman, I am constantly asked "Why haven't you ruptured her membranes?" ...I say, well my experience (going along with the evidence) this is what's going to happen and it's not necessarily going to be a quicker baby. ...there was one situation a few months ago when the team leader asked if I had ruptured her [the woman's] membranes and I said "No." And it was just "For heaven's sake go in there and do it. I'm sick of sitting out here listening to her scream." And I just thought "This is her [the woman's] experience. She is vocalising because she needs to. It's helping and I am not going to do anything just to make someone else happy" [Interview].

Brenda would have found it hard *"...a couple of years ago" [Interview]* not to comply with the team leader's instructions, *"...but now, no" [Interview]* as she has *"...more confidence in myself and confidence in my practice" [Interview]*. She believes that the experienced midwives:

"...stick to their old ideas (an ARM does speed the labour up) and I've said to them "But read – there's evidence out there...in journals, there's papers been written" and it's just "Ah, no. I've been a midwife for 30 to 40 years, I know" [Interview].

Speaking from decades of experience, Vicki thinks that:

"...[midwives] are responsible for these patients [women] and they should be allowed to practice – as long as it's safe practice. ...I am sure you would get statistics if [midwives] weren't practising safely, there would be a continuous line up of complaints. Just let them [midwives] practice how they practice" [Interview].

Protection of cultural norms such as, established patterns of practice and behaviour is considered central for stability of the core midwifery cultural group. Some less experienced midwives are beginning to question the basis of these known practices and behaviours.

KEEPING THE BALANCE

Midwives working in Delivery Suite provide care for most women experiencing a normal vaginal birth. The professional culture and limited resources permit midwives to work largely independently when providing intrapartum care. The O&G Staff Specialist of the unit is supportive of the way midwives work within Delivery Suite and the limited number of doctors available in the unit promotes midwifery autonomy, therefore, Cait advises that:

"...even though it's a rotation of [O&G] registrars, they very much come, immediately within the first week to understand that we [midwives] will manage anything that's within our scope [of practice] and they are not to interfere unless we ask them" [Interview].

Midwives consider they have:

"...a great understanding, a professional relationship with our multidisciplinary peers (our doctors) in that we'll only ask for intervention or medical input if it goes outside our scope of practice" [Cait, Interview].

This collaborative, professional relationship leads to midwives referring or liaising with doctors when required, for example:

"If there's any delay in the first stage or second stage, or problems within first stage or second stage...we will refer to the registrar" [Cait, Interview].

Midwives value their autonomy and recognise their professional obligation regarding maternal and fetal outcomes for well women experiencing normal vaginal birth. Vicki appreciates medical input when required:

"I like to have a medical person [so] I can say they were also part of the decision, even if I am guiding them to that decision, especially if there is a senior registrar on – it is very reassuring. ...I like medical back-up. I know it's not the modern midwifery belief, but I do. I like it because I am the most senior person around so, [pause] and I don't want the responsibility" [Interview].

Liaising with doctors (even if those doctors have limited expertise) is considered an essential step when there are grounds for midwifery intrapartum referral. The following scenario illustrates a midwifery-medical working relationship in Delivery Suite. The woman (antenatal booking weight 44 kilograms) has been in the second stage of labour for more than one hour and the midwife has requested a medical review. The partner speaks fluent English and is used as a translator as the woman

has reverted to her Asian language. Maternal position during second stage and birth is semi-recumbent on the bed. Following a telephone discussion (outside the birthing room) between the midwife and doctor, a vacuum extraction is to occur:

The midwife explains to the woman and partner what the doctor is going to do [a vacuum extraction]. The doctor performs a VE (doesn't say anything to anyone). He then explains to the woman and partner that he will perform a vacuum and "...pull the baby out." Midwife grimaces and looking at the woman and partner, but also talking to the doctor at the same time says "Guide the baby through sounds better…" ...Midwife gets the vacuum equipment and midwife (2) enters the room... Stirrups are positioned by Midwife (2). Midwife (1) explains to the woman what is happening. ...Partner asks if the woman's position is OK. Midwife (2) says the woman will have to move down the bed. Midwife (1) explains to the doctor that she attended an in-out [urinary] catheter four and a half hours ago. After another contraction – the doctor performs a VE (without saying anything) and attends an in-out catheter. Midwife (1) explains to the woman what is happening and encourages use of gas [for pain relief] if she wants it. She connects vacuum equipment to the pump. The doctor lubricates the vacuum cup and attempts to insert into the woman's vagina – difficulty putting cup in vagina – vaginal orifice is small. Cup is now in place and midwife (1) works the vacuum pump. The doctor pulls on the vacuum and encourages the woman to push. FHS. The woman is gasping – breathing heavily. Doctor pulling. Midwife (1) reassures the woman – it is OK to wait for a pain before pushing. Midwife (1) voice is calm, encouraging. FHS... Doctor pulling. FHS. Doctor requesting local for an episiotomy (introitus is very small). Doctor gives local – scissors – cuts (several bites) – pulls. Asks midwife to release suction - a large baby's head is born. Baby [a boy, birth weight 3,705grams] is placed on the woman's abdomen on top of the white gown she is wearing... Midwife (1) gives doctor more local, gets a light [to illuminate genital area], congratulates the woman and partner and says "You did very well." ...Woman is breathing heavily on the gas as the doctor administers local around the perineal/ vaginal area and commences suturing. The woman begins to bleed heavily from the vagina – midwife (1) rubbing fundus – apologises to the woman and explains what is happening to the partner.

Midwife (2) is resuscitating the baby in the cot, with blow-over oxygen. Midwife (1) walks over to look and help. The woman's eyes are closed – she is using the gas. Partner turns towards the baby – looking. Partner asks the doctor if the perineal trauma is normal. Doctor says the episiotomy plus baby caused a big tear of the perineum (the perineum looks as though it has exploded). Doctor is trying to fit bits of the perineum together (tissue connected but all hanging in bits and he shuffles it around to try and work it out - like a jigsaw) – all posterior trauma. The woman is using the gas, eyes closed, quiet. Partner talking to the woman – she does not respond. Midwife (2) gives the baby (wrapped in a bunny rug) to the partner to hold [Field notes, Observation 10].

In the above scenario midwife (1) explains to the woman and partner what is happening as the doctor performs a VE, in-out urinary catheter and vacuum birth. She attempts to advocate for the woman and partner as the doctor performs the vacuum procedure. The woman has no voice.

TIMING AND SECOND STAGE

As an instrumental birth increases the risk of perineal trauma, Biyu expresses frustration at the time limitation placed on the second stage of labour by organisational policy:

"...it makes me feel like...I am running out of time. ...I feel constrained and I feel that you are damned if you do and damned if you don't. If I don't tell the doctor - if anything happens, I am solely responsible and if I tell the doctor that the second stage is slightly delayed according to the time limits, then it's an instrumental and even though I know both mum and baby are OK" [Interview].

Biyu recognises normal individual variation in length of second stage and the need to individualise care. However, there is awareness a medical decision related to

clinical care in the above situation is non-negotiable. Sally concurs with Biyu's sentiments:

"Even [if] we've got head descending, ...how many times we just have a baby on view? ...but we need more than an hour. ...In [a] short time – they [the doctor] want to do a vacuum" [Focus group 4].

Adele confirms the one hour policy time limitation on the second stage of labour has little flexibility and the doctor decides *"...whether there's gonna be further intervention or if they're gonna let her keep going" [Focus group 4].* Biyu believes it is a:

"...blame thing. Because we know there's progress there, the fetal hearts [are] good, [we are] reassured. But you need to follow the policy – then you need to inform the doctor and the doctor makes the decision. Though you tell them the history – they [woman have] progressed nicely and all this stuff...they usually come [to the Delivery Suite]. Some of them (I mean the team now) [current doctors] like to come and assess themselves, which is fair enough I guess because they are responsible too you see. They come and they need to assess the lady and they need intervention because they see what they see [decision made from a medical perspective]" [Focus group 4].

The midwives know doctors are reluctant to extend the length of the second stage for longer than one hour because *"They get nervous" [Adele, Focus group 4].* Adele explains the fear behind medical officer decision-making:

"Babies don't have enough reserve in second stage like in first stage. ...their condition can deteriorate a lot more rapidly in second stage, especially if you've got someone actively pushing for an hour. And if they're having three or four contractions in ten minutes and you've got her pushing for an hour, you need to be

concerned about what that means. What effect that may have on the baby so, I guess it's generally accepted that an hour is getting towards the upper limit" [Focus group 4].

Adele explained later that changes in policy relating to length of second stage had been a medical response to an adverse birth outcome.

A significant proportion of midwives adapted practice in response to organisational policy time limits on second stage. This midwifery practice behaviour was aimed at facilitating normal birth and reducing the risk of a medical decision for an instrumental birth. Time limits are circumvented in a variety of ways for example, finding the fetal head on view as an identifier for a woman being fully dilated is one midwifery control on practice. Biyu advises how a one hour limitation on second stage has influenced her practice:

"That is when I start to do the perineum massage. ...I do the finger massage [holds up one index finger] and it works – 99% works. They [women] push really well. Within one hour they have the baby" [Interview].

However, some midwives rigidly adhere to policy timeframes without attempting any adaptation to practice. Midwifery actions of facilitating normal birth and limiting unnecessary instrumental births by adapting clinical practice to 'work around' organisational policy requirements, may have implications for reducing the incidence and severity of perineal trauma. These covert interventions occur because some midwives feel powerless or constrained by medical decisions or policy parameters.

WHO HAS POWER AND CONTROL DURING CHILDBIRTH?

The cultural context of care within maternity does not *"...allow her [the woman] to have a say...that's not our culture here" [Mary, Focus group 1]*. In addition, a number of Asian women and support people are advised antenatally that during labour and birth they are not to keep asking midwives questions and demand things. Consequently, there could be a maternal expectation during childbirth that *"I should zip my mouth..." [Sopheap, Interview]* and some people (particularly those who do not speak English) are likely to be thinking:

"...don't upset that midwife because if you upset [them] they probably [won't] like [it]. Then they don't like to look after you... If you upset the midwife it will...look bad" [Sopheap, Interview].

As a result, Asian women may often present to Delivery Suite with a reduced sense of ownership of their impending labour and birth, and a limited awareness of choice or control. A submissive behaviour is considered a cultural norm for the Asian woman and partner and most midwives recognise *"There is a passiveness about them" [Colette, Interview]*. Furthermore, some midwives know that Asian people unable to speak English *"...are disadvantaged [during childbirth], of course they are" [Colette, Interview]* although:

"...you can't label everybody as such. You will get some that will be OK – everything seems to be OK. But you do get others [pause]. I think they are probably the people who don't speak any English and who have recently arrived in the country. They haven't had any exposure to the other cultures at all…" [Colette, Interview].

Colette considers these women may feel:

"...probably very frightened I would think and very [pause] - this is all something new. Maybe never been to a hospital like this before. ...They are very passive people...so, I don't think they are going to speak up and say "Look, I don't want you to do this" or "I don't want to do it this way" or "I want something else", you know? ...They don't want to rock the boat. You know, we are the people at the hospital - they don't want to be on bad terms with anybody. I have had some nice dealings with these people. I really like them. They are really lovely people" [Interview].

Maternal vulnerability and lack of ownership and control of their labour and birth have implications for normal childbirth, including the incidence and severity of perineal trauma. When the majority of labouring Asian women and their support people arrive in Delivery Suite, they experience traditional processes of care, which undermine individualism. This institutionalised disempowerment begins when the labouring woman is shown into a birthing room and is invariably asked by an unknown midwife to remove her clothes and change into a plain white hospital gown. The gown is short sleeved, ties at the back (usually at the back of the neck) and when the woman is off the bed the gown flaps open and reveals all. During birthing room observations only one woman was wearing her own clothes (a long sleeved jumper and a tee-shirt underneath). The following birthing room observations provide a view of the power and control dynamics between the woman, support person and midwife during the second stage of labour. In the first scenario the woman is not fluent in English, whereas the partner is:

Midwife stands back against the bathroom wall looking at the woman... The partner is standing next to the woman who is sitting on the toilet. ...The woman says nothing,

eyes closed... Contraction. Midwife to woman "This is the time, focus, you have the energy. You keep saying the pain [is] not there but I can feel it." Midwife squats in front of the woman and says "Push, harder, harder! Quick deep breath in and again, and again. Keep going, keep going! This is how you do it, just a little bit more!" Midwife to midwifery student "You can see her perineum, instead of stretching, it is swelling up." Woman says "Pain." Midwife squats "OK, one, two, push, it is coming, push it, push!" Hand resting on woman's abdomen - feeling for a contraction "And again, like that. Short one. It [contraction] has gone." Midwife pulls on sterile gloves, squats in front of the woman, hand on abdomen. Contraction "OK, hold your leg up. Push down (midwife has her fingers in the woman's vagina) and again. Good, it [fetal head] is there." ...Midwife to the woman "You want to go to bed?" The midwife walks out of the bathroom. The partner comes out of the bathroom with the woman hanging around his shoulders. She is walking crab-like, knees bent, towards the bed. Midwife to the partner "What is the matter? Why can't she walk right?" Partner says "She can't." Midwife and partner help the woman onto the bed, the lower half of her body exposed. Midwifery student checks the FHS with the CTG. Midwife goes out of the room, returns and says to the woman "Try to have baby by one [-o-clock] right? [laughs, looks at midwifery student]." ...Midwife to woman "Come on, you don't have much pain. As soon as you have the pain, push. Don't wait very long, use it." Midwife standing waiting for the next contraction. Midwife to midwifery student "See how shiny it is [the perineum], looks like that and they tend to tear." Woman's eyes open when the midwife says this. She and partner both heard because the midwife is standing next to the woman. They don't say anything [Field notes, Observation 9].

In the above observation the midwife encourages the woman and says *she* can 'feel' the pain of the contractions when the woman is unable to, directs the woman how and when to push, does not explain or gain consent prior to a VE, influences where the woman will give birth and proceeds to talk 'over' the woman as though she is not there. The woman and partner submit to this controlling approach and, although

they are noticeably concerned about the comments regarding tearing of the woman's swollen perineum, say nothing. The woman and partner are compliant. Clearly, the midwife holds the balance of power and control during this event. Contrast the above observation with the following one, which is a midwifery student's follow-through, currently being supervised by a midwife who recently completed her training. Both woman and partner speak fluent English:

The woman is...facing the lower half of the bed and resting the upper half of her body on a bean bag (covered with a sheet) that has been placed onto the bed. A blue absorbable sheet has been placed on the floor between the woman's feet to catch any vaginal loss. ...Midwife and midwifery student laughing/talking quietly to each other. Midwife explains to the partner how contractions slow down at this stage. Both midwife and midwifery student crouching down looking at woman's genital area and anal pouting as the woman pushes. Woman gently moaning during contraction. Midwife to midwifery student "...she is comfortable. ...Midwife to woman "All your hard work has paid off [woman's name]. Baby is happy too." ...Midwifery student to woman "Good girl. That was an excellent push. Only push with the pain [woman's name]..." Partner stroking woman's lower back (circular motion), smiling at midwife, then looks intently at woman's face. Contraction - involuntary pushing. Student midwife "Very good darling." Midwife "That's fabulous!" Midwifery student "Push. Push." Faeces and blood stained fluid dripping...onto blue sheet. ...No one touching the perineum. Hands hovering but not touching. Midwifery student turns on all room lights and says "Yes, that's better. Very good pushing darling." ...Midwife to woman "Are you OK? How are your legs? Are you OK to stand? No response. Midwife looking at partner and midwifery student says "She seems to be OK for now." Contraction – woman moaning quietly (totally focused within herself). Partner holding woman around top half of her body – comforting. ...All standing quietly. ...Contraction. Midwifery student "Very good, and again." Anal pouting, fetal head visible (about 7cm in diameter) at introitus. Midwife checks FHS. Midwife to woman "How are you feeling [woman's name], OK?" Woman says "Yes" quietly [Field notes, Observation 6].

The woman is encouraged and referred to by name, the partner has a participative role and receives reassurance and explanation, and maternal involuntary pushing is supported. Occasionally, the midwifery student does direct the woman to push but this is said in a quiet, gentle voice, which does not dominate or appear to influence the woman. A focus on the woman as an individual and a more equal partnership between all participants is evident in this second example. However, a shift in the balance of power is apparent when the room lights are turned on without the woman or partner being asked if they would like this to occur. The midwifery student is instinctively using a learnt practice and the midwife does not make comment.

Some clinical practices are thought to undermine maternal control, as Rose explains:

"...if you get them [women] pushing a lot earlier [in second stage]...they don't seem to have as much control in themselves and what they're doing. And they seem to depend more on their support people and midwives to tell them what to do cos they're getting tired." [Interview].

Despite this, most midwives direct women how and when to push during the second stage of labour. Vicki describes the meaning behind this practice:

"...you're just giving them some direction to use what their body's already doing" [Vicki, Focus group 3].

Midwives are in control during this situation and most women seem to strive to comply. Conversely, some midwives espouse waiting for the 'fetal head on view' as their routine practice when providing intrapartum care. However, stated individual midwifery practice does not always reflect everyday practice observed in the

birthing room setting. Maternal control, particularly during crowning and birth of the fetal head, is thought to play a crucial role in reducing perineal trauma:

"She has to control the breathing. She has to control the pushing – the expulsive force. It's critical" [Vicki, Focus group 3].

The majority of midwives feel that if they can *"Get the lady to control the delivery" [Vicki, Focus group 3]* the incidence and/or severity of maternal perineal trauma will be reduced following birth. The following observational extract provides a view of control surrounding the immediate birth of the baby. The maternal position is semi-recumbent on the bed. The woman speaks minimal English:

Midwife places the midwifery student's hand (three fingers) onto the fetal head and with the other hand places two fingers either side of the perineum (bracing the perineum). The midwife quickly puts her finger in the woman's vagina again, as the head moves forward as the woman is pushing. Midwife says to the woman "Slowly! Small push. Stop! Stop! And again." Partner translates. Midwife to the woman "Cough for me." The woman is breathing rapidly. The fetal head is born slowly... [Observation 9].

The woman and partner respond to the directions and needs of the midwife as best they can. The midwife's message of slow birth of the fetal head seems to be getting across to the woman. Maternal self-control is advocated by midwives as vital in reducing perineal trauma during childbirth:

"Guiding the woman through [birth to minimise perineal trauma]...is all about control, [the woman's] self-control – you are in control of yourself. It is very important because if they [the woman] have lost their control, that's when you [the midwife] have lost everything" [Biyu, Interview].

Anh explains that when a woman giving birth loses control:

"...they'll just push regardless of what you tell them to do because they're not going to hold back the pain. They just want the release of that pressure. ...they lose your [midwife's] guidance and then she's not listening anymore because she [the woman] is just vocalising so, you have to do what she wants – [what] her body's telling her to do basically. ...your [midwife's] first control is...to be able to control the baby's crowning. ...[If] you can't get her to listen to you...you are not controlling. You are literally letting the baby slip through the whole birth" [Focus group1].

This maternal loss of control is thought to compromise perineal integrity and Sally believes Asian women *"...are more difficult to control" [Focus group 4]* than Caucasian women. Conversely, Mary feels that it is not about the midwives actually having *"...control of the woman..." [Focus group 1]* during birth of the fetal head. It is that *"She's just tuned into you" [Focus group 1].* As a midwifery student, Elizabeth finds that:

"When they're [women] standing or squatting [during birth] it's like the midwives walking into the [birthing] room and [thinking] "Oh, she's in control – I'm not. Because she's not where I want her to be [on the bed]. So they back off a little bit [are less controlling]. I think it's harder to visualise the peri when people [women] are standing or squatting, or doing whatever they feel comfortable with. It can be harder because you can't get underneath [to visualise the perineum]. You're like - I don't particularly want blood in my eyes today" [Interview].

During the study only one woman was observed to be standing upright off the bed during second stage. No woman was observed giving birth in an upright position. Brenda mentions the importance of *"...including them [the woman] in all the decision making..." [Focus group 3]*, to support maternal control and help reduce

risk of perineal trauma. However, maternal decision making and ownership of labour and birth were rarely seen in Delivery Suite. The maternity care system limits the control afforded to women during intrapartum care and Vicki confirms that women *"...have to understand, they've got no choice..." [Focus group 3],* particularly when there is an increased workload. Midwives recognise when Delivery Suite is busy they are unable to provide the care women need and the current maternity system, Colette feels, is *"...like a little factory – you're in [the woman] and you're out, and that's it" [Interview]*.

OWNERSHIP OF BIRTH SPACE

The interior of the birthing room is usually an unfamiliar place to the majority of women and support people. During birthing room observations, parental room ownership was seen to consist of an occasional radio or CD being played in the background, which was largely controlled by the partner. Otherwise, no other form of maternal birth space ownership was identified. The birthing room environment was observed as being usually under the control of the midwife for example:

Midwife (2) enters the room, walks over to the light switch and turns the lights on fully [Field notes, Observation 7].

The opinions of the woman or partner regarding change to the room environment are not sought in the above observation. Occasionally some midwives consider the environmental needs of the woman:

...room semi-dark (some lights turned off). Woman is lying on her right side on the bed, with the bed head slightly raised.... ...Midwife to woman "I will just put the big light on so, I can see if anything is there (turns lights on). Oh, sorry. I just need to see if I can see anything. It's a bit bright" [Field notes, Observation 10].

Others do not, as it is common practice to turn on all room lights during the second stage, especially when birth of the baby is close. Most women are not consulted when this change in birth environment occurs, for example:

The majority of the room lights are turned off (the room is dark). Just the bathroom and one room side light is turn on. Very quiet in the room. Midwife walks into the room and turns all the room lights on, raises the bed and moves the birthing trolley close to the bed. Midwife says to the woman "You don't have to lie on your side. You can stand up, sit on the toilet – whatever makes you feel comfortable. If you feel like pushing you can push." Partner translates to woman [in an Asian language]. The woman is lying completely flat on the bed with legs resting to the right side – tilting the fundus. The lower half of her body is covered with a sheet [this is removed] [Field notes, Observation 12].

The woman remains on the bed, is physically turned to a semi-recumbent position by a second (more experienced) midwife and stays in this position for birth.

Some midwives are aware of the importance of the need for maternal privacy during childbirth. Unfortunately, the need for privacy within the birthing room is not guaranteed as noted in the following observation:

Maternal position is on the bed, semi-recumbent, legs flopped apart (like a frog). The midwife enters the birthing room, half sits on the bed, facing the woman and says "...big push now." The woman is groaning, making small sounds/gasps at the end of each push. Someone (not in uniform) walks into the room, asks the midwife to sign something (says sorry), gives the form to the midwife to sign, then takes it back and walks out of the room. As this occurs, the woman opens her eyes wide, raises her head and looks as the person walks into the room. When the person leaves the room the woman rests her head back against the pillow, eyes close, relaxes again, lips slightly apart. Another contraction [Field notes, Observation 14].

The woman's facial expression was one of fear. She had no control, was physically fully exposed and vulnerable. There was no maternal advocacy - no one advised the person not to continue entering the room. The curtain usually pulled across the room door to enhance privacy was in place. No one observed the woman's fearful expression or body language – they were looking at the person who had just walked into the room. Other observed intrusions of maternal privacy prior to birth included midwives knocking on the door, entering the room and asking the often heard question of *"Can I have the [medication cupboard] keys?" [Field Notes, Observation 8]* to a midwife walking into the room and saying *"Sorry, I have to get something." No one looks or says anything to her [Field notes, Observation 17]*. Privacy can also be linked to practical aspects of individual midwifery clinical practice such as:

"I don't do a lot of VEs as such. I am not a believer in [pause] – personally [I feel] it's an invasion of a woman's privacy. I do feel that quite strongly. And it's just, you know, I'm a woman [laugh] and I think 'Is this really necessary?' So, I try to avoid doing too many if I can" [Colette, Interview].

Some midwives feel a lack of maternal consultation and consideration regarding the birthing room environment is *"...an obstetric practice, not midwifery practice..." [Brenda, Interview],* with a significant number of midwives forgetting that *"...it's her [the woman's] experience, not ours [midwives]" [Brenda, Interview]*.

SUMMARY

This chapter explored interpersonal relationships within the midwifery cultural group working in Delivery Suite. As a cohesive group of experienced midwives who

have worked together for many years, they are protective of their clinical practice. Most are challenged by new practices they hear being discussed or observe being practiced by less experienced midwives and midwifery students in the birthing room setting. Attempting to minimise perineal trauma for Asian women is associated with an ongoing clinical practice evolution embedded in the power and control dynamics within the midwifery cultural group in Delivery Suite.

Perineal integrity is an important focus for midwives, with peer pressure and occasionally, shaming and blaming tactics being applied in an attempt to maintain what are understood to be safe standards of clinical practice. Midwifery power and control is significantly curtailed when a maternal medical referral is initiated. Discretely circumnavigating the rules of organisational policy is a known midwifery practice strategy to facilitate normal vaginal birth. This midwifery initiative aims to reduce the risk of instrumental birth, with associated reductions in the incidence and severity of perineal trauma. Placing power and control into the hands of the woman during childbirth is an unrecognised practice for most midwives.

The following discussion chapter considers the implications of the findings of this ethnographic research.

CHAPTER 8

DISCUSSION

Chapters 4-7 described the meaning behind midwifery practice when providing intrapartum care for Asian women in Australia. The ethnographic results have highlighted a context of care in which reducing perineal trauma is viewed by midwives as one aspect of optimising childbirth for Asian women in Australia. This study clearly revealed the broad cultural impact of a fragmented maternity system on midwives and Asian women in a Delivery Suite. Midwifery practice culture provides an illustration of the care surrounding and experienced by Asian women during the second stage of labour and birth. Patterns of routine care and behaviour revealed attitudes, values and beliefs that left the midwife in control of childbirth rather than the woman.

When this study commenced, national (Dahlen & Homer 2008; Dahlen, Ryan, et al. 2007) and international (Guendelman et al. 2006; Handa, Danielsen & Gilbert 2001; Kudish et al. 2006; Kudish, Sokol & Kruger 2008) research had identified Asian ethnicity as a significant risk factor for severe perineal trauma during vaginal birth. A recent systematic literature review examined whether Asian ethnicity was an independent risk factor for this childbirth complication (Wheeler et al. 2012). Current evidence was found to lack clarity in determining why Asian ethnicity increased vulnerability for this birth trauma. My review (Wheeler et al. 2012) highlighted that commonly cited unknown risk factors need to be identified if the incidence and severity of perineal trauma in Asian women is to be better managed. For the first time, ethnography provided an opportunity to explore every day

midwifery practice in caring for Asian women during the second stage of labour and birth, within a hospital based Delivery Suite setting in Australia.

This chapter explores the impact, on a midwifery practice culture, of long term exposure to the current maternity system and model of care in an Australian Delivery Suite within an acute hospital setting. The influence of midwifery care practice on the Asian woman's childbirth experience and perineal integrity are considered and alternative care strategies are presented. New ways of thinking are presented to enable the reframing of midwifery intrapartum practice culture within an acute hospital setting.

A FRAGMENTED MIDWIFERY CULTURE OF CARE

This ethnography revealed a midwifery culture of care that sustains a fragmented maternity system. The system was seen to shape midwifery behaviour and practice, and influence the Asian woman's experience and outcomes during childbirth. While midwifery led continuity of care is known to confer significant benefits to the birthing woman such as, less medical intervention and a reduced incidence of episiotomy (Hodnett, Downe & Walsh 2012; Sandall et al. 2013), the system of care identified in this study ensured that there was no continuity of carer throughout the maternity experience. Midwives were rostered to work within different areas of practice (ANC, Delivery Suite, Postnatal Ward, Special Care Nursery), with a few rotating through each department. This marginalised Asian women and reduced their ability to be in control of the birthing process. The system imbalance undermines maternal satisfaction (Hodnett, Downe & Walsh 2012; Sandall et al. 2013) and prevents midwives from working within their full scope of practice

(Homer et al. 2009), reflecting the everyday reality of most midwives practising in Delivery Suites in Australian hospitals.

Within Delivery Suite, a culture of care permeated with attitudes, values and beliefs driving behaviour that at times were in opposition to midwifery best practice. Maternal disempowerment and lack of ownership of childbirth was common practice. Consequently, Asian women displayed varying degrees of submissive behaviour, compliance to the system and to the midwife providing intrapartum care, similar to behavioural features identified by Priddis, Dahlen and Schmied (2011) in Caucasian women. Midwives were aware they were continually facing and working against barriers created by a fragmented system that could adversely affect women's childbirth experiences and outcomes. This ethnography revealed how such a fragmented system created tension for midwives to conform to the parameters of medicalised care, thus amplifying risk for Asian women during childbirth. McLachlan et al. (2012) confirm a potential cascade of negative maternal experiences and outcomes such as, an increased risk of caesarean birth or perineal trauma, as the unfortunate consequence of this historical placing of normal childbirth for well women into medicalised care. The findings of this study enforce the notion of a fragmented medicalised system.

There is national (Homer et al. 2009; Reiger & Lane 2009) and international (Blaaka & Eri 2008; Gagnon 2011; Pollard 2011; Seibold et al. 2010) evidence that describes how the fragmentation of care and working alongside a dominant medical culture deskills midwives. Midwives in this study viewed the focus of their practice as supporting normal birth and yet they tended to integrate a medicalised philosophy within their own practice. This blended, midwifery-medicalised care was

paternalistic and further disassociated the role of the women. For example, the majority of Asian women participants were surrounded by a culture of care where the focus was on the system, midwifery practice was controlled by medically based policies, midwives directed birthing room events and maternal compliance was expected.

Many studies have reported that a medicalised workplace culture is known to compromise the midwife's ability to facilitate normal birth and increase the intervention rate for healthy women (Priddis, Dahlen & Schmied 2011; Seibold et al. 2010). Midwifery practice philosophy views childbirth from an attitude of confidence, knowing that for the majority of women, childbirth is a safe, normal, physiological experience and risk can be stratified (Australian Nursing & Midwifery Council 2006; Gagnon 2011; International Confederation of Midwives Council 2005). A medicalised practice philosophy is antagonistic towards midwifery philosophy, given that it is based on an acute care risk aversion approach, as childbirth is considered potentially pathological (MacKenzie Bryers & van Teijlingen 2010). Consequently, once midwives have been acculturated into a medicalised model of care they experience difficulties when attempting to realign their practice to a midwifery philosophy (Gagnon 2011). Therefore, it can be assumed that midwives working within a medicalised model are at risk of being assimilated into a philosophy of care, so affecting how they view practice.

Within this fragmented culture, midwives must adhere to medicalised policies that regulate the timing of care. However, midwives can interpret these policies within their broadest framework, or beyond. This provides midwives with some informal capacity to support normal variation in the birthing process in line with women's

needs thereby, decreasing the risk of medical intervention and increasing opportunities for normal birth. The midwife's ability to independently support the woman through the second stage of labour and birth are constrained within a culture where timing gives no consideration to the normal birthing process and the need to provide woman centred care.

Midwives, within this culture of care, lacked any perception of authority outside their own group and, at times, had to covertly initiate practice rather than openly confer with medical officers. Often cited in research (Hobbs 2012; Van kelst et al. 2013), this covert behaviour reshaped practice and childbirth outcomes, without midwives having to directly challenge medical officers, or the system. This type of behaviour occurs when group members believe the dominant group are secure in their control and there is no other way (Haslam, Reicher & Platow 2011). This underlines the powerlessness felt by the midwifery group to initiate practice change in this fragmented model of care and their perceived lack of authority within the hospital organisation.

BUILDING THERAPEUTIC RELATIONSHIPS

The findings of this ethnography identified that the fragmentation of care reduced the midwife's and woman's ability to establish a therapeutic relationship. In order to establish and sustain such a relationship, Delivery Suite midwives need to be familiar with the individual childbirth needs of women. Antenatal birth plans provide midwives with an opportunity to understand the woman's birth expectations and needs (Kuo et al. 2010) particularly when there is a language barrier. In contrast, the ethnographic findings identified that maternal birth plans, or documentation related to individual requests during childbirth, were not evident

within the Delivery Suite. Consequently, individual birthing needs were unknown until arrival in Delivery Suite (usually in labour), but commonly were not pursued by midwives providing intrapartum care.

When arriving in the Delivery Suite, it was normal that this was the first time the woman and midwife had met and the first time the woman had stepped into the Delivery Suite environment. In this system, women lacked control and the ability to make requests or decisions in relation to care, which compromised the therapeutic relationship. Typically for Asian women within this culture of care, it appeared their unmet childbirth needs had the potential to increase the risk of perineal trauma. Midwives knew that a therapeutic relationship would help curb maternal fear, improve the birth experience and decrease the risk of poor birth outcomes. A measure of the quality of care within this health system is the midwife-woman relationship (Bharj & Chesney 2010; Hodnett et al. 2011; Howarth, Swain & Treharne 2011; Hunter et al. 2008; Lundgren 2007; Walsh & Devane 2012). However, there was evidence within this ethnography that in the absence of an effective relationship there is added risk that midwifery practice could contribute to escalating and/or sustaining fear in women, which is known to increase the risk of perineal trauma (Lindgren, Brink & Klinberg-Allvin 2011).

The results of this study demonstrate that within Delivery Suite, a midwifery acceptance of the medicalised care model, fragmented midwifery practice and created barriers to woman centred care. As a result, some midwives, in facing fragmentation challenges, would direct practice to try to enhance woman centred care by controlling and overcoming problems created by the system thereby, enhancing therapeutic relationships.

TRUST AND COMMUNICATION IN MIDWIFERY PRACTICE

The ethnographic results revealed effective communication between the midwife and Asian woman was considered essential when trying to reduce perineal trauma and build a trusting relationship. Within this ethnography, maternal fear was seen to significantly escalate when the midwife was unable to communicate and so, failed to develop a trusting relationship. Communication barriers influenced the ability of the midwife to develop trusting relationships with the women.

During the study the majority of Asian women were unable to speak, or were not fluent in, English. The study also identified that all women, with English as a second language, reverted to their first language during the second stage of labour and birth. This suggests that women from a non-English speaking background, though able to speak English, may be further challenged during childbirth by needing to communicate in their first language. This means that women, with English as a second language, will potentially experience difficulties communicating with the midwife during the second stage of labour and birth. The importance, therefore, of support people for this vulnerable group may be critical in ensuring that a communication link between the attending midwife and woman is sustained. Access to hospital interpreters within the Delivery Suite would go some way to addressing this issue.

Within this study, no woman was provided access to a hospital interpreter during childbirth. The presence of an unknown face-to-face interpreter in the birthing room during the second stage of labour and birth was thought not to be helpful for the woman or midwife. At the same time, Delivery Suite midwives were conscious that

the inability to establish trust and effective communication with the women at this crucial time would significantly increase the risk of severe perineal trauma.

An inability to effectively communicate during childbirth has the potential to negatively impact on a woman's experience and create difficulties for the midwife providing care (Puthussery et al. 2008; Straus, McEwan & Hussein 2009). White, Oosterhoff and Nguyen (2012) draw a vivid picture of the importance of partner and family participation, and support during birth, for one ethnic group of women unable to speak the main language of their country of residence. The authors identified how easily a healthcare system can undermine birth traditions and the ability of women to communicate. Hofstede (2001) explains how being separated from a familiar culture and not being fluent in a country's language, could force women into an outsider role, restrict understanding of contexts such as, a Delivery Suite, and depending on level of acculturation, has the potential to trigger distressing physical and social symptoms of culture shock. Furthermore, any intercultural communication could miss the intricacies and contextual meanings behind conversations, which strengthens the argument for the need to access interpreters within Delivery Suite (McCarthy et al. 2013).

Midwives have a professional responsibility to assist women and support people in being able to effectively communicate with health carers during childbirth (Australian Nursing & Midwifery Council 2006; World Health Organization (WHO) 2006). Not offering the services of a hospital interpreter can be considered unethical practice (Torres & De Vries 2009). However, the usefulness and how, and when healthcare interpreter services should be accessed during childbirth, appears to vary for midwives and women, and may be culturally dependent (Puthussery et al.

2008; Straus, McEwan & Hussein 2009). Further research on this topic is required and could explore the interaction between midwifery and women from different cultural backgrounds (whose first language is not the main language of their country of residence), cultural acceptance of the presence of support people, and the use of healthcare interpreters during intrapartum care for minority ethnic groups.

On first contact with maternity services, midwives, educators and managers need to consider development of communication resources for all women, with English as a second language. Following community consultation, these resources should be designed to assist and support effective communication between the woman and health carers throughout the maternity experience. Maternal, hand-held communication resources such as, mobile phone verbal translation apps could enable documentation of an individual birth plan (in both the woman's first language and in English) developed between the woman, the health professional providing antenatal care and an interpreter as required. The original copies of the birth plan would be filed in the healthcare records to be accessible when the woman arrives in Delivery Suite. Availability of mobile phone verbal translation apps throughout maternity services for example, ANC, Delivery Suite and birthing rooms could facilitate midwifery-woman communication, understanding and rapport. Communication resources will support continuity of care, the development of trusting relationships and facilitate a more woman focused approach.

Midwives in Delivery Suite, by becoming more aware of the woman's individual childbirth requests, will enhance the midwife-women relationship and practice environment. One strategy to enhance communication between midwives and women would be the development of culturally specific education programmes.

Maternity services could target their top, non-English speaking presentation groups to identify traditional birthing customs. The focus of these programmes needs to be on knowledge concerning cultural needs, requirements and sensitivities. It would be important to involve the community and consumers to ensure the integrity, relevance and contents of the programme for women giving birth.

The study has highlighted the challenges of poor communication and how this can impact on a midwife's ability to build trusting relationships. If midwives are to minimise risk of perineal trauma and build a trusting relationship, different communication resources need to be implemented to improve childbirth outcomes.

THE PHYSICAL ENVIRONMENT OF DELIVERY SUITES

The ethnography identified issues with the physical environment of care which influenced maternal childbirth experiences and outcomes. Many authors have suggested the need to restructure the physical environment of Delivery Suites situated within acute hospital settings (Foureur et al. 2011; Lepori, Foureur & Hastie 2008; Odent 1984; Shin, Maxwell & Eshelman 2004). Foureur et al. (2011) advise how the physical design of a birthing room can reduce or increase the fear felt by women. This has a myriad of implications for birth outcomes, one of which is perineal integrity. The authors have developed an audit tool to compile information on the independent effects of Delivery Suite designs on birth outcomes and where women feel safe to give birth, as current evidence remains inconclusive (Hodnett, Downe & Walsh 2012).

The Delivery Suite in this ethnographic study was situated within a conventional, acute hospital setting. The physical environment of the Delivery Suite and birthing

rooms were designed and organised like other acute care clinical ward environments. The hospital bed was the focal point of each birthing room, a clock was on the opposite wall to the bed, clinical equipment was generally in full view, staff hand washing facilities were located outside the room, the door of each room opened directly onto the busy main Delivery Suite corridor and sounds from rooms could be easily heard, although the doors remained closed. On the positive side, an ensuite in each room included a toilet and shower, a curtain screened the room for privacy when the door was opened, room dimensions were generous and there was natural light from the double glazed external window. Midwives were comfortable in this familiar working environment where the routine patterns of practice and behaviour surrounding childbirth were enacted, with women mostly lying on the bed. As described by Lepori, Foureur and Hastie (2008) and confirmed by the ethnographic results, this clinical birthing room interior design was seen to influence Asian women and midwives to behave in ways which negatively impacted on the normal birth process. This may have increased the risk of poor birth outcomes, including the incidence and severity of perineal trauma.

The clinical interior design of the birthing rooms in this study may well be confronting for women from ethnically diverse groups and would be foreign to most women experiencing their first pregnancy. This birthing environment may contrast sharply with familiar, traditional birthing customs such as a home birth and being surrounded by family who assist with the birth (White, Oosterhoff & Nguyen 2012). These authors describe how deeply embedded childbirth customs for example, those associated with the birth environment, can be seen as essential from a cultural perspective, but may not be recognised or available in the hospital birth setting. For

example, the woman being able to experience labour and birth in a culturally safe, secure, silent environment, or use of a '*pieu'* (a cloth suspended from a beam) whilst in the squatting position for birth. If we are to achieve effective engagement with culturally diverse groups, then we need to work with women and their families in order to learn, identify and consider adapting safe, culturally specific needs for labour and birthing environments in Delivery Suites.

The findings of this ethnographic study demonstrated that the birthing room physical environment dictates the pattern of care, predetermining behaviour and interactions. Within this environment, midwives, women and support people have their place. The ethnography identified how quickly women and support people learn where their place is and what behaviour should occur. In order to better accommodate woman centred, individualised care there is a need to reconfigure the physical environment of Delivery Suites and birthing rooms to better support a philosophy of normal birth from the women's point of view. In this way, maternal fear can be minimised and greater development of a midwife-woman therapeutic relationship can be achieved.

The physical environment of one birthing room in this ethnography was different. There had been an attempt to change the room from being clinically imposing to a more home like environment by installing a low double pine bed and matching furniture. Midwives allocated this room only to women and families experiencing a stillborn baby. Otherwise, this room was not observed to be in use. Midwives avoided the use of a non-clinical birthing room design. Whilst there was recognition of the need to create a room environment that is more like home, they were uncomfortable in this environment preferring instead to practice within a more

clinical space. Alternative birthing room designs need to be considered by midwives, leaders and managers to reduce physical barriers and enhance engagement by midwives to practice in environments that support women during childbirth.

In addition, in modifying the physical environment, community and midwifery consultation is essential to ensure that birthing rooms are appropriately adapted to accommodate various physical environmental requirements of particular cultural groups. A birthing environment in which Asian women feel safe would improve the childbirth experience and reduce negative outcomes such as, significant perineal trauma. Women should be provided with opportunities to visit Delivery Suite and the birthing room environment to increase maternal familiarity, which may help to reduce fear. Locating staff hand washing facilities inside the birthing room would reduce the need for midwives to leave the room. Access to a telephone interpreter was not possible as there were no telephones installed in any of the birthing rooms. Telephones need to be readily positioned within all birthing rooms to enable woman to access interpreter facilities during childbirth. Delivery Suites need to ensure women and support people are aware they can access hospital interpreters, when required. Open access to interpreters should assist midwife-woman understanding, increase knowledge, reduce fear of the unknown and help minimise negative birth outcomes such as, severe perineal trauma.

COLLABORATIVE CONTINUITY MODELS OF CARE

The ethnography identified that there was a distinctive lack of collaboration within this context of care in relation to intrapartum decision-making. During these episodes, equal partnerships dissolved leading to medical decision-making being

dominant. This lack of collaboration created tension within midwives as they were forced to relinquish their personal philosophy of care. To enhance care practices different models are evident that better support a midwifery philosophy of care. One such model gaining significant evidence for improved outcomes for women is midwifery led continuity of care models within a hospital system. Sandall et al. (2013) in a systematic review, confirmed the safety and efficacy of midwifery led continuity of care models for women birthing within a hospital setting. Sandall et al. (2013) suggest that a caseload midwifery model positions the midwife as lead carer for a specific number of women, with a second midwife partner available if needed. Alternatively, another collaborative continuity model of care can be provided by a small team of midwives.

In contrast to medically-led or shared care model of care, hospital-based midwifery continuity of care collaborative models have been found to offer women significant benefits. For example, women are more likely to know the midwife providing care and to experience spontaneous vaginal births, with less birth interventions and episiotomies (Sandall et al. 2013). These positive birth outcomes support the notion that midwifery led continuity of care facilitates the midwife-woman therapeutic relationship, reduces maternal fear, strengthens ownership of childbirth and lowers the incidence, and severity of perineal trauma.

There are a variety of cost effective, midwifery led continuity of care models that could be considered (Devane et al. 2010; Hollowell et al. 2011). However, there is limited evidence regarding community based midwifery led models of care in Australian acute hospital settings (Monk et al. 2013). Monk et al. (2013) suggest that a hospital-based model of care may be a more feasible option in the current

social and political climate. It is clear that development and introduction of a locally designed hospital based midwifery continuity of care model, specifically for women with communication barriers, would help strengthen the midwife-woman therapeutic relationship, improve birth outcomes and strengthen collaborative care.

A collaborative culture between all health care disciplines will strengthen the safety and quality of maternity care (Downe 2010). Midwives in a continuity of care model would need to be working in partnership with the multi-disciplinary maternity healthcare team and be referring women as required. Reiger and Lane (2009) and Homer, Brodie and Leap (2008) advise that inter-disciplinary professional respect, trust, accountability and recognition of authority underpin an efficient collaborative approach to maternity care. Indeed, there is evidence and support for all maternity service disciplines to adopt a collaborative care approach for women of all levels of risk receiving maternity care (Australian Health Ministers' Conference 2011). However, national (Reiger & Lane 2009) and international (Downe 2010) evidence describes the difficulties commonly associated with achieving collaborative practice between disciplines working in maternity care services. Nonetheless, within this ethnography there were elements of a professional practice partnership operating within the Delivery Suite.

The ethnography found midwives re-establishing practice boundaries each time new trainee medical officers rotated into Delivery Suite. A medical referral for healthy women expecting a normal birth would occur if midwifery assessment identified concerns. Otherwise, medical officers were not required to enter the birthing room environment. Midwives were taking professional responsibility for the care of healthy women, with no identified medical or pregnancy complications. As

midwives provided intrapartum care for all women, the professional inter-personal 'boundary behaviour' had become part of normal practice culture.

Whatever a woman's level of risk, the inter-disciplinary ways of professionally relating to each other remained collegial and consistent between midwives and medical officers, regardless of seniority. The cohesive efficient way that midwives worked together, and communicated with all disciplines, generated a level of trust and respect from most medical officers. Midwives had managed to create their own version of an intrapartum midwifery led model of care and achieve a form of collaborative inter-disciplinary practice culture, within a fragmented medicalised system.

Working together was considered essential due to limited resources and staffing. A medical decision, however, was essentially not negotiable and midwifery authority was not recognised. As a result, a balanced interdisciplinary professional partnership did not exist in Delivery Suite between midwives and medical officers. Midwives were primarily leading the model of intrapartum care in Delivery Suite and yet there was a lack of recognition of collaboration and, more specifically, midwifery authority by management, the organisation and the medical profession. In moving forward, if collaborative practice and a more balanced interdisciplinary professional partnership are to be achieved, then midwifery expertise and authority need to be acknowledged and recognised within organisational cultures.

SOCIAL PROCESSES, INTERPERSONAL RELATIONSHIPS AND CHANGING PRACTICE

The ethnography revealed that the Delivery Suite midwifery group expressed frustration at the inability to change practice and yet at the same time, there was evidence of avoiding practice change. Social processes seemed to regulate behaviour within this context of care, whereby resistance to change emerged and tension escalated. Resistance was evident in the Delivery Suite, particularly when new knowledge and practices were being introduced. The behaviour that surfaced was most evident in experienced midwives, who chose instead to continue existing practices. This enabled a culture to emerge that avoided practice change and resisted the utilisation and translation of evidence. Hence, within this practice environment, experienced midwives had capacity to influence how evidence can be utilised and translated, placing at risk childbirth outcomes such as, perineal integrity, and potentially compromising women's experiences.

Interpersonal relationships within the midwifery group, in relation to perineal practices, were seen to circulate within three overlapping social processes. First, the cohesive subgroup of more experienced midwives was extremely protective of accepted and existing practice norms, with various influential strategies applied to maintain the practice status quo and behaviour. The second subgroup included the less experienced midwives and midwifery students who brought alternative philosophies and practices to the cultural group table. Tensions would surface as these groups interacted, although generally the experienced midwifery subgroup dominated, resulting in rejection of practice changes suggested by the second subgroup.

A smaller, third subgroup emerged within the study and was made up of a few less experienced midwives and students wavering between a desire to change practice or 'fit in' and remain aligned to the experienced midwifery subgroup. This resulted in sustaining a resistance to change and minimising the utilisation and translation of evidence. The subgroup of highly experienced midwives remained in control and hence could set the standards for acceptable practice in this unit. Not only were hospital staff exposed to this dominant culture of care driven by experienced midwives, but so were women, visitors and their families. Experienced midwives had created their own dominant hierarchy within the Delivery Suite. This hierarchical controlling behaviour had become part of normal hospital based midwifery culture.

The social division embedded within the Delivery Suite midwifery culture highlighted within this study, was also recently identified by Keating and Fleming (2009) in an Irish study conducted across three hospital maternity units. The study identified how the majority of senior midwives applied pressure to ensure midwives conformed to established medical care parameters thereby, protecting practice norms. Midwives, attempting to support normal physiological birth, perceived feelings of powerlessness, frustration and distress similar to the findings of this ethnography. Group pressure to conform to practice norms was also found in an earlier study, with midwives being described as an oppressed group and highly resistant to change (Kirkham 1999). Additional studies continue to describe similar patterns of behaviour by hospital based midwives towards midwifery colleagues and students (Begley 2001a, 2001b, 2002; Fenwick et al. 2006; Fenwick et al. 2012; Hobbs 2012; Hunter 2004, 2005). There is wide concern regarding the existence of

this midwifery culture of care within acute hospital settings such as, Delivery Suite. The continued dominance of this midwifery culture of care leads to resistance towards innovation, woman centred care and utilisation, and translation of evidence. Understanding why groups behave as they do would help to explain the evident struggle of midwives to maintain existing practice and avoid change.

ORGANISATIONAL CULTURE-TOWARDS BEST PRACTICE

The findings of this ethnography highlighted resistance to practice change and knowledge acquisition by midwives. The nature of an organisational, hierarchical culture, as in this study, acts as a barrier to change being initiated by midwives. As a consequence, motivation for change within this type of culture usually occurs from elsewhere rather than directly from clinicians providing care (Maden 2013). The ability to change and adapt is considered essential for organisational effectiveness and survival (Battistelli, Montani & Odoardi 2013; Price & van Dick 2012), however, this is not a feature of hierarchical organisational cultures, which include a multiple level structure and chain of command. Instead, hierarchical organisational cultures emphasise control, rules and standardisation (Jacobs et al. 2013; Suppiah & Sandhu 2011). Within the study, the hierarchical organisation culture meant midwives often, when trying to ensure normal birth, perceived feelings of powerlessness. A symptom of this organisational culture was powerlessness and acquiescence by midwives, demonstrated by body language and facial expressions, and surfacing as frustration in practice.

Dominant organisational cultures have been found to influence health care performance outcomes in acute hospital settings (Jacobs et al. 2013). Furthermore, an effective organisational culture is necessary for attaining knowledge acquisition

and innovation within the workplace (Liao et al. 2012; Wang, Su & Yang 2011). Application of three validated organisational cultural features of individualism-collectivism, power distance and uncertainty avoidance, enabled Wang, Su and Yang (2011) to identify the type of organisational culture that would be most supportive of knowledge enhancement and innovation. Organisational cultures incorporating features of high collectivism (focused on teamwork and cooperation), low uncertainty avoidance (tolerated diverse opinions and behaviours, and able to suggest alternatives to established practice routines based on new knowledge) and low power distance (facilitated people sharing knowledge and working together), were found to have the most effective knowledge creation abilities. In contrast, individualistic organisations (focused on individual goals, rarely shared knowledge), with high uncertainty avoidance (needed standardisation and sameness) and high power distance (task focused, avoided knowledge sharing, tightly controlled employee activities), were found to limit knowledge creation. Taking these features into account, the ethnography demonstrated an organisational culture within the Delivery Suite of low collectivism, high uncertainty avoidance and high power distance. This framework assists to clarify and explain why there appeared tensions within the Delivery Suite and between midwives towards practice change, knowledge acquisition, and innovation.

Organisational cultures that better support and sustain practice change, knowledge acquisition, and innovation could promote improvement in the woman's childbirth experience, and outcomes thereby, potentially reducing the incidence and severity of perineal trauma. It is apparent there is a need for organisational cultural change

within the acute hospital setting if Delivery Suites and midwives are to better meet the needs of women.

THE LEARNING ENVIRONMENT

The ethnography identified that within the Delivery Suite midwives practised in isolation thereby, reducing the impact of a learning environment. This has consequences that can jeopardise the quality and safety of care unless effective processes are in place that sustain an organisational learning culture (Cho et al. 2013; Oliver 2012). There was little evidence to support this notion throughout the ethnographic study. A supportive learning environment facilitates development of individual and group abilities to grasp the meaning behind best practice evidence, which sustains change (Garvin, Edmondson & Gino 2008). This would enable midwives to transform practice to go in whatever direction is safe and clinically appropriate in order to meet the needs of women and their families.

Throughout the study, many participants commented that they perceived they worked in isolation, often unaware of activities taking place within other birthing rooms. This situation compromises learning opportunities and stifles practice change, which can impact on childbirth outcomes such as, perineal trauma. Midwives were observed to be practicing in isolation in the birthing room and receiving no objective feedback from another clinician. Throughout the study, during the second stage of labour, it was common practice for midwives to be alone, providing intrapartum care for the woman until birth was imminent. In this situation, learning in the practice environment confers little advantage to the individual, team or organisation (Dayaram & Fung 2012).

Enhancement of the learning environment can be achieved through the use of feedback. The midwife was not able to receive objective feedback from the woman or support people. However, feedback is critical to the development of practice. Without feedback there is lack of insight regarding safety and quality of care (Battistelli, Montani & Odoardi 2013). Feedback on practice and behaviour is a proactive strategy that enables the individual to become aware of strengths, gaps and learning needs. Awareness of practice issues increases motivation to work towards solutions on safety and quality of practice. If practice issues are not identified there will be fewer incentives to initiate change.

Another strategy that can enhance the learning environment is a performance appraisal process undertaken within the organisation. Regular workplace feedback has been found to support positive behaviour towards change in people who are highly resistant to change (Battistelli, Montani & Odoardi 2013). Departmental performance appraisal between manager and individual midwives needs to occur in Delivery Suite if cultural change and a learning environment are desired. The effectiveness of an appraisal process in raising awareness of practice issues or motivating change in Delivery Suite is unknown. The learning environment within Delivery Suite could impact on the health of women (Bick et al. 2012; Ho et al. 2010). The failure to establish an effective learning environment has serious implications for translation of evidence into practice, particularly in relation to the quality and safety of care, including care of the perineum during childbirth.

Within the ethnography, practice for many midwives had become stagnant. A standardised organisational process was found to be dominant and, although new knowledge and practices were introduced to the unit, most experienced midwives

resisted practice change. Most midwives had not adopted recent practice evidence for minimising the risk and complications of childbirth and, in particular, for reducing perineal trauma. There seems to be a disconnection with the translation of evidence in practice.

The learning environment was noted to impact on all who transited through the Delivery Suite. Of interest was the impact of the learning environment on midwifery students and newly graduated midwives. Newly graduated outsiders found the majority of midwives had difficulty accepting alternate modes of practice. Depending on the individual midwife, even minor changes to the rituals of routine in the birthing room setting such as, dimming the lights had the potential to create a defensive response aimed at the student or recently qualified midwife. Most midwives within the Delivery Suite were unable to tolerate alternative practices that went against their own practice norms for example, using a non-touch technique for birthing the baby's head, or placement of hands to support the perineum during birth. Other midwives applied a less authoritarian stance, advising of 'their way' of doing things in practice.

Recently qualified midwives and midwifery students in this environment were not able to practice in the way they were taught and as a result, experienced discord between their own philosophy or practice preferences, and the practices they were pressed to adopt in this setting. These findings are supported by an Australian study (Fenwick et al. 2012) that identified how a Delivery Suite midwifery culture can significantly impact on novices workplace experience.

A midwifery culture of resistance to practice change in Delivery Suite ensured that not all women received evidence-based care during the second stage of labour and

birth. Midwifery team leaders and educators need to better develop departmental based learning environments by applying multiple educational strategies (Johnson & Kimsey 2012; Rangachari, Rissing & Rethemeyer 2013), which sustain education programmes targeting safety and quality of practice. Facilitating development of midwifery reflective practice skills is one important educational initiative that would increase insight into practices affecting perineal integrity.

It was evident throughout the study that reflecting on practice tended to decrease as the experience of the midwife increased. During interviews and informal conversations, it was not uncommon for facial expressions to change and pauses to occur when considering the evidence underpinning individual practice. It was apparent in the study that reflection on evidence described as supporting practice, rarely included awareness of current research recommendations. Development of reflective practice skills would provide insight into the effects of a variety of practices on the woman's experience and childbirth outcomes such as, the incidence and severity of perineal trauma.

Reflection on practice helps to clarify group values, beliefs and practice, which strengthens safety and quality of care (McCormack, Manley & Garbett 2006). Australian midwives are expected to be able to reflect on, analyse and learn from practice experience thereby, supporting ongoing professional development (The Nursing and Midwifery Board of Australia 2006). Reflective practice is embedded in the Australian midwifery competencies. This concept supports the development of analytical, reasoning and evaluative skills and is now considered an essential component of practice by numerous professions and organisations worldwide (Bakioglu & Dalgic 2013; Dawber 2013; Morgan et al. 2013; Williams 2013).

Building midwifery skills in reflexivity would help raise awareness of best practice, current individual and group practice culture. A group problem-solving intervention provides individuals with an opportunity to gain insight and take ownership of their behaviour (Geldenhuys 2012). Building individual and group capacity for reflection on practice is an essential beginning step for midwives to reduce fear of the unknown and gain insight into the benefits of openness towards a variety of knowledge acquisition methods. Regular midwifery group case review meetings would stimulate discussion and reflection on practice. Non-threatening de-identified case reviews could help stimulate thought and raise questions regarding recommended best evidence for practice.

It is essential to ensure midwives are aware of current best evidence for practice and at the same time not take away their confidence to practice autonomously (Bick 2011). Development of skills to critically review research evidence would grow as they become familiar with the process. This learning process could be facilitated by midwives, educators and leaders, with the relevant expertise in reflective practice and ability to critically review current evidence on practice. As midwives become more confident in their review of current practice research, their ability to discern best evidence for practice would develop within the group.

Group feedback on the result of audits, from anonymous independently gathered stories of women's childbirth experiences, would raise awareness on how midwifery culture and practices are perceived by consumers. Furthermore, being able to recognise the impact and implications of embedded practice for women, support people, midwives and other disciplines may facilitate consideration of cultural change. It is important to encourage and assist midwives to participate and take

ownership of regular unit based learning initiatives. Empowerment of midwives is the vital ingredient (McCormack, Manley & Garbett 2006). Managers and leaders are able to provide support but, to be successful, midwives need to be aware, and have ownership of, these learning evidence-based practice initiatives.

Two reflective practice initiatives were available for midwives in Delivery Suite during the time this ethnography was undertaken. An 'Essentials Of Care' programme, supporting ongoing development and evaluation of clinical practice, was, and continues to be, available through the NSW health system (NSW Health 2009; NSW Ministry of Health 2013) . Underpinned by emancipatory practice, the programme framework promotes person centred care and aims to engage clinician participation in order to facilitate a culture of ongoing practice improvement and evaluation. Care evaluation includes maternal feedback (stories) and clinical audits via observation in maternity departments attended by independent auditors. There has to be clinician and managerial engagement within the programme.

The second learning initiative involved availability of reflective practice groups (RPG). This RPG programme was accessible for midwives and involved participation in regular confidential monthly group meetings, with the same trained group facilitator in a venue that was away from the clinical setting. Group size was limited to eight of the same attendees and attendance was voluntary. An RPG meeting would enable a midwife to raise a clinical issue or event related to an experience or observed practice situation. Supported by the group and facilitator, the midwife reflects on the clinical situation. RGP has been found to facilitate clinician reflexivity, self-awareness and positively affect practice (Dawber 2013; Long et al. 2006) and a variety of clinical reflective models (individual and group focused) are

being used nationally and internationally by various professions in healthcare settings (Bondas 2010; Lawlor 2013; Lynch & Happell 2008).

There was no evidence of midwives in Delivery Suite accessing either of these reflective practice programmes during the time this ethnography was conducted. Reflective practice skills, which include awareness of the impact of practice on the maternal childbirth experience and consideration of individual philosophy on practice, can support transformation of practice to achieve greater quality and safety of care (McCormack, Manley & Garbett 2006; The Nursing and Midwifery Board of Australia 2006). Successful implementation of these learning initiatives, however, is dependent on the existence of a supportive organisational and leadership culture towards clinician reflective change in practice (Bondas 2010; Lawlor 2013; Lynch & Happell 2008).

SOCIAL IDENTITY

Barriers to organisational and practice change can be formed by personal and group stress related responses to events (Lazarus 2006). This ethnography observed midwifery responses to perceived workplace stressful events. For example, some midwives were observed using coping strategies to alleviate anxiety caused by initiation of practices viewed as threatening the status quo. Use of overt or covert feedback towards the perceived 'deviant' midwife or student ensured realignment of practice to the existing ways. Situational demands were also observed to influence the way people coped with emotions (Lazarus 2006). Fluctuating workloads and level of staffing on an evening shift found midwives rushing from room to room trying to provide care for every woman. At times things were missed such as, monitoring maternal fluid intake. Women were often left alone – sometimes while

they were pushing. This was seen to generate midwifery and maternal anxiety. Occasionally, midwives were seen to become stressed or angry towards a midwife who had allowed this lapse in care to happen. The midwife was blamed for not working fast enough. Anxiety was deflected onto the individual, although organisational resources, processes or structure may have been the issue.

Individual or group anxiety is thought to be a key barrier to practice change (Baker et al. 2009). Anxiety levels influence the characteristics of an organisation and change is known to disrupt systems supporting containment of anxiety (Geldenhuys 2012). Therefore, using defensive individual or group behaviours to avoid practice change is an unconscious way of decreasing anxiety and holding onto control.

Kirkham and Stapleton (2000) describe how midwives could view practice change as threatening, particularly when there is a perceived lack of professional influence within the workplace. As a high level of workplace autonomy and regular feedback on performance is known to support a reduction in anxiety and enable innovation in practice (Battistelli, Montani & Odoardi 2013), organisational leaders should consider incorporating these workplace change initiatives. Such workplace modifications in midwifery autonomy and regular feedback on practice will require organisational and tertiary support from midwives, leaders, managers and educators as midwifery makes its way towards a modified social identity in practice.

The ethnography demonstrated that within this Delivery Suite, midwives had created a social identity which scripted behaviour, values, attitudes and beliefs towards practice, women and the organisation. This group had the power to (re)shape the values, attitudes, beliefs and behaviour of their members and were able to alter the way their group related to other groups (Buchanan & Huczynski 2004).

This midwifery-oriented, formal 'psychological group' offered the individual midwife shared goals and a sense of identity. Midwives were aware, or became aware, of expected group behavioural norms and there was dependency upon each other to function efficiently as a group.

Being able to predict each other's behaviour supports the stability of group behaviour (Buchanan & Huczynski 2004). Highly influential informal 'psychological groups' naturally develop within formal organisational groups when people start to socially interact. Hence, it is not unexpected to be able to identify the nature of this group within the participants of the study, which enabled the cohesive, tightly knit subgroup of the more experienced Delivery Suite midwives to surface. Midwives strongly identified with this informal 'psychological group', which encouraged the individual to learn and conform to group norms (Hogg, van Knippenberg & Rast III 2012). This type of informal group tends to focus on autonomy and basic needs such as, self-esteem (Buchanan & Huczynski 2004). Informal group hierarchies support development of individual and group identities.

As a group, Delivery Suite midwives relied on each other and generally worked well together. The subgroup of experienced midwives trusted and supported each other. Knowing and working together for many years enabled an awareness of individual practice strengths and weaknesses. Known practice weaknesses had the subgroup supporting the individual midwife, when necessary. The subgroup cohesion and demarcation from the main midwifery group enabled experienced midwives to enjoy the benefits of both groups. The emotional and goal directed support provided by workplace relationships was important (Adams & Crafford 2012).

Goal conflict was experienced most days in Delivery Suite, when departmental resources did not support midwifery philosophical approaches towards normal birth. Alternative goals were chosen until the workload enabled a return to preferred behaviour (Unsworth, Dmitrieva & Adriasola 2013). This could partially explain the difference in preferred practice described by midwives compared to actual practice observed in the birthing room setting. Furthermore, over many years some midwives had unconsciously altered their philosophies to meet the needs of the medical and hierarchical organisational culture and structure, therefore, what they think they do may not be what they actually practice.

The main organisational social identity sources for Delivery Suite midwives were within the group. Any change that may undermine social identity could be perceived as a threat by the group (Gover & Duxbury 2012), particularly if the group holds a lower status level within the organisation (Callan et al. 2007). Lower status groups are less open to change and more insecure than higher status groups. When people feel threatened they have greater difficulty adjusting to change – a behaviour pattern identified in this ethnography. Perceptions of threat evoke negative emotions that can lead to undesirable behaviour. The evidence of a negative group behavioural response to change could again partly explain midwifery resistance to practice change within the study. Hence, midwifery social identity can influence values, attitudes, beliefs and behaviour, and sustain or resist organisational culture. A situation well described in the literature (Hughes, Deery & Lovatt 2002; Pollard 2011).

Callan et al. (2007) and Gover and Duxbury (2012) highlight the importance of social identity for groups, and individuals, and describe how this can impact on

change initiatives within organisations. Providing organisational support for both the current and new social identities during a change process may be one way of reducing a midwifery group perception of threat on personal or group status (Gover & Duxbury 2012). This could help facilitate the process of organisational change, acquisition of knowledge and strengthen group identity.

Group identity strengthens as shared goals are realised, with leadership playing a significant role in identity formation (Thomas, Martin & Riggio 2013). A strong midwifery social identity can support transformation of practice (Haslam, Reicher & Platow 2011). This could be achieved by a midwifery clinical leader, recognised by the group as being a group advocate, working together with midwives to (re)shape practice and provide guidance through the change process. Leadership guidance should be based on, and correlated with, collective group decisions made before commencement of any change process in Delivery Suite. With organisational support, inclusion of all key professional groups will facilitate the change process and help strengthen a collaborative culture in maternity services (Downe 2010).

The clinical midwifery leader should be seen by the midwives as being part of, and a representative of, their group and be fully aware of what is important to the group. Based on a social identity theory framework, this democratic collaborative process of group decision making strengthens the group and the leadership (Haslam, Reicher & Platow 2011). The clinical midwifery leader needs to ensure the midwifery group is fully aware of the social identity methods being employed and should focus on strengthening group cohesion, and a shared identity as the change process proceeds. To this end, education programmes for current and future leaders should facilitate

understanding on how the focus of leadership should be based on social identity theory and practices.

A change process in Delivery Suite, based on a leadership social identity framework, will support midwives to modify and strengthen their organisational group social identity. This will enhance midwifery knowledge acquisition and practice change thereby, opening up opportunities for intrapartum best practice and change in midwifery models of care for Delivery Suites situated in acute hospital settings. In this way, it is conceivable that all midwives will have an increased capacity to view the childbirth experience through the eyes and ears of all women. Placing the woman at the centre of care in an emotionally and clinically safe environment (El-Nemer, Downe & Small 2006), would promote the quality and safety of care, improve childbirth outcomes and reduce the likelihood of severe perineal trauma.

STRENGTHS AND LIMITATIONS

ETHNOGRAPHY- LIMITATIONS

There are a number of limitations for this study. This ethnography was conducted with only one group of Delivery Suite midwives, in an acute hospital setting located within metropolitan Sydney. Whilst the data may be limited in generalisability, the fact that all midwives working in Delivery Suite consented to participate in the study strengthened veracity of findings. Additionally, the range of participant clinical experience (novice to more than three decades) strengthened study findings and will resonate with clinicians.

The context of intrapartum care provided in tertiary, regional, rural or remote hospital settings, or alternative models of midwifery care were not portrayed by this study, therefore, implications of study findings are limited for these settings.

During the study observations, midwives would leave the birthing room for a variety of reasons such as, providing intrapartum care for other women. Consequently, the midwife was mainly observed in the birthing room caring for the Asian woman. There may have been other activities and processes not observed, therefore, the findings present only one interpretation of every-day care activities.

There is a possibility that a midwife's practice behaviour may change when under direct observation (Hammersley & Atkinson 2007). Prolonged field work, however, increased familiarity, appeared to gradually build a sense of trust and acceptance, so reducing tensions that may have affected behaviour.

Another limitation is that women participants and support people were not interviewed, so assumptions have been made about what they thought, or were feeling.

Future research could consider replication of this study, within a variety of national and international childbirth settings, including tertiary, regional, rural and remote contexts in Asian and Western countries. In this way, research limitation and bias could be reduced, and findings of this study could inform midwifery practice. Ultimately, this would improve outcomes and experiences during childbirth for Asian women.

STRENGTHS OF ETHNOGRAPHY

This ethnographically informed thesis demonstrates the value and strength of undertaking clinical research and immersion in practice using this methodology. More specifically, the ethnography has assisted in uncovering everyday practice relating to perineal trauma in Asian women, within a clinical setting. Ethnography enabled the world of clinical practice, and one culture-sharing group of Delivery Suite midwives in Australia, to be made visible. The realist style lens of ethnography was chosen to provide an authentic cultural description of contemporary midwifery practice. Ethnography enabled the researcher to directly observe, hear and feel what was going on in everyday practice in order to learn and understand how and why midwives do what they do (Fetterman 2010; Van Maanen 2011). The ethnographic findings give voice to this midwifery group, within the context of their everyday working environment.

An additional strength of ethnography is in the detailed and rich description of the context of practice which arises from prolonged fieldwork (Fetterman 2010; Stewart 1998). Two years of fieldwork (as evident within this thesis) provided sufficient exposure to experience, learn and understand the midwifery role of caring for Asian women and reducing perineal trauma during childbirth. Prolonged ethnographic fieldwork enables development of positive field relationships thereby, enhancing the rigour and validity of the study.

Ethnography enables comparison of data from multiple sources and broadens the context to inform findings. The triangulation of ethnographic data (observation, interviews and focus groups) strengthened the credibility and validity of findings (Bryman 2004; Burns & Grove 2005; Fetterman 2010; Hammersley & Atkinson

2007; Rock 2008; Stewart 1998; Van Maanen 2011; Wolcott 2008). An ethnographic lens enables the researcher to obtain a view of individual and group practice, providing glimpses of multiple layers of reality coexisting and operating to influence practice. Ethnographic use of detailed field notes offers rich insight into everyday roles and activities compared to other methodologies, so strengthening veracity of findings. An ethnographic framework increases data reliability and validity, and provides time to gain knowledge, maintain accuracy, and strengthen understanding of the culture being explored (Silverman 2006).

Ethnography provides for intense consideration of the data which leads to greater understanding of phenomena (Fetterman 2010; Silverman 2006; Stewart 1998). Contemporaneous data collection and transcription offers opportunities for learning, reflection, and building understanding of cultural norms and differences in the everyday milieu surrounding practice culture. Ethnography facilitates immersion in the data (in and out of the field), enabling more realistic analytical reasonings, comparing and contrasting within the data, gaining of insights, and theorising. Ethnographic techniques such as, interrater checks adds rigour to the interpretive phase of the research process. A process of interrater reliability enhances trustworthiness of ethnographic findings (Silverman 2006).

TRANSFORMING PRACTICE: IMPLICATIONS AND RECOMMENDATIONS

From this ethnography there are a number of implications and recommendations that can support the transformation of practice to enhance the experience for both women and midwives. Five key areas have surfaced from this ethnographic study

which support change within Delivery Suite practice. The ethnographic study presented in this thesis provides implications and recommendations for clinical practice, education, organisational management, policy and research.

CLINICAL PRACTICE

The ethnographic study has implications and recommendations for future clinical practice. The following implications and recommendations are based on this ethnographic study:

- Care should be individualised and centred around the woman, and significant others
- Following community consultation, development of communication hand-held resources for antenatal women (whose first language is not English) needs to occur. Multi-lingual birthing room midwife-woman-support person communication resources could take the form of laminated cards and posters.
- Antenatal birth plans should be translated into other languages. Completion of a birth plan by the woman should be facilitated by the midwife and hospital interpreter.
- Alternative birthing room designs need to be considered to reduce physical barriers and enhance engagement of midwives to practice in environments that support women during childbirth.
- Locating staff hand washing facilities inside the birthing rooms will reduce the need for midwives to leave the room.

- Telephones need to be installed in each birthing room to ensure maternal and midwifery interpreter access.
- A locally designed hospital based midwifery continuity of care model, specifically for women with communication barriers, should be designed following consumer and midwifery consultation.

EDUCATION

The ethnographic study has implications and recommendations for future educational initiatives. The educational and learning implications and recommendations of the ethnographic findings include the following:

- Simulations of best practice such as, supporting women experiencing a normal physiological birth and reducing perineal trauma, should occur regularly in Delivery Suite.
- Multiple educational strategies are required to target safety and quality of practice. Supportive professional development and educational resources for midwives are required to facilitate reflective practice skills, the ability to critically review research, expand computer skills and conduct regular case reviews.
- Maternity services should identify the traditional childbirth customs of their top non-English presentation groups. This programme would focus on knowledge of women's cultural needs, requirements and sensitivities. Consumer participation would lend relevance to presentations.

- Educational programmes for midwives should be developed focusing on current midwifery philosophy, woman centred care, continuity of care and the enablers and barriers for a normal physiological birth.
- Education programmes for current and future leaders should facilitate understanding on how the focus of leadership should be based on social identity theory and practices.

ORGANISATIONAL MANAGEMENT

The ethnographic study has implications and recommendations for future organisational management. The management implications and recommendations of the ethnographic findings include the following:

- Midwifery leadership should involve a midwifery clinical leader, with interpersonal skills to be seen as part of the midwifery group and be conversant with a social identity theory framework, and practices.
- Those planning and managing maternity services should consider alternative midwifery models and directions for care. Consumers, midwives, medical officers, managers and leaders providing clinical care should be involved in the development of locally appropriate models of care.
- Midwifery expertise and authority need to be acknowledged and recognised within organisational cultures.

POLICY

The ethnography has implications and recommendations for future development of Delivery Suite policies and guidelines. The following implications and recommendations are based on the ethnographic findings and include the following:

- A collaborative, interdisciplinary approach will facilitate development of Delivery Suite and maternity inter-departmental evidence-based practice policies. This would support provision of coordinated, evidence-based maternity care.
- Midwifery autonomy needs to be evident within policies to reflect a midwifery philosophy of care supportive of physiological birth.

RESEARCH

The ethnographic study has implications and recommendations for future research. The following research activities are based on the ethnographic thesis:

- Studies need to be conducted within a variety of national and international childbirth settings, including tertiary, regional, rural and remote contexts in Asian and Western countries to compare findings with this thesis.
- Multi-centred studies are needed to identify appropriate communication resources to support woman centred care.
- Multi-centred studies are required to explore the childbirth experiences of women and families from culturally and linguistically diverse groups, within a hospital-based Delivery Suite setting.

- A research project should follow the design, implementation and evaluation of a locally designed hospital-based midwifery continuity of care model, specifically for women with communication barriers.
- Studies exploring the role of maternal fear in perineal trauma during vaginal birth are required.

FEEDBACK TO PARTICIPANTS

Midwifery participant and management feedback on the study progress and findings occurred throughout the research process. Observational and interview transcriptions were handed back to individual participants for verification. Towards the end of the study, focus group participants were advised of, and asked to reflect on, study findings. After leaving the field, midwifery participants were advised of the progress of the study process when contacting the researcher. The study site hospital and participants were aware that formal feedback on the study results would occur as soon as possible following completion of findings. The Director of Nursing and Midwifery of the study site and the Delivery Suite MUM were advised of the near completion of this thesis in December, 2013. Inservices will commence at the study site hospital Delivery Suite in early 2014.

SUMMARY

The findings of this ethnography will resonate with midwives in Australia, exposed to a traditional, hospital based Delivery Suite. The ethnography enabled a midwifery group's cultural knowledge and embedded patterns of behaviour, practice, language, values, and beliefs to be seen, highlighting the interconnected processes and activities within every day practice. A fragmented maternity system created tension

for midwives to conform to the parameters of intrapartum medicalised care, which increased the potential of severe perineal trauma for Asian women. Midwifery acceptance of this medicalised model fragmented midwifery practice and created barriers to best practice. In response, midwives had created their own version of a midwifery-led model of care in Delivery Suite by achieving a form of collaborative inter-disciplinary practice culture. This was seen as a way of distancing healthy women from a system and medicalised model that adversely affected childbirth experiences and outcomes.

Midwives were found to be positioned in a system and cultural context that conflicted with their philosophy of care. This led to deskilling of midwives and variation in practice. Practice was generally not evidence-based and change in practice was avoided. Midwifery-woman trusting relationships and effective communication links were considered key to supporting a reduction in perineal trauma for Asian women. The impact on midwifery practice culture and implications of long term exposure to a discordant system and model of care were evident.

The meaning behind midwifery avoidance to practice change was explored within this Delivery Suite context. This ethnography has uncovered some of the reasons why a midwifery culture may develop resistance to practice change and knowledge acquisition. Women rely on midwives to provide intrapartum care based on the best available evidence. Non-evidence-based practice and a focus on maintaining the practice status quo has the potential to compromise perineal integrity and significantly affect the quality and safety of intrapartum care. Therefore, it is

essential to consider characteristics within an organisational culture that may influence the capacity of knowledge acquisition and learning for staff.

An overarching framework based on leadership social identity theory offers midwifery, healthcare organisations, policy makers and governmental agencies an alternative approach for improving maternity services. The evidence for changing maternity systems towards a more democratic, collaborative, midwifery-led focus is compelling. A strong midwifery social identity can support transformation of practice, promote the quality and safety of care, improve childbirth outcomes and reduce the likelihood of severe perineal trauma for all women.

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APPENDIX 1: PUBLICATION

Wheeler J, Davis D, Brodie PM, Fry M, Homer CSE. (2012) Is Asian ethnicity an independent risk factor for severe perineal trauma in childbirth? A systematic review of the literature. *Women and Birth* 25(3):107-13. **DOI:** 10.1016/j.wombi.2011.08.003

Abstract

Objective: To undertake a systematic review of the literature to determine whether Asian ethnicity is an independent risk factor for severe perineal trauma in childbirth.

Method: Ovid Medline, CINAHL, and Cochrane databases published in English were used to identify appropriate research articles from 2000 to 2010, using relevant terms in a variety of combinations. All articles included in this systematic review were assessed using the Critical Appraisal Skills Programme (CASP) 'making sense of evidence' tools.

Findings: Asian ethnicity does not appear to be a risk factor for severe perineal trauma for women living in Asia. In contrast, studies conducted in some Western countries have identified Asian ethnicity as a risk factor for severe perineal trauma. It is unknown why (in some situations) Asian women are more vulnerable to this birth complication. The lack of an international standard definition for the term Asian further undermines clarification of this issue. Nevertheless, there is an urgent need to explore why Asian women are reported to be significantly at risk for severe perineal trauma in some Western countries.

Conclusion: Current research on this topic is confusing and conflicting. Further research is urgently required to explore why Asian women are at risk for severe perineal trauma in some birth settings.

Keywords: Severe Perineal Trauma; Anal Sphincter Laceration, Asian ethnicity, Episiotomy.

APPENDIX 2: STUDY INFORMATION (WOMAN)

SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

SUBJECT INFORMATION - PREGNANT WOMAN

Midwives' practices and perineal trauma in Asian women experiencing spontaneous vaginal birth.

You are invited to participate in a study that will focus on understanding what midwives do to reduce perineal trauma for Asian women during the second stage of labour and birth. Severe perineal trauma following vaginal birth can lead to short and long term problems for quality of life and wellbeing. Therefore, it is important to try and stop this severe trauma from happening. Asian women have an increased risk for this childbirth complication.

We hope to learn about midwifery clinical practice and what influences the incidence of perineal trauma, for Asian women, during the second stage of labour and birth. This study aims to develop recommendations for best practice principles for midwifery clinical practice during the second stage of labour and birth, in order to reduce the incidence of severe perineal trauma for Asian women.

The researcher, Janet Wheeler, is a postgraduate doctoral research student at the University of Technology, Sydney (UTS). Professor Pat Brodie, is the chief investigator of this study and supervisor of the student researcher.

You were selected as a possible participant in this study because you are pregnant and you are of Asian descent.

If you decide to participate, the researcher will observe and listen to what happens in the birthing room when you are in labour and give birth to your baby. The researcher will write down things they see or hear in the birthing room. It is estimated that the length of time observation will occur is between 2 to 3 hours.

There is no reason to expect that there will be any emotional risks involved with this study. However, if you feel as though you need the support of a counsellor following participation in the study, please feel free to contact the researcher, Janet Wheeler, telephone xxxx xxx xxx. If you need an interpreter to talk to us, please contact the Telephone Interpreter Service, xxxxxx, and ask them to contact us by telephoning the names and numbers listed on page 2 of this information sheet.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or except as required by law. If you give us your permission by signing the consent form, we plan to present the results at a national or international midwifery conference and publish articles in Midwifery journals. Results will describe midwifery clinical practice when attempting to reduce the incidence of perineal trauma during the second stage of labour and birth, for Asian women. Research findings may provide a much clearer picture of best practice principles and have broad implications for midwifery clinical practice for reducing perineal trauma for Asian women, experiencing a spontaneous vaginal birth.

In any publication, information will be provided in such a way that you cannot be identified.

SUBJECT INFORMATION - PREGNANT WOMAN (continued)

(Midwives' practices and perineal trauma in Asian women experiencing spontaneous vaginal birth.)

It is not anticipated that you will incur any additional costs if you participate in this study. There is no cost to you for any tests specifically related to this research study. You will not receive any payment for participation in this study.

Your decision whether or not to participate will not prejudice your present or future treatment or your relationship with Sydney South West Area Health Service or any other institution cooperating in this study or any person treating you. If you decide to participate, you are free to withdraw your consent and to discontinue your participation at any time without prejudice.

If you have any questions, please feel free to ask us. If you have any additional questions later, please contact:

- your study researcher, Janet Wheeler, xxxx xxx xxx,
- Chief Investigator and Supervisor, Professor Pat Brodie, telephone xxxx xxxx, postal address: Faculty of Nursing , Midwifery & Health, City Campus, UTS, PO Box 123, Broadway, Sydney, NSW, 2007, or
- UTS Research Ethics Officer, telephone 9514 9615, email: researchethics@uts.edu.au,

If you need an interpreter to talk to us, please contact the Telephone Interpreter Service xxxxxx and ask them to contact us by telephoning the names and numbers listed above

You are making a decision whether or not to participate. Your signature on the consent form indicates that, having read the information provided above, you have decided to participate.

Complaints may be directed to the Ethics Secretariat (xxxx), SSWAHS Area Health Service, (Address, telephone numbers, fax and email address) and UTS Research Ethics Officer, telephone: 9514 9615, email: researchethics@uts.edu.au

You will be given a copy of this form to keep.

APPENDIX 3: STUDY CONSENT (WOMAN)

SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

Project No:.....

CONSENT FORM-PREGNANT WOMAN

Midwives' practices and perineal trauma in
Asian women experiencing spontaneous vaginal birth.

1. I, ... of .... , aged .....years, agree to participate as a subject in the study described in the subject information statement set out above.

2. I acknowledge that I have read the Subject Information Statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

3. Before signing this Consent Form, I have been given the opportunity to ask any questions relating to any possible physical and mental harm I might suffer as a result of my participation. I have received satisfactory answers to any questions that I have asked.

4. My decision whether or not to participate will not prejudice my present or future treatment or my relationship with Sydney South West Area Health Service or any other institution cooperating in this study or any person treating me. If I decide to participate, I am free to withdraw my consent and to discontinue my participation at any time without prejudice.

5. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

6. I understand that if I have any questions relating to my participation in this research, I may contact the study researcher, Janet Wheeler, on telephone xxxx xxx xxx, who will be happy to answer them.

7. I acknowledge receipt of a copy of this Consent Form and the Subject Information Statement.

Complaints may be directed to the Ethics Secretariat (xxxx), Sydney South West Area Health Service, (xxxx Address, contact telephone numbers and email address).

Signature of subject _____ Signature of witness _____

Please PRINT name _____ Please PRINT name _____

Date _____ Date _____

Signature(s) of investigator(s) _____

Please PRINT Name _____
Date:

APPENDIX 4: STUDY INFORMATION (MIDWIFE)

SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

SUBJECT INFORMATION - MIDWIFE

Midwives' practices and perineal trauma in Asian women experiencing spontaneous vaginal birth.

You are invited to participate in a study that will focus on understanding what midwives do to reduce perineal trauma for Asian women during the second stage of labour and birth. Severe perineal trauma following vaginal birth can lead to short and long term problems for quality of life and wellbeing (Sultan & Thakar, 2002). Therefore, it is important to try and stop this severe trauma from happening. Asian women have an increased risk for this childbirth complication (Dahlen, Ryan & Homer, 2007).

We hope to learn about midwifery clinical practice and what influences the incidence of perineal trauma, for Asian women, during the second stage of labour and birth. This study aims to develop recommendations for best practice principles for midwifery clinical practice during the second stage of labour and birth, in order to reduce the incidence of severe perineal trauma for Asian women.

The researcher, Janet Wheeler, is a postgraduate doctoral research student at the University of Technology, Sydney (UTS). Professor Pat Brodie, is the chief investigator of this study and supervisor of the student researcher.

You were selected as a possible participant in this study because you are a midwife who is working in a Delivery Suite.

If you decide to participate, the researcher will observe and listen to what happens in the birthing room when you provide care during labour and birth for a woman of Asian origin. The researcher will write down things they see or hear in the birthing room. It is estimated that the length of time observation will occur is between 2 to 3 hours.

Interviews will be conducted by the researcher with individual midwives as soon as possible following the birth. The interviews will be recorded by the researcher. Focus groups on the research topic will be conducted by the researcher with Delivery Suite midwives. Data collection will be by audio recorder and note taking.

There is no reason to expect that there will be any emotional risks involved with this study. However, if you feel as though you need the support of a counsellor following participation in the study, please feel free to contact the researcher, Janet Wheeler, telephone xxxx xxx xxx.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or except as required by law. If you give us your permission by signing the consent form, we plan to present the results at a national or international midwifery conference and publish articles in Midwifery journals. Results will describe midwifery clinical practice when attempting to reduce the incidence of perineal trauma during the second stage of labour and birth, for Asian women. Research findings may provide a much clearer picture of best practice principles and have broad implications for midwifery clinical practice for reducing perineal trauma for Asian women, experiencing a spontaneous vaginal birth. In any publication, information will be provided in such a way that you cannot be identified.

SUBJECT INFORMATION - MIDWIFE (continued)

(Midwifes' practices and perineal trauma in Asian women experiencing spontaneous vaginal birth.)

It is not anticipated that you will incur any additional costs if you participate in this study. There is no cost to you for any tests specifically related to this research study. You will not receive any payment for participation in this study.

Your decision whether or not to participate will not prejudice your present or future relationship, work environment or status with Sydney South West Area Health Service or any other institution cooperating in this study. If you decide to participate, you are free to withdraw your consent and to discontinue your participation at any time without prejudice.

If you have any questions, please feel free to ask us. If you have any additional questions later, please contact:

- your study researcher, Janet Wheeler, xxxx xxx xxx,
- Chief Investigator and Supervisor, Professor Pat Brodie, telephone xxxx xxxx, postal address: Faculty of Nursing , Midwifery & Health, City Campus, UTS, PO Box 123, Broadway, Sydney, NSW, 2007, or
- UTS Research Ethics Officer, telephone 9514 9615, email: researchethics@uts.edu.au,

You are making a decision whether or not to participate. Your signature on the consent form indicates that, having read the information provided above, you have decided to participate.

Complaints may be directed to the Ethics Secretariat (xxxx), SSWAHS Area Health Service, (Address, telephone number, fax, and email address) and UTS Research Ethics Officer, telephone: 9514 9615, email: researchethics@uts.edu.au

You will be given a copy of this form to keep.

References:

Dahlen, H. G., Ryan, M., & Homer, C. (2007). An Australian prospective cohort study of risk factors for severe perineal trauma during childbirth [Electronic Version]. *Midwifery*, 23, 196-203. Retrieved 2007, June 5 from http://www.sciencedirect.com/science/journal/02666138.

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APPENDIX 5: STUDY CONSENT (MIDWIFE)

SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

Project No:.....

CONSENT FORM-MIDWIFE

Midwives' practices and perineal trauma in Asian women experiencing spontaneous vaginal birth.

1. I, ... of .....
.....
agree to participate as a subject in the study described in the subject information statement set out above.

2. I acknowledge that I have read the Subject Information Statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

3. I consent to audio taping of any interviews.

4. Before signing this Consent Form, I have been given the opportunity to ask any questions relating to any possible physical and mental harm I might suffer as a result of my participation. I have received satisfactory answers to any questions that I have asked.

5. My decision whether or not to participate will not prejudice my present or future relationship, work environment or status within Sydney South West Area Health Service or any other institution cooperating in this study. If I decide to participate, I am free to withdraw my consent and to discontinue my participation at any time without prejudice.

6. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

7. I understand that if I have any questions relating to my participation in this research, I may contact the study researcher, Janet Wheeler, on telephone xxxx xxx xxx, who will be happy to answer them.

8. I acknowledge receipt of a copy of this Consent Form and the Subject Information Statement.

Complaints may be directed to the Ethics Secretariat (xxxx), Sydney South West Area Health Service, (Address, telephone number, fax, email address) and UTS Research Ethics Officer, telephone: 9514 9615, email: researchethics@uts.edu.au

Signature of subject	_____	Signature of witness	_____
Please PRINT name	_____	Please PRINT name	_____
Date	_____	Date	_____

Signature(s) of investigator(s) _____

Please PRINT Name _____

Date: _____

APPENDIX 6: RESEARCH PARTICIPATION

(WOMAN) NOTIFICATION

THIS WOMAN WANTS TO PARTICIPATE IN THE [redacted] MATERNITY UNIT STUDY

(she has signed a consent form)

Please call Jan Wheeler
(any time of the day or night)
immediately on admission when this woman presents to Delivery Suite in labour:

Mob: [redacted]

Please ring any time - 24 hours a day, 7 days a week.
THANK YOU!

APPENDIX 7: OBSERVATIONAL TEMPLATE

Observational Template/Guide

Midwife No: **Woman No:** **Date:** **Start time:** **Finish time:**

Data Collection	Notes	Reflections
Emotional/Psychological Relationship between midwife/woman & support people □ Rapport □ Trust □ Communication Woman: □ In control □ Quiet □ Vocal □ Anxious/worried □ Distressed		
Aspects of labour Midwife instructions for pushing: □ What is said? □ How is it said? □ Type of pushing: involuntary/instructed/mixed Position in labour: □ standing, lateral, semi-recumbent, upright kneeling, all-fours, squatting, lithotomy, other. Place labouring: □ bed, shower, bath, toilet, floor, chair, other. Environment: □ Calm, tense, quiet, noisy, private, public. □ Midwife actively involved, distant, quiet, vocal, confident, indecisive, authoritative, intrusive. □ Partner/support person present. □ Partner/support person actively involved/not involved, encouraged/discouraged by midwife.		

Birth Elements of practice: □ Perineal massage □ Hot/cold compress □ Hands on/off the perineum □ Flexion/no flexion of fetal head □ Episiotomy □ Manual distension of vagina/perineum □ Other □ Extent of tear/intact Dialogue: □ What is said? □ How is it said? □ Slow, unrushed birth □ 1st stage commenced □ 2nd stage commenced □ Time of birth □ 3rd stage completed □ Other-describe		
Intuitive: What am I: □ Hearing. □ Thinking. □ Sensing. □ Feeling.		
Birth outcome **Mother:** □ Extent of perineal trauma □ Other genital trauma □ Third stage: active/physiological/retained placenta □ Perineal trauma assessed/sutured by midwife □ Other birth events **Baby:** □ Gestation □ Gender M/F □ Weight □ HC □ Skin to skin □ Apgars □ Resuscitation □ Method of feeding		

Demographic information **Woman:** □ Ethnicity □ Country of birth □ Not English speaking □ Height □ Booking Weight □ Parity □ Education □ Employment □ Age □ Length of time in Australia **Partner:** □ Ethnicity □ Country of birth □ Age □ Length of time in Australia		

APPENDIX 8: INTERVIEW GUIDE

INTERVIEW GUIDE
Prompts for the interviews

Beginning of the interview:
The purpose of these questions is to build rapport with the participant.

- How long have you worked in the Delivery Suite?
- How do you feel about your current position as a midwife in the Delivery Suite? What is it like?

Topic Area: Midwifery clinical practices.
The purpose here is to get the midwives to talk about their individual clinical practices and to identify what clinical practices they think reduces the incidence of perineal trauma.

- Can you describe what clinical practices you use when caring for women during the second stage of labour and birth?
- What do you do in the birthing room to help women have a normal second stage of labour and birth?
- Can you describe any clinical practices you use during labour and birth that may help minimise perineal trauma?
- What clinical practices do you think make a difference to the incidence of perineal trauma? Why?
- Are any clinical practices encouraged or discouraged in the Delivery Suite for example, hands on or off the perineum, performing an episiotomy, instructed pushing (directing the woman when and how to push)?

Topic Area: Effect of ethnicity.
The purpose here is to get the midwives to talk about their clinical practices when caring for Asian women during labour and birth.

- Could you describe your clinical practices when caring for women from different ethnic groups, in labour and birth?
- What about Asian women? What is going on when you care for these women compared to other women?
- Can you describe the behaviour of Asian women during the second stage of labour and birth?
- Do you find Asian support people make a difference to how the labour and birth progress? Could you describe why?

Topic Area: Incidence and severity of perineal trauma.
The purpose here is to get the midwife to draw a picture as to what affects perineal trauma in Asian women.
When caring for Asian women during the second stage of labour and birth:

- What do you think are the main causes of perineal trauma for Asian women?
- Do you have certain expectations as to what will occur to the perineum during birth of the baby? Why?
- Do you think there is a difference of outcome for perineal trauma between Asian women, depending on their country of birth or ethnic origin? Could you please explain?

- Do you think it makes a difference to perineal trauma if the woman cannot speak fluent English? Why?
- Do you think Asian women have an increased incidence of perineal trauma? Why?

Close of interview:
Thank the midwife and provide an opportunity to suggest anything else they think may influence perineal trauma in the second stage of labour and birth for Asian women, or to make any other comments on this topic.

Invite the midwife to contact me if they think of anything else after the interview.

(Information below would be on a single page. This is information would be collected from the midwife being interviewed)

Midwife

Interview Date:

1. Country of birth: …….....
2. Ethnicity: ……
3. Is English your first language? Yes / No (please circle)
4. What other languages do you speak? ……..
5. How long have you been practicing Midwifery? ……
6. Did you train to become a Midwife in Australia? Yes / No
7. If "no" to question 6, where did you train to become a Midwife? ……..
8. How long have you worked in the Delivery Suite at xxxx Hospital? ……

Thank you for answering these questions. Your support for this study is really appreciated.

APPENDIX 9: AHS HUMAN RESEARCH ETHICS COMMITTEE APPROVAL

SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

Human Research Ethics Committee [redacted]
[redacted]
Phone: [redacted]
Facsimile: [redacted]

January 21, 2008

Ms Janet Wheeler
Maternity Unit
[redacted]

Dear Ms Wheeler,

Project No **2007/140 - Midwifery Clinical Practice Interventions and Perineal Trauma in Asian Women Experiencing Spontaneous Vaginal Birth**

The SSWAHS Human Research Ethics Committee wishes to acknowledge receipt of your correspondence with regards to the above project.

As all of the issues raised by the Committee have now been satisfactorily addressed, formal approval is hereby granted for this study to proceed as a Category A Project. The committee has approved the following documentation:

- Consent Form – Midwife – Version 3.1 [redacted] Hospital, SSWAHS, 14/1/08
- Subject Information – Midwife – Version 3.1 [redacted] Hospital, SSWAHS, 14/1/08
- Consent Form – Pregnant Woman – Version 3.1 [redacted] Hospital, SSWAHS, 14/1/08
- Subject Information – Pregnant Women – Version 3.1 [redacted] Hospital, SSWAHS, 14/1/08

Ethics clearance is granted for periods of up to twelve months. This project will be due for renewal on 30th November, 2008 and you must provide a Progress Report (attached) or final report by this date. If no report is supplied, ethics clearance for this project may be cancelled.

Your attention is drawn to the attached document *Guidelines for Investigators* which sets out not only the principles under which research should be conducted, but also **the conditions under which Ethics approval is granted by the Committee**. Also enclosed for your information, is a copy of the document *Guidelines for Responsible Practice in Research and Dealing with Problems of Research Misconduct*.

Please note that the Committee must be notified **IMMEDIATELY** of any untoward or unexpected complications or side affects arising during the project or of any ethical or medico-legal problems that may arise. Also, any changes to the original protocol must be submitted to the Committee for approval.

Would you please quote the above project number in all future correspondence relating to this project.

Yours sincerely,
Production Note:
Signature removed prior to publication.

PROFESSOR MICHAEL FROMMER
Chairperson
SSWAHS Human Research Ethics Committee

For: Mr Mike Wallace
Chief Executive, SSWAHS

Category A: Projects with limited risk potential, including quality assurance surveys.
Category B: Projects with significant patient risks.
Category C: Drug trials (international/national) sponsored by drug companies and already covered for risk evaluation and monitoring of adverse reactions.

APPENDIX 10: UTS HUMAN RESEARCH ETHICS COMMITTEE APPROVAL

17 March 2008

Professor Pat Brodie
CB10.07.209
Faculty of Nursing, Midwifery and Health
UNIVERSITY OF TECHNOLOGY, SYDNEY

Dear Pat,

UTS HREC REF NO 2008-72 – BRODIE, Professor Pat, HOMER, Professor Caroline, (for WHEELER, Ms Janet, Doctor of Midwifery student) - "Midwifery clinical practice interventions and perineal trauma in Asian women experiencing spontaneous vaginal birth" [*External Ratification: Human Research Ethics Committee [redacted] HREC approval: 2007/140, period of approval November 2008].*

At its meeting held on 11/03/2008, the UTS Human Research Ethics Committee considered the above application, and I am pleased to inform you that your external ethics clearance has been ratified.

Your UTS clearance number is UTS HREC REF NO. 2008-72R

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 02 9514 9615.

Yours sincerely,

Dr Chris Zaslawsk
Acting Chairperson,
UTS Human Research Ethics Committee